A Review of the Regulation and Oversight of Assisted Living Residences in the State of Rhode Island

A Report to Governor Donald Carcieri

Submitted December, 2005

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TABLE OF CONTENTS

Executive Summary

In June 2005, Governor Donald Carcieri called upon the Rhode Island Office of Health and Human Services and its managing director, Jane Hayward, to conduct a comprehensive review of the State's assisted living system with the goal of ensuring the safety of the nearly 3,500 residents statewide as well as their access to quality care and services. The review included the close examination of the State's role in the regulation and oversight of the 68 assisted living residences operating in Rhode Island.

The review found that, for the most part, the assisted living system in the State today is an appropriate and safe supportive housing option, particularly for the elderly, which represent the majority of the 3,500 Rhode Islanders living in this type of supportive housing setting.

Preface

The review was precipitated by a tragic event at the Beechwood Assisted Living in Central Falls, involving the death of a resident and the assault of an employee, both allegedly at the hands of another resident. The Beechwood incident caught many Rhode Islanders off-guard. Not only were such violent acts in the assisted living setting unexpected, but the victim who was murdered and her alleged assailant did not fit the public's image of a typical assisted living resident: both were well under age 65 and needed supportive housing as a result of serious physical and behavioral health disabilities.

Additionally, news accounts suggested that the Beechwood residence was falling into disrepair, riddled with safety risks, and struggling to provide even the bare bones services required for assisted living licensure in Rhode Island. With this information in mind, the OHHS commenced its review and sought to identify ways the State could use its existing authority to prevent similar tragedies from occurring in the future.

The initial focus of the review was the assisted living industry in Rhode Island today and the State's process for licensing residences and assuring compliance with the minimum safety and service standards established in State law, as specified in existing Department of Health regulations. Once the review began, it quickly became clear that the assisted living industry and the State's role defy easy categorization. At present, the industry encompasses a diverse array of licensed residences that differ significantly, not only in the type of living arrangements they offer and the scope of services they provide, but in the fees they charge as well.

The State's responsibilities proved to be equally multifaceted. In addition to oversight of licensed residences, the State provides subsidies to nearly one-quarter of all assisted living residents and is now one of the industry's principal payers. In reviewing the Beechwood incident in this broader context, several important findings emerged.

Findings in Brief

In Rhode Island, the term assisted living applies to a licensed residential care setting providing supportive services. Although usually thought of primarily as a living environment for seniors with functional limitations, it has become a housing option for adults with disabilities under age 65 as well.

The assisted living industry has evolved on parallel tracks that reflect the segmentation in the populations it serves. One of the principal challenges the State faces is assuring that residences on both tracks have the capacity to provide both appropriate services and a safe living environment.

On the market driven track are the residences widely recognized by the general public as a housing option for elders requiring some assistance with personal care, meals, and social activity. These residences offer living accommodations, services and amenities to meet almost any preference or need.

About two-thirds of the residences licensed in the State today are in the market-driven segment of the industry. The typical resident is white, female and between the ages of 85 and 94. She privately pays the residence fee, which averages $2,688/month in the Providence market, and any additional charges for special amenities and services she receives. Her residence includes fifty living units or more and may resemble and function like a high-end hotel or an apartment complex.

For the overwhelming majority of residents today, most of whom are elderly and live in this market-driven segment of the industry, assisted living is an appropriate and safe supportive housing option. During the review, we did find areas where the State, the industry and many of these residences could do a better job for the people they serve, particularly with respect to disclosing information, conducting assessments, and planning and coordinating services. Overall, however, we concluded that the quality of services and the living environment in the assisted living residences on the market track are consistent with the image that the industry projects and with the expectations of seniors, their families and the general public.

The assisted living residences that have evolved on the second track differ significantly from their market-driven counterparts, though required by State law and regulations to meet the same standards for licensure. This segment of the industry emerged largely to fill the gap in affordable supportive housing for low-income seniors and adults with disabilities, rather than respond to market driven demands. Today, they cater almost exclusively to the growing number of low-income individuals under age 65 who have chronic and disabling physical and/or behavioral health conditions and rely on public subsidy to cover all or some portion of their monthly living costs.

As the population they serve has limited income and resources, residences on this track often operate at the financial margins. Though they differ, most provide the minimum level of services required for assisted living licensure and offer modest living accommodations and few amenities. The one feature all of these residences share is they are not market-driven, profit-making enterprises. Rather, the residences on this track are needs-driven.

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Currently, about 22 of the 68 licensed residences in the State fall into this needs-driven segment of the industry. The typical resident is 58 years old and has both a physical and behavioral health-related disability. He is eligible for Supplemental Security Income (SSI) payments and a special supplement for assisted living totaling up to $1154/month, nearly all of which goes toward payment to the assisted living residence for room, board, and services. This amount is less than half of the average monthly payment for the market-driven residence in Providence, noted above, that accepts mostly private pay residents. He lives in a residence with fewer than thirty other individuals, most of which are also under age 65, and shares a room.

For the many of the individuals living in the residences on the needs-driven track, assisted living is not a choice; rather it is the only available housing option. Although we found residences on this track that offer high quality services in a environment with minimal risks, we also found many that do not have the capacity to routinely provide the appropriate level of service coordination, trained staff, or safeguards.

As the subsidies the State provides to residents living in the needs-driven segment of the industry have grown over the last decade, so too has its leverage as the primary payer for the services provided to them. The Department of Human Services, the Department of Elderly Affairs, the Department of Mental Health, Retardation and Hospitals and, to a limited extent, the Department of Corrections, all have varying degrees of responsibility for deciding who receives subsidies and how they are paid. Along with the Department of Health, these State agencies are thus integral players in the State's oversight and financing system for assisted living.

In reviewing the Beechwood incident in the context of this system, we found an array of inadequacies stemming primarily from the under-utilization of the State's licensing authority and financial leverage. Among the most notable of these inadequacies are the general lack of interagency coordination, insufficient access to public information and inefficient use of available resources as well limited supportive housing alternatives statewide. We also found a number of areas where the industry and individual residences have fallen short, including with respect to the scope assessments, staff training, service coordination and risk monitoring. We have proposed a series of recommendations in this report designed to address these inadequacies and to raise the bar for assisted living in the areas of services, safety, and transparency.

Review Process

At the request of Governor Carcieri, the OHHS conducted a thorough examination of the assisted living system in Rhode Island. This process included:

- A state-by-state review of assisted living regulations and financing policies in this country;
- The examination of current policies in Rhode Island that affect assisted living residences, including State law, regulations, screening and assessment protocols used by state agencies, and state-subsidized options for housing with services;
- An in-person tour of nine assisted living residences by OHHS Managing Director Jane Hayward and others, including one that specializes in HIV/AIDS care, a special care unit for residents with dementia, several closely affiliated with nursing facilities, and a number of facilities that serve a younger population with substance abuse issues, mental or behavioral health issues.
- Input from assisted living stakeholders, including General Assembly staff and representatives, the AARP, the Alzheimer's Association of Rhode Island, the state long term care ombudsman, the Rhode Island Assisted Living Association, the Rhode Island Council of Community Mental Health Organizations, the state's mental health advocate, the Department of Elderly Affairs, the Department of Human Services, the Department of Corrections, the Department of Health, and the Department of Mental Health, Retardation, and Hospitals; and
- Two industry-wide, stakeholder meetings.

Over the span of several months, information was gathered and evaluated. That evaluation has been completed and what follows includes an overview of the workings of the assisted living system in our State, specific findings relating to resident safety, resident assessments and oversight and regulation, as well as recommendations for improving the system to enhance the safety and well-being of all residents. The findings and recommendations contained in this report support the following basic objectives:

- Assure the state fully exercises its licensing authority and financial leverage to promote safe and appropriate care in assisted living residences.
- Improve resident screening and assessments to ensure that all assisted living residents are comprehensively evaluated to determine their specific care needs, identify and address any potential safety and health risks, and inform decisions about whether an assisted living residence is an appropriate service setting at admission and periodically thereafter.
- Ensure that the under 65 population with disabling chronic and disabling physical and/or behavioral health conditions have access to appropriate specialized services to meet their service needs.
- Improve consumer information to provide prospective and current assisted living residents with information to make informed choices about their care.
- Enhance care coordination in general to assure that assisted living residences coordinate a range of services to meet each resident's needs.

- Strengthen the oversight of assisted living residences to protect the safety of residents and to assure access to quality care.
- Address financing concerns to make long-term policy changes which improve future options for assisted living services for more Rhode Islanders, including the lowest income frail elders and adults with disabilities.

By considering the specific findings in this report and juxtaposing them over these goals and objectives, a series of recommendations addressing a number of issues including resident safety, transparency of information, licensure and staffing, coordination of services, evaluating and assessing residents, and public financing have emerged. The recommendations are broken into three distinct groups: those that will be implemented immediately; those that should be achievable in the short term (within six months); and, those that would require a longer period of time (one year) in order to implement.

Recommendations

Immediate

The immediate implementation of these recommendations will help to ensure the safety of current assisted living residents.

- Exclude convicted felons on probation or parole who are subject to electronic monitoring from residing within assisted living residences.
- Fully implement and continuously monitor recently developed Department of Corrections (DOC) protocols strengthening oversight of and the exchange of information about individuals on probation and parole that are residing in the assisted living setting.
- The Department of Human Services and the Department of Elderly Affairs should use their joint authority under current law to establish a new and permanent certification process specifically for licensed assisted living residences now admitting public pay recipients receiving SSI by March 1, 2006.

Short Term

The implementation of these recommendations within six months by the Department of Health and the OHHS will ensure that revised regulations for licensing assisted living residences are proposed to ensure that assisted living is an appropriate setting for all who reside there*:*

- Require licensed residences to use a standardized comprehensive screening instrument that covers cognitive, behavioral health and functional impairments both prior to admission and at six-month intervals.

- Require licensed health care providers and facilities making referrals to assisted living residences to disclose in writing all available information about the health status of prospective residents to the full extent confidentiality and privacy laws allow.
- Reduce the required 30 days of notice before discharging an assisted living resident to 14 days notice when a resident violates the residence's policies related to behavior and adherence to care plans.
- Require that licensed residences use a standardized form to disclose key information to consumers, such as services and costs; criteria for admission, discharge, and continued stay; and any particular types of residents or specialized populations the residence admits or serves. To assure consumers have ready access to the information on the form, the Department of Health should also make a summary available at a single location on its website.
- The authorizing statute for the SSI-D program, §R.I.G.L 40-6-27, should be amended to provide the State with the flexibility permitted under federal law to expand the supportive housing options covered under SSI-D, by July 1, 2006.

In order to enhance the coordination of care and/or services for all residents, the Department of Health should revise regulation to:

- Require assisted living residences to provide service coordination.
- Strengthen training requirements and continue education requirements for all assisted living staff, including Administrators.

The Department of Health should further revise regulations to enhance the oversight of the assisted living system in Rhode Island. Related recommendations include:

- Mandate the notification to assisted living residents about the State Long-Term Care Ombudsman to include an expanded explanation of the Ombudsman's role and responsibilities in protecting their rights and advocating on their behalf.
- Develop, with input from other OHHS agencies, the requirements for a new level or sub-category of licensure for residences serving individuals who have needs that extend beyond personal care assistance due to a condition or impairment requiring specialized services or living arrangements.
- Take the appropriate legal steps required to adopt whistle-blower protection for staff, residents, and family members who report problems about assisted living residences to a government agency (in addition to existing protection for reporting to the Ombudsman).

Within six months, the OHHS should implement the following recommendations that address public financing for assisted living to improve future options for all Rhode Islanders including the lowest income frail elders and adults with disabilities:

- Lead an interagency effort to designate a single point for screening and assessing the eligibility of public pay applicants, and adopt joint administrative rules that establish and standardize the procedures for the screening and assessment process and ensure that the rights of applicants are protected and observed.
- Submit a report to the Governor that compares the cost and effectiveness of providing publicly financed services to adults with disabilities in assisted living versus other residential settings with capacity to offer a comparable array of community-based services and supports.

Long Term

Within one year, the Department of Health should implement the following recommendations that increase consumer options and continuity in Rhode Island's system of long-term care:

- Permit continued stay for established residents who have a need for and access to skilled nursing care delivered by an agency (e.g., home health care agency) independent from assisted living administration and staff.
- Strengthen and broaden the staffing and service requirements for licensed residences that have a dementia level of licensure.
- Prepare legislation that adds assisted living residences that have at least one full-time registered nurse on staff to the list of settings in which Nursing Assistants are authorized to practice. In addition, the Department should revise its regulations to include assisted living residences as a setting in which Nursing Assistants may demonstrate continued employment for purposes of renewing their certification.
- Develop standards for the oversight of medication administration aides as well as a statewide registry identifying, at a minimum, the date of certification.
- Develop a more "resident centered approach" for ensuring licensed residences comply with regulations and provide appropriate services as well as a safe living environment.

Within one year, the OHHS should implement the following to ensure that assisted living placements are appropriate and that financing for supportive housing options are addressed:

- Adopt a standardized, and easy to administer assessment tool with the capacity to be used across long-term care settings.
- Lead an interagency effort focusing on adopting or developing payment options that are more responsive to the variable needs and service

requirements of public pay residents and the licensed residences where they live, including modifications to the State-funded Supplemental Security Income enhanced payment for assisted living (SSI-D).

- Convene an interdepartmental workgroup to develop a plan to ensure the State utilizes all of the available sources of funding for assisted living.

Conclusion

Overall, assisted living in Rhode Island is an appropriate and safe supportive housing option, for the elderly population in particular. The changes recommended in this report reflect Rhode Island's long-standing commitment to protect the health and safety of its citizens and, once implemented, will ensure that both the State and the industry have the capacity to address the inadequacies in the assisted living system found during the course of this review, particularly those affecting the vulnerable population of adults with disabilities under age 65.

Specifically providing residents, staff and regulators with the tools to make informed decisions, conduct thorough assessments, develop appropriate care plans and effectively coordinate services, will improve the quality and safety of the environment in assisted living residences industry-wide. Similarly, developing licensure and payment standards that recognize the differences in residences and the populations they serve will enhance the State's capacity to provide effective oversight and assure greater accountability.

The goal of these recommendations is to institute a series of policies and procedural safeguards that will have a wide-ranging and positive impact on the status of the assisted living industry in Rhode Island – an impact that will make tragedies like the one at Beechwood far less likely to occur in the future.

PART I

OVERVIEW OF ASSISTED LIVING

Introduction

The State law establishing licensed assisted living residences was initially enacted in 1981. At that time, assisted living was just emerging as an alternative to nursing home care for relatively healthy and affluent seniors who could no longer live on their own without supportive services. Over the next decade, assisted living was successfully marketed as the living arrangement of choice for the elderly during the phase between living at home and in a skilled nursing facility. More recently, assisted living has also become a housing option for a small but growing number of adults under the age of 65 who have physical and/or behavioral health-related disabilities. In an effort to keep pace with the expansions in the industry and the population it serves, the State law was revised and re-titled as the Assisted Living Residence Licensing Act (R.I.G.L. 23-17.4) in 2001.

The Act delegates the responsibility for licensing and regulating assisted living residences to the Department of Health. The department has adopted rules and regulations establishing the minimum standards for licensure in such areas as ownership and management, staffing levels and qualifications, assessments and care planning, service coordination and delivery, and resident safety and rights. In addition, the Act affords the department the discretion to create levels of licensure to distinguish between residences with the capacity to offer additional or specialize services to higher-need populations. [1] Assisted living residences opting to admit residents with dementia must meet the minimum requirements for licensure as well as higher standards related to staffing and safety.

By law, the Department of Health is also responsible for ensuring that licensed assisted living residences operate safely and in accordance with State law, rules, and regulations. Given the nature of the assisted living industry in the State, fulfilling this enforcement role is a challenge. For example, there are currently 68 licensed assisted living residences in Rhode Island with the capacity to house about 3,500 people. They vary in size from 14 to 177 beds and charge monthly fees that range from $1,100 to $4,000 or more, depending on the specialized services and amenities they provide. Although each of these residences was required to meet the same set of standards for licensure, they range in locations and accommodations from water-view resort to urban homeless shelter. In short, every licensed assisted living residence in the State is in some sense unique.

The financial and service needs of the populations licensed assisted living residences serve are just as diverse. One of the key defining features of assisted living is the varied ways residents pay for services, room, and board. As has long been the case, the majority of residents are elderly and pay for assisted living services with their own resources – referred throughout this report as “private pay” residents. Over the last five years, there has been a significant increase in “public pay” residents -- both seniors and adults with disabilities -- who receive government subsidies covering some or all of the monthly costs for assisted living.

[1] One levels of licensure signifies whether the physical structure of a residence is safe (F1) or ill-suited (F2) for a resident who may be incapable of self-preservation in a fire. Another level of licensure identifies whether a residence employees personnel appropriate to administer medications (M1) or assist residents who take medications on their own (M2). Assisted living residences opting to admit residents with dementia must meet the criteria for both the F1 and M1 classifications as well as several other added requirements.

The State's process for providing financial support to public pay residents poses its own unique set of challenges. At present, the State uses two financing mechanisms to support low-income residents: the State-funded enhancement to Supplemental Security Income (SSI) for people living in licensed residences (referred to here as SSI-D) and two Medicaid Section 1915 (c) Home and Community Based Service Waivers -- the Home and Community Services (HCS) waiver and the Rhode Island Housing and Mortgage Finance Corporation (RIHMFC) waiver, both of which are jointly funded by the federal and State government. The Department of Elderly Affairs (DEA) administers both waivers and assesses public pay applicants to determine whether they meet the eligibility requirements for each form of assistance. Additionally, public pay residents may qualify for Medicaid coverage of medical and health care services that are not available in the assisted living setting or covered by one of the waivers – e.g., prescription medications, primary and acute care services, etc.

Under the State's complex financing scheme, a resident receiving public subsidy for assisted living may qualify for SSI-D cash support only, both SSI-D cash and one of the waivers, or waiver support only. The type of financial support residents receive often affects the range and type of assisted living settings open to them as well as the service capacity of the residences.

As this overview suggests, the assisted living industry in Rhode Island defies easy description. The distinguishing characteristic, to the extent that there is one, is the great variation that exists in the living arrangements, scope of services, and range of amenities offered by licensed assisted living residences in the State. This variation can be traced to two inter-related factors: (1) law and regulations that grant assisted living residences wide latitude in defining the services they provide and populations they serve; and (2) the segmentation that has occurred within the industry that is due, in part, to whether residences have the resources to re-define and/or remake themselves in response to market forces.

What is Assisted Living in Rhode Island?

In Rhode Island, as in many other states, the term assisted living is used to describe a licensed residential care setting providing supportive services. To clarify what the term actually means, we looked at current law, regulations and industry practices and spoke with a variety of stakeholders. This process revealed that, at present, there is no clear consensus about what assisted living is or should be. There is, however, strong agreement and the statutory language to back it up, about what assisted living excludes.

For example, the Assisted Living Residence Licensing Act establishes quite clearly that a residence is not a health facility or care establishment licensed by any State agency under any other name. The implication is that any supportive living arrangement that provides assisted living services -- defined in statute as lodging, two meals a day, and personal care assistance -- and is not explicitly excluded in the statute, is or could be a licensed assisted living residence.[2]

[2] By law, the term assisted living residence excludes: any health care facilities licensed by the Department of Health (e.g., skilled nursing facilities) as well as any *establishment and facilities* licensed by the Department of Mental Health, Retardation and Hospitals (e.g., residential homes for individuals with mental health and development disabilities), the Department of Children, Youth and Families (e.g., group homes), or any other State agency.

Similarly, the boundaries of the "social" model of services that assisted living provides have been largely dictated by the statutory provisions explicitly prohibiting residences from providing the level of care typically associated with a medical model -- i.e., medical or skilled nursing services routinely offered by health facilities.[3]

Thus, the law has allowed residences to define themselves, and has led to confusion about the distinctions between assisted living residences and health facilities, both as discrete service systems and integral components of a continuum of care. It has also made it difficult to address several of the critical questions facing the industry today about the services different types of residences can legitimately and appropriately provide.

How the Assisted Living Industry Evolved?

One of the causes and consequences of the ambiguity about assisted living is the segmentation of the industry. Indeed, over the last twenty years, the industry has evolved on two distinct tracks – one driven by market forces and the other in response to the lack of supportive housing options for low-income seniors and adults with physical and behavioral health disabilities who rely on public subsidies and assistance.

On the market track, there is the growing array of assisted living residences that primarily serve the elderly. As most seniors privately pay for assisted living, they have the advantage of choosing among residences that offer a wide variety of amenities. Consequently, assisted living residences in this category are as diverse as the preferences of the people they serve. For example, some of these residences look and operate like high-end hotels or retirement communities; others provide a more modest living environment and resemble a moderately priced apartment complex.

Although they vary in size, living environment, and amenities, all the assisted living residences that are shaped by market forces function much like any other business seeking to thrive in a competitive market place: they are responsive to resident demands and expectations, as well as to the bottom line. When State policy-makers crafted the initial statute establishing assisted living licensure, assisted living residences on this market-driven track are probably what they had in mind.

In contrast to the majority of assisted living residences that are market-driven, there is the group of residences that have evolved to fill a housing need for low-income residents that receive public subsidy to live in assisted living. As noted earlier, though some of the individuals living in these residences are elderly, most are adults with disabilities under the age of 65 who have behavioral health and/or physically disabling conditions. For many of these residents, assisted living is not necessarily the preferred or best option. Often, it is both the only supportive housing available and the sole alternative to living in a shelter or on the streets.

Assisted living residences in this category also differ in size and living environment. The smaller congregate housing residences with a capacity of 25 residents or less, like Beechwood Senior Living, often have the look and feel of a bed and breakfast, a fraternity house, or a shelter.

[3] The provisions defining *assisted living resident* in R.I.G.L § 23-17.4-2 state: "Resident means an individual not requiring medical or nursing care as provided in a health care facility but who as a result of choice and/or physical or mental limitation requires personal assistance, lodging and meals and may require the administration of medication."

As they derive most of their income from public pay residents with few private resources, these residences offer few amenities or "extras."

Most, like the people they serve, function at the financial margins. Despite their differences, the one feature they all have in common is that, by and large, they are not profit making enterprises. They exist largely to fill the gap in affordable supportive housing for low-income seniors and adults with disabilities, rather than respond to market driven demands. These residences are largely hidden from the public's eye, and thus rarely identified as licensed assisted living residences. As is explained at greater length in the next part of this report, it is in these residences where individuals with the most complex needs live - - i.e., non-elderly with disabilities - - and where the scope and quality of service coordination differs the most.

Contextual Changes Affecting the Industry

The segmentation of the assisted living industry and uncertainty about its role did not develop in a vacuum. Over the last twenty years, changes in both the population it serves and in government policy and priorities have had a significant impact on the way the industry has developed. Among the most influential are the following:

- *Demographic Shifts*. As the proportion of the State's population over age 65 has increased, the market expanded for supportive residential living arrangements for relatively affluent and healthy seniors seeking to retain as much of their independence as possible.
- *Additional Medicaid Coverage Options*. To offset the rapid rise in the cost and utilization of institutionally-based long term care, the federal government established the Section 1915(c) Home and Community Based Services (HCBS) waiver program, allowing states to offer Medicaid services to low-income seniors and adults with disabilities living in the community who might otherwise require more expensive institutional care. As assisted living is considered a community-based services setting, it is a service option covered under HCBS waivers. Rhode Island currently has two HCBS waivers.[4]
- *Changes in State Policy*. The State created a service vacuum in the mid-1980s when intermediate care facilities (ICFs) were eliminated by the State as a class of licensed, regulated, and reimbursable health providers. Thereafter, many facilities that were once ICFs, congregate housing operations, or board and shelter care homes sought licensure as assisted living if they did not meet the State's standards for licensure as health facilities.
- *Expansions in State Funding*. In the early-1980's, the State created a supplement to the federal SSI payment for eligible individuals residing in the assisted living setting. Since 1998, when changes were made in the authorizing statute, State contributions to this program have doubled. This SSI policy, along with recent expansions in eligibility for coverage under the HCBS waivers, have resulted in a sharp rise in the number of assisted living residents receiving public subsidies – from about 400 in 1997 to 931 today.
- *Resource Constraints.* As the demand for supportive residential living arrangements has gone up, the supply of alternatives to assisted living has not increased apace, especially for non-elderly adults with disabilities who have little or no income. Over the last several

[4] The State obtained approval for its first HCBS waiver applicable to assisted living in 1990s – the Department of Elderly Affairs' Home and Community Services Waiver. The State received federal approval for a second HCBS waiver in 1990s as well, as part of a Rhode Island Housing and Mortgage Financing Corporation (RIHMFC) demonstration project to increase affordable supportive housing options for the elderly.

years, persistent budget shortfalls at both the national and state level have restricted and/or cut the public funds available to finance existing and develop new residential care options that serve individuals with specific types of disabilities (e.g., physical or behavioral health) or characteristics (e.g., history of substance abuse or violence).

Taken together, these important changes provide the context for the assisted living industry's growth and development. Indeed, all have to some degree reinforced the trends segmenting the industry and contributed to the uncertainty about the appropriate role of assisted living in the continuum of housing, residential services, and health care.

In the sections of the report that follow, we review key issues in assisted living and explore at greater length the implications of the factors and trends outlined for the industry and the people it serves as well as for the State in its dual role as overseer and payer.

Part II of the report presents our findings in four general areas: the assisted living population today; the licensure and oversight of residences; the assessment process used by the State and the industry; and the State's system for providing financial support for assisted living residents.

PART II

FINDINGS - ASSISTED LIVING IN RHODE ISLAND TODAY

Introduction

This section of the report presents a portrait of the assisted living industry today focusing on the findings of our review that warrant the attention of stakeholders and State policymakers. For the sake of clarity, critical findings and issues have been summarized in text boxes throughout this portion of the report

SECTION 1
The Assisted Living Population: Who they are and where they live?

The number of public pay residents has grown significantly in recent years and now constitutes the most diverse segment of the assisted living population.

The assisted living population in Rhode Island reflects and reinforces the segmentation of the assisted living industry into market-driven and needs-driven groups of residences.

As indicated in Figure 1, the majority of assisted living residents are private or self-pay. However, the number of public pay residents – both elderly and adults with disabilities – has been increasing in recent years. As indicated earlier, public pay residents may be receiving the State supplement to SSI (SSI-D) only, SSI-D and support through one of the waivers, or waiver support only. Since 1997 the number of public pay residents receiving SSI-D alone or in conjunction with one of the waivers has more than doubled, from 373 to a high of 895 today. When the waiver only public pay residents are added to the mix, the overall total rises to 931. As of September 1, 2005, about 618 of the public pay residents were SSI-D only, 277 were SSI-D and waiver supported and 36 residents were waiver only. [5]

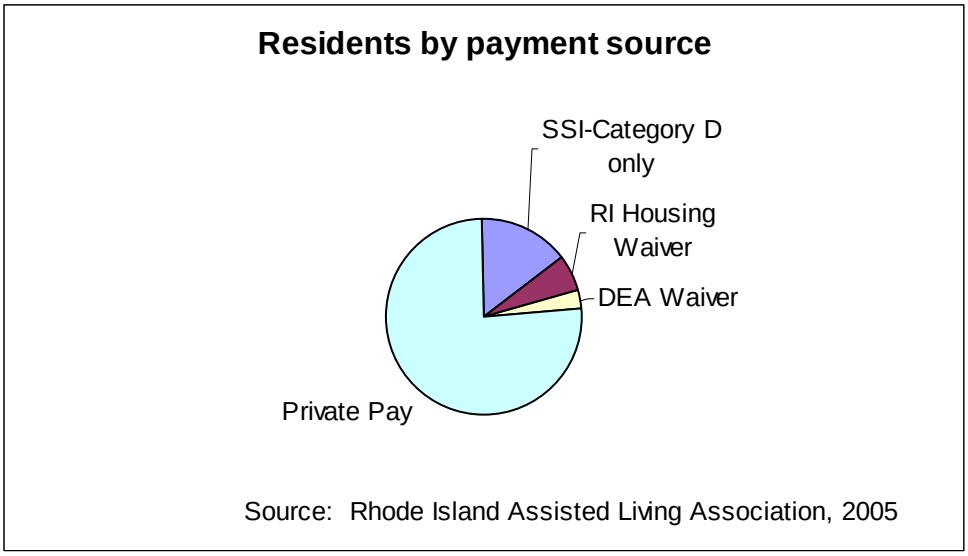
According to industry sources,[6] assisted living residences statewide are typically filled to 90% of total capacity. Given this occupancy rate, of the 3,150 beds filled on September 1, 2005, close to 30% of all assisted living residences were public pay.[7]

[5] Based on data compiled by the DHS and the DEA. See also, Department of Human Services and New England States Consortium, Systems Organization (NESCO), " SSI Supplement for Assisted Living: Health Survey Report," January 2005.

[6] Figure provided by Rhode Island Assisted Living Association. Note: more recent figures suggest the occupancy rate is closer to 88%.

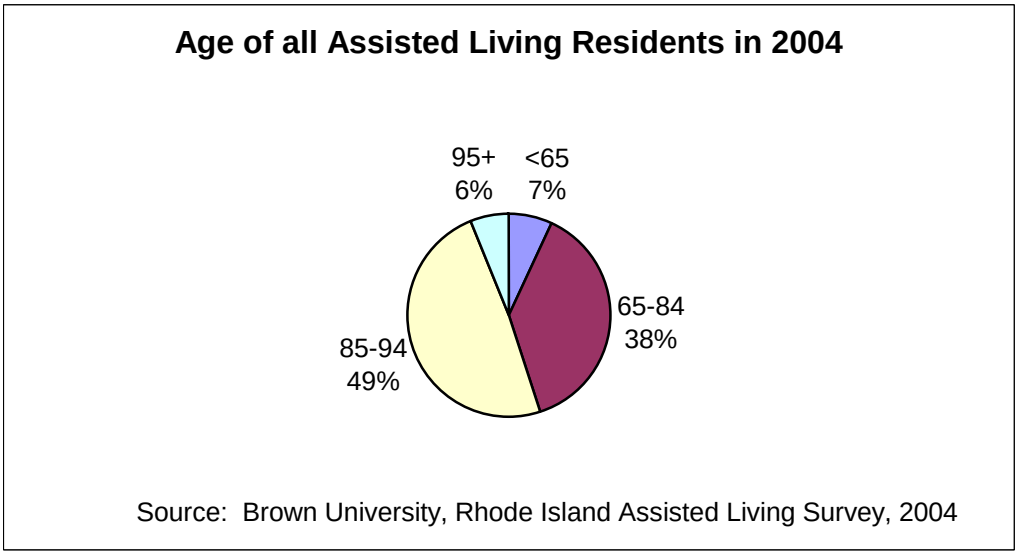
[7] As of September 1, 2005, there were 931 public pay residents.

Figure 1.



As Figure 2 shows, the overwhelmingly majority of assisted living residents are elderly. This means that at the 90% occupancy rate of 3,150, only 221 of the total number of assisted living residents were under age 65 in 2004. This number is just slightly above the percentage of residents over age 95.[8]

Figure 2.



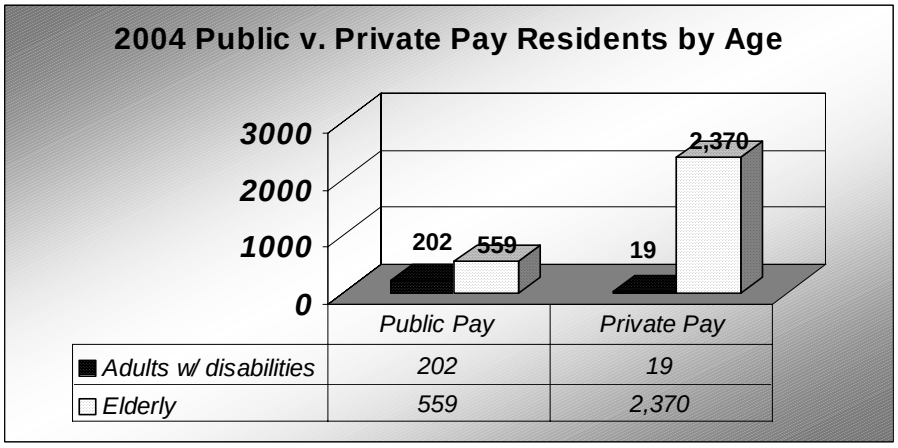
[8] Laliberte, Linda and Lima Julie, "Rhode Island Assisted Living Survey," Brown University, Center for Gerontology and Health Care Research Brown University, September 2004.

The assisted living population has varied needs, some of which may not be met appropriately through as a social model.

When the assisted living population for 2004 is broken down further to show private versus public pay residents by age, several important distinctions surface. (See Figure 3.) Specifically, about 24% (761 of 3,150) of the total number of assisted living residents in 2004 were public pay.

The available data indicates that about 202 of the 761 public pay residents were under the age 65.[9] With a total of 221 assisted living residents under age 65 in 2004 (both public and private pay), this means that 92% (202 0f 221) were public pay. As of September 1, 2005, the DHS industry sources indicate that the total number of non-elderly residents with disabilities stands at about 260; the most recent data available indicate that 254 of them are State-funded public pay. By September 1, 2005, the number of assisted living residents under age 65 increased to about 260. Approximately 254 of the 260 non-elderly residents were public pay. These figures suggest that nearly all of the residents with disabilities under age 65 that entered assisted living in the last year received State subsidy.[10]

Figure 3.



Source: Data derived from the Brown University and DHS-NESCO Studies

The trends in growth of the non-elderly population in assisted living population under-age 65 are noteworthy for several reasons. First, virtually all of these residents receive SSI-D payment only. The SSI-D payment provides monthly payments directly to the resident of up to $575 (adjusted for other income), in addition to the federal SSI payment of up to $579 (adjusted for other income), for a total of up to $1154. Given that $55 of the total combined SSI and SSI-D payment is reserved for a personal needs allowance, there is just over $1,100 available to cover the total costs of assisted living, including room, board and personal care services. This does not approach the substantially higher monthly fees charged by most of the "market-driven" assisted living residences. Consequently, there are far few living options for non-elderly public pay residents receiving SSI-D.

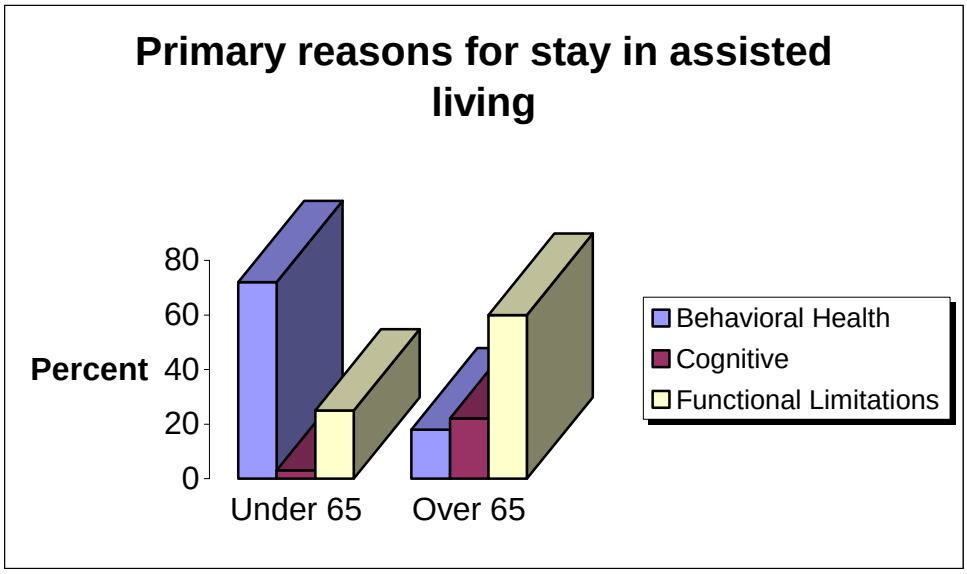
[9] Numbers derived from caseload data developed by the DHS showing the average number of SSI-D recipients per month in SFY 2004 and SYF 2005 and information about the number of waiver recipients per month in CY 2004 provided both the DHS and the DEA: 728 per month SSI-D only (505) and SSI-D and waiver (223); 3 DEA waiver only and 30 RIHMFC waiver only = 761 public pay residents per month. The DHS estimates that about 40% of the SSI-D only population are under age 65.

[10] There is evidence that the remaining six are receiving assistance through the federal Veterans Administration.

Over half of the total 68 assisted living residences in Rhode Island served the public pay population in SFY 2005. Twenty-three (23) of these residences catered solely to residents receiving SSI-D only. Note that of the residences serving SSI-D recipients who are, on average, under 65, all have 20 beds or fewer.

Second, as shown in Figure 4, residents under age 65 are not only more diverse than their elderly counterparts, but also tend to have more complex behavioral health care needs. For example, one recent study found that nearly 60% of the non-elderly residents reported having a serious mental health condition that require medication/counseling for ten years or more.[11] Whereas assisted living is often transition point for seniors between their homes and a skilled nursing facility, it is often the equivalent of a board and shelter care home or step down or "passage" facility for residents under 65, many of whom were living in more restrictive institutional settings including hospitals and behavioral health treatment centers and correctional facilities.

Figure 4.



Source: Data derived from Brown University study, RIALA and the DHS-NESCO Studies

Frail elderly residents have a wide and varied range of physical, cognitive and behavioral health limitations. There is generally a residence open to those with private resources or covered by one of the State's Medicaid waivers offering the accommodations, services and amenities they may require. Based on our review, it is questionable whether many of the residences in the segment of the industry that serves the non-elderly adults with disabilities have the resources and capacity to provide the level of service coordination members of this population so often need. Though there are residences serving adults with challenging physical and behavioral health conditions that provide excellent care, many do not have the staff or expertise to assure residents are safe and able to access required services on a regular basis. Thus, it is not clear that the assisted living residences serving the population under age 65 always provide the most appropriate service setting.

[11] Ibid. DHS-NESCO study.

Older adults with dementia are another sub-population of assisted living residents whose needs may exceed the resources of residences without "special care" or "dementia" units designed to provide specialized services and accommodations. There is substantial evidence suggesting that many of the elderly in assisted living who have dementia are undiagnosed, and untreated. Often, the staff of licensed residences is not trained to detect cognitive impairments or decline and, as such, are not equipped to develop an appropriate care plan. For example, when researchers independently evaluated assisted living residents in other states, they found that between 40% and 70% had the signs and symptoms of dementia (including Alzheimer's-related dementia), though not all had been diagnosed or were receiving specialized services.[12]

At this juncture, the prevalence of dementia among Rhode Island's assisted living residents is unknown. However, just over 10% of the total bed capacity in assisted living residences in the State is covered under a "dementia care" level of licensure. (See figure 5). Most of these beds are in special units within larger residences; typically there are between 18 and 24 beds reserved for residents with dementia in these units. Only two of the 68 residences in the State have obtained a dementia care level of licensure that covers all the beds in the residence.

We found significant differences in the physical environments and service menus of the residences with dementia licenses. Currently, State regulations for licensure require that dementia care units be secure to protect the safety of residents who may wander. Several of the residences with a dementia care level of licensure have opted to meet this requirement by establishing *locked* units.

Although locked units are allowed under existing regulations, there are reasons for concern. Specifically, in a locked unit, staff must enter a code on an electric door keypad to gain entry or to exit. The locks on these doors are designed to release in the event of a fire. How, if at all, the releases function in other types of emergencies/natural disasters was not immediately clear. In addition, in the health care world, locked units are typically reserved for individuals who are at a continuous risk for self-injury and require on-going monitoring by trained staff. It is questionable whether assisted living is an appropriate care setting for individuals with cognitive impairments that have reached this level. Moreover, we raise this issue to highlight the apparent discrepancy between the high degree of security and the generally low level of staffing required in regulation for the assisted living residents with dementia.

There is a growing consensus among policy experts that assisted living can and should be an early intervention capable of preventing some of the potential harm to health caused by unchecked decline in cognition, function, and behavior. Indeed, the assisted living philosophy, which places a premium on individual autonomy and choice, may help residents with dementia retain their sense of independence longer.

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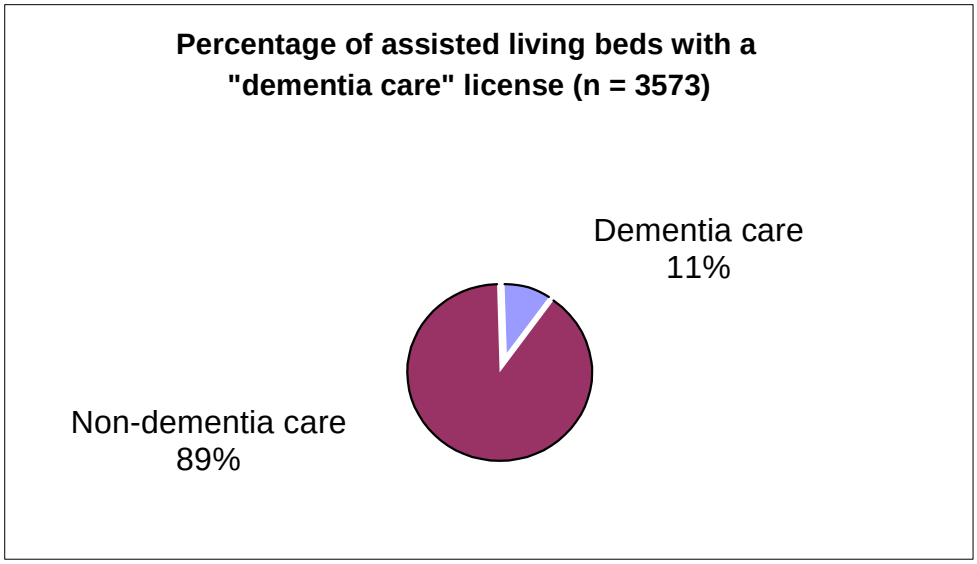
[12] Rosenblatt A, Samus QM, Steele CD, et al., "The Maryland Assisted Living Study: Prevalence, Recognition, and Treatment of Dementia and Other Psychiatric Disorders in the Assisted Living Population of Central Maryland, "*Journal of the American Geriatrics Society*, 52(10):1618-1625, 2004. Sloane PD, Zimmerman S, and Ory MG, "Care for Persons With Dementia," in *Assisted Living: Needs, Practices, and Policies in Residential Care for the Elderly*, S Zimmerman, PD Sloane, and JK Eckert (eds) (Baltimore, MD: Johns Hopkins University Press, 2001) pps. 242-270.

Figure 5.



As most dementias decline progressively, any residence that admits or retains an individual with signs and symptoms of dementia must have the capacity to plan, monitor and coordinate the appropriate services. Moreover, to maintain a positive and healthy care environment for residents with dementia, all of the following must be in place: adequate screening and assessment for cognitive, functional, and behavioral decline; adequate levels of staffing to monitor and provide care for residents; and appropriate safety precautions to guard against negative consequences for behaviors like agitation, aggression, or wandering in a setting that allows for some degree of independence. The current regulations for assisted living residences obtaining a dementia care level of licensure acknowledge the need for such services and safeguards. Yet, as national research and anecdotal evidence demonstrate, there are a significant number of assisted living residents with dementia that have not been detected. Additional services and safeguards may be warranted to ensure the needs of these residents are identified and promptly and responsibly met.

SECTION 2
Assisted Living Residences: How they are licensed and regulated?

As stated above, assisted living residences are not health facilities because they do not provide medical or skilled nursing care. Instead, as stated in statute, they "provide directly or indirectly…personal assistance to meet the resident's changing needs and preferences." Depending on the needs and requests of the resident, personal assistance may include help with activities of daily living, with taking medications, making arrangements for health and supportive services, monitoring health, safety, and well-being, as well as providing recreational, social, and personal services.[13]

[13] R.I.G.L. 23-17.4-2 Definitions.

As noted earlier, it is up to each assisted living residence to determine its level of service within this definition, and, consequently, the types of residents it has the capacity to serve. As a result, there is great variation in the level of service and level of residents' need among assisted living residences that share the same broad licensing guidelines and regulatory oversight. This is a disservice to consumers, for whom level of licensure is one of the few objective distinctions made between assisted living residences.

Licensure Process

When new assisted living residences first apply to the Department of Health for a license, there is an initial inspection conducted to confirm the information on the license application. Thereafter, each assisted living residence sends a renewal application and fee ($250.00, plus $50.00 per licensed bed) to the Department of Health in November or December, to continue licensure for the following year. The Department of Health reviews the renewal application for any changes in status, but otherwise processes every application without consideration of the residence's inspection history or quality of care data (e.g., complaints or recent deficiencies.)

The renewal application contains limited information about the assisted living residence: its bed capacity, its for-profit/non-profit status, name of Administrator, contact information, address and phone number, type of ownership, parent organization, and information regarding ownership and maintenance of land and building. Residences also indicate on a checklist the services it provides, including housing, activities, medication administration and/or assistance, referrals, transportation, housekeeping, laundry, assistance with personal care needs, food services, fiduciary agent, or other.

Finally, assisted living residences must indicate on their application which level of licensure they seek in three categories:

- F1 or F2. Residences with an F1 license may admit residents who cannot self-preserve in the case of an emergency. Residences with an F2 license must be able to ensure the self-preservation of residents.
- M1 or M2. Residences with an M1 license may administer medications to residents. Residences with an M2 license may only assist residents in the self-administration of medications.
- "Dementia care". Any residence that has one or more residents displaying symptoms of dementia that demonstrate safety concerns, inappropriate behavior, inability to self-preserve, or who need additional support specifically related to their symptoms, must obtain a dementia care license. Any segregation of residents into a "Special Care" or "Dementia" unit in assisted living also requires a "dementia care" license.

Within the Assisted Living Residence Licensing Act, the Department of Health has the statutory authority to establish additional licensing levels beyond those cited in statute (F1 or F2, M1 or M2, or "dementia care" licenses).[14]

[14] RIGL 23-17.4-6(c)

Licensure Standards

Given changes in resident population, the three broad categories of licensure are no longer sufficient to objectively classify assisted living residences according to the level of service they provide.

The Assisted Living Residence Licensing Act allows for the establishment of levels of licensure to provide consumers and regulators with information about the scope and types of services a residence is authorized to provide. Evaluating residences against their level of licensure is one of the principal methods used by inspectors from the Department of Health to assess whether a residence has the structures and processes in place to meet the needs of its residents. The current categories of licensure address only certain resident needs (i.e., assistance with evacuation, appropriately administered medication, specialized care for dementia).

For example, licensed residences admitting individuals who do not have the ability to self-preserve in case of an emergency must obtain an F1 license and adhere to the National Fire Protection Association (NFPA) Life Safety Code for health facilities. All residences licensed at the F2 level must meet the basic physical plant requirements stipulated in regulations.

Residences that obtain an M1 license to administer medications to residents (e.g., remove medication from a container and/or administer oral or topical drugs) must meet certain requirements above and beyond the requirements for M2 licensees, such as:

- Employ registered nurses, licensed practical nurses, or unlicensed persons who completed a state-approved course in drug administration for this purpose (i.e., "medication technicians".)
- Provide indirect supervision of unlicensed staff by nurse or physician
- Conduct and document quarterly evaluations of unlicensed employees by physician or nurse supervisor
- Have a licensed nurse or pharmacist check medications against a physician's orders
- Restrict administration of injectable medications to licensed nurses
- Record each medication dose in individual medication records

Even with these requirements, medication administration is the area in which more deficiencies are cited than any other.

Residences that obtain a "dementia care" license must meet the following requirements:

- Have an F1 and M1 license
- Ensure that staff have 12 hours of training beyond the ten required of all direct care staff, including at least understanding various dementias; communicating effectively with dementia residents; and managing behaviors. Continuing education also must include these dementia-related topics.
- Have a registered nurse on staff and available, though not necessarily on-site, for consultation at all times. The nurse must have appropriate training and/or experience with dementia to manage and supervise all resident dementia-related health and behavioral issues.

- Provide a secure environment appropriate for the resident population
- Meet the requirements of a residence offering a Special Care Unit or Program, including disclosure to residents of services, philosophy, staffing, resident activities, and program costs.

In addition to specific requirements for the three levels of licensure, all residences must adhere to the requirements stipulated in "Rules and Regulations for Licensing Assisted Living Residences" (R23-17.4-ALR) and "Rules and Regulations for the Certification of Administrators of Assisted Living Residences" (R23-17.4-ALA), promulgated by the Department of Health. A sampling of these requirements is listed here:

Administrative management	At all times, a resident must have at least one awake staff member age 18 or older and (it may be the same person) at least one staff member with CPR training.
Requirements of a Certified Administrator	A residence's administrator must demonstrate either successful completion of a program administered by an organization approved by HEALTH, or a college degree that includes course work in gerontology, personnel management, and financial management; and undergo thirty-two hours of continuing education from an approved program every two years (including programs offered by long-term care trade associations, the Alliance for Better Long Term Care, the Alzheimer's Association, and accredited colleges.)
Staffing	Staffing must be sufficient to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being of the residents, according to the appropriate level of licensing.
Employee training	All direct care employees must receive ten hours of initial training, including at least fire and emergency procedures; recognition and reporting of abuse, neglect, and mistreatment; assisted living philosophy; resident rights; confidentiality; basic sanitation and infection control; food service; medical emergency procedures; basic knowledge of aging-related behaviors; personal assistance; assistance with medications; safety of residents; record-keeping; service plans; reporting; and (where appropriate) basic knowledge of cultural differences. Continuing education must be provided as appropriate, and must include the same topics required in the initial training. All other employees must have a minimum of 2 hours of training and orientation.
Personnel records	Residences must maintain certain records on each employee, including job description, evidence of credentials, documentation of education and continued training, and the result of a criminal records check.
Management of services	Residences must have policy/procedures that includes description of all resident services, the assessment process, documentation of personal care services, a policy for assisting residents in locating and/or obtaining needed services and for reporting incidents, discharge criteria, and instructions for employees regarding advance directives.
Quality assurance	Residences must maintain a documented, ongoing quality assurance program that reviews resident services, resident satisfaction, and incidents; evaluates processes; and tracks quality indicators at least annually.
Disclosure	A residence must provide each individual seeking admission with written disclosure that includes licensure level, admission and discharge criteria, resident rights, and available services.
Resident assessment	Prior to admission, each potential resident will undergo a comprehensive assessment conducted and signed by a registered nurse, which is used to determine whether the residence can sufficiently serve the individual.
Nurse review	In residences where a full-time-equivalent licensed nurse is on staff, nurse review

	of residents and their health status must take place every 90 days. In residences where a licensed nurse is not on staff, this review must take place every 30 days.
Service plans	Service plans should be developed for each resident, including services and interventions needed, description of services rendered, and entity responsible for arranging the service.
Food services, housekeeping, and laundry services	Residents must be provided three balanced, varied meals per day, have a safe, clean, and sanitary environment, and have laundry services provided or facilities arranged.
Medication services	Staff members who are not licensed qualified providers are permitted only to assist residents in the self-administration of medications, but are not allowed to administer medication. Appropriately licensed staff members, as well as unlicensed authorized personnel who have completed a state-approved course in drug administration ("medication technicians") may store and administer medications and monitor health indicators including blood pressures, adverse reactions, and glucose levels.

We heard from stakeholders in Rhode Island that many assisted living staff do not have appropriate training, and that assisted living administrators do not conduct ongoing training as is necessary to keep up with staff turnover. Rhode Island's requirements for level of staffing and staff training are less stringent as compared with other states in New England.

Staff training requirements for licensed residences are weaker than in neighboring states.

Connecticut and Massachusetts both require over twenty-five hours of initial training for assisted living staff[15], whereas in Rhode Island, all staff must have two hours of orientation and training in certain areas. Staff with direct resident contact are required to only have a minimum of ten hours of orientation and training.[16] By contrast, staff in Maine's assisted living residences are required to take a six-day training course.[17]

There is no requirement for standardizing disclosure forms across residences.

A 2004 investigation by the Government Accountability Office (GAO) found that information from assisted living residences on services, cost, and staffing, as well as admission, continued stay, and discharge criteria, is often presented to consumers in a confusing, inconsistent manner.[18] Given the variety of amenities found across residences, this information can be vital to consumers whose needs may not be adequately met by certain residences. Information is not always readily comparable, because the format of the disclosure form varies.

Residents are often not aware of their rights or of the State advocates that can help residents protect those rights.

Rhode Island law requires assisted living residences to post the "Rights of Residents" and provide a copy to each resident upon

[15] Carlson, Eric. Critical Issues in Assisted Living: Who's In, Who's Out, and Who's Providing the Care. National Senior Citizens Law Center. May 2005. Available at:
[16] Ibid., Rules and Regulations, Section 8.7, 8.8
[17] The National Center for Assisted Living. Regulatory Review 2005, Available at: http://www.ncal.org/about/2005_reg_review.pdf
[18] GAO. Assisted Living: Examples of State Efforts to Improve Consumer Protections. April 30, 2004. GAO-04-684.

admission.[19] These rights include a description of state agencies that are available to respond to violations of those rights. Nonetheless, we found that there is a need for clarification on the role of advocates who are available to investigate and resolve complaints on behalf of residents.

Many licensed residences do not arrange services sufficient to meet diverse resident needs.

Currently in regulation, assisted living residences are responsible for arranging services identified in a resident's individualized service plan, based on the assessment of the resident. Residents often have a broader set of needs beyond those that licensed residences generally provides, and accordingly, some licensed residences are more involved with connecting residents to outside service providers. Although service coordination is achievable and appropriate for residents, existing minimum requirements for staff qualifications are generally insufficient to achieve comprehensive service coordination.

Current regulations do not promote continuity of care for assisted living residents.

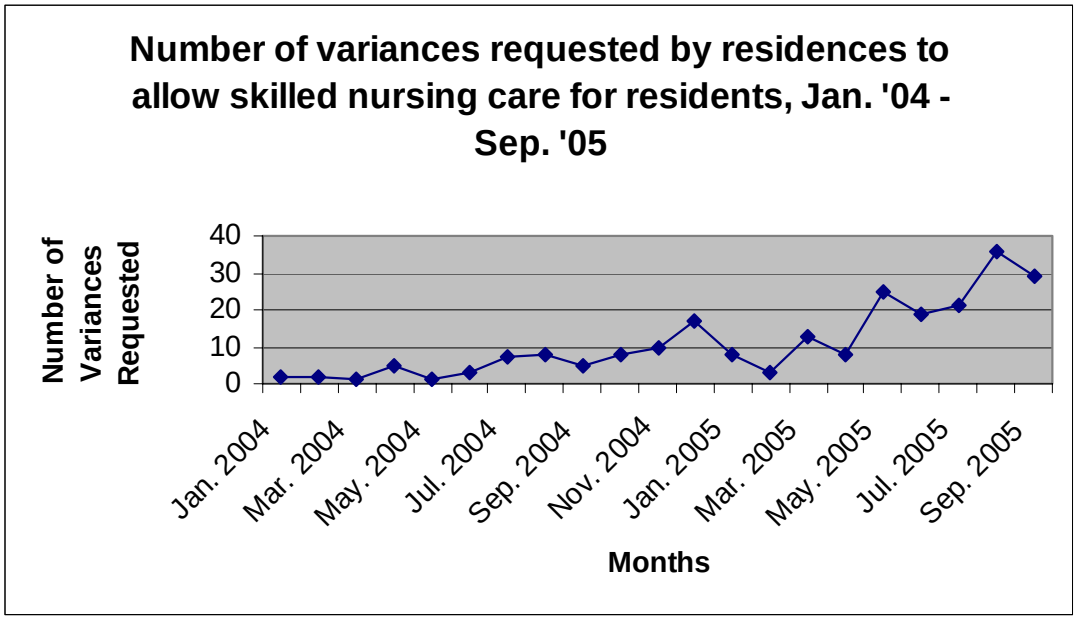
Some assisted living residences provide adequate staffing levels and training sufficient to assure service coordination. We found that in these residences, many of the individuals needing medical or skilled nursing care would benefit from staying in place and bringing in outside services instead of experiencing the trauma often associated with transferring to a health facility, even if only on a temporary basis. Under statute, residents requiring medical or skilled nursing care for more than twenty-one (21) days must be discharged.[20] Exceptions are made when such care is provided by a licensed hospice agency and the residence assumes the responsibility for ensuring care is provided, or when the Department of Health grants variances.[21]

The Department of Health reports an increasing number of requests in the past six months for variances to allow residents to receive skilled care for longer than the 21 days currently permitted under State regulations. (See Figure 6.) Some residents and providers would prefer to allow a home health care agency to deliver skilled services. This is often the case when an individual has lived in a particular residence for a lengthy period of time and views it as *home*. Some residences are co-located with licensed nursing facilities to respond to this need. Other residences are associated with independent living units in which residents may hire home health agency staff to provide services.

We found that the limits on access to skilled care can be disruptive to residents, as their health care needs change on a continual basis. The solutions note above that have been implemented to address the question of how to provide a continuum of care in one location is evidence that the State must reconsider existing policies to address this issue, not only in assisted living but in the long term care system more generally.

Figure 6.

[19] R.I.G.L. 23-17.4-16.1
[20] Section 1.28, R23-17.4-RESIDENCES, Definition of a "resident"
[21] Section 1.28, ibid.



The right of residents to have 30-day notice before involuntary discharge restricts the ability of residences to be responsive to the safety needs of other residents.

We heard from providers that the requirement to give 30 days of notice before discharging a resident was burdensome. In their view, the notice requirement puts other residents and staff at risk of harm when an individual fails to follow house rules or adhere to the terms of the resident agreement or refuses medication or behavioral treatment that causes an adverse change in a condition or impairment.

Under current regulations, a residence is prohibited from discharging an individual without 30 days of advanced written notice even in the presence of a life-threatening emergency. Regulations stipulate that residences have valid grounds for discharge when a resident is a danger to himself/herself or to others, but the thirty days' notice still applies. A change in this rule requires a balance between protecting the due process rights of individuals and assuring the safety of residents and the larger community.

Oversight

The Department of Health's oversight of assisted living is modeled on the federal requirements for nursing facility oversight, yet is assigned proportionally fewer resources in which to complete similar tasks.

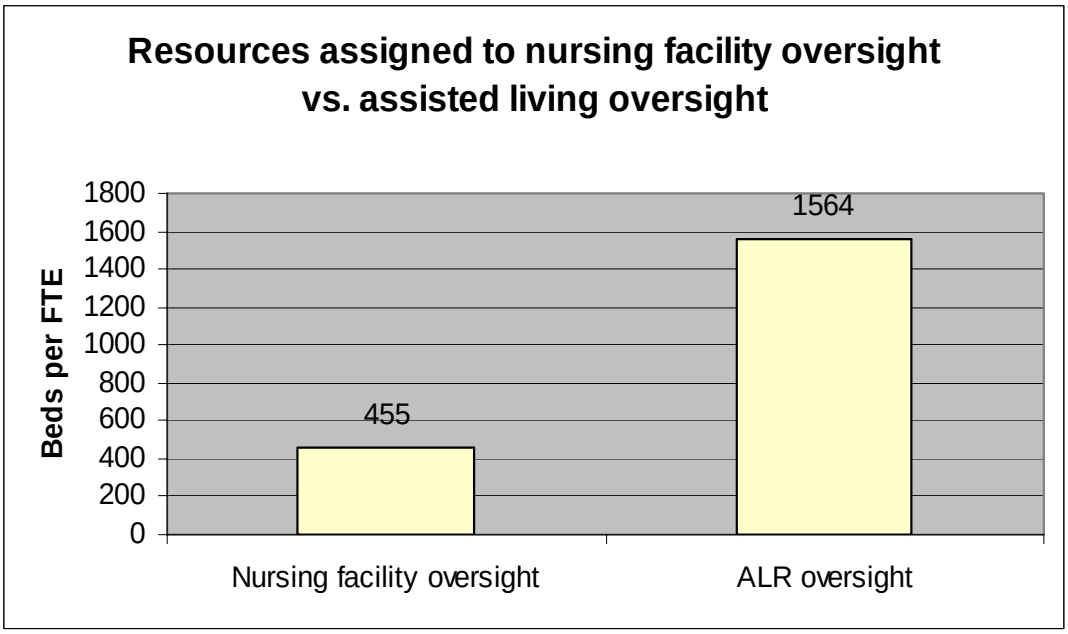
The process the Department of Health currently using for determining whether an assisted living residence is in compliance with State regulations is modeled on the system developed by the federal government for inspecting nursing facilities financed through Medicare and Medicaid. Inspections occur as part of regular checks on residences or as the result of a complaint. Residences are cited with deficiencies for each violation of the regulations found during an inspection.

The Department of Health provides initial notice of concerns during an exit interview with the residence. A formal written statement citing any deficiencies identified during the

inspection is then sent to the residence. The residence has 15 days to respond with a plan of correction corresponding to each deficiency cited. The Department of Health reviews the plan and must provide the residence with an acceptance or rejection within 15 days. If the proposed plan of correction is unacceptable, the residence must revise and resubmit the plan.

The resources committed for nursing facility inspections are substantially greater than those available for assisted living oversight. Figure 7 shows the disparity in resources. According to department officials, this disparity largely stems from differences how they are financed: the costs for nursing home inspections are offset by federal dollars whereas assisted living inspections are entirely State-financed. With 22 full-time equivalents, the ratio of nursing facility beds per full-time inspector is about 455. By comparison, with assisted living oversight, there are 2.3 FTEs assigned and, as a result, over three times as many assisted living beds per inspector. The lower level of resources available for assisted living oversight affects the caseload of inspectors as well as the process for conducting inspections. Specifically, nursing facility inspectors operate in teams of four; in assisted living, the inspector who makes visits to licensed residences works alone for the most part.

Figure 7.



Consumer Protection

Current regulations miss opportunities to assure resident safety, consumer protection, and improve quality of care.

We identified four areas where regulations could be strengthened to assure the safety of all assisted living residents:

- *Medication administration staff oversight* - Medication management problems top the list of most-cited deficiencies in Rhode Island's assisted living residences. Currently, regulations allow unlicensed "medication technicians" who have taken a state-approved course and are indirectly supervised by licensed nurses or physicians to administer oral or topical drugs and monitor health indicators. Supervisors make quarterly reviews of this type of personnel. The State does not currently track unlicensed employees providing medication services who are disciplined for errors or misconduct by supervising nurses or physicians. As a result, there is no mechanism for alerting members of the industry that a particular medication technician has been disciplined and may require review/remediation before taking a similar job in another residence.
- *CNAs' scope of practice* - We found that State law limits the scope of practice of CNAs to licensed health care facilities, as defined in R.I.G.L. 23-17. Assisted living residences, although not licensed health care facilities, often seek to employ individuals with current registration CNAs, because of their training and experience in personal care services. However, under current law, CNAs must demonstrate employment in licensed health facilities annually to renew their registration with the Department of Health. A CNA's employment in assisted living does not meet this requirement, even in those instances in which the residence has licensed nurses on staff. Consequently, CNAs working in assisted living residences often take a temporary positions in a hospital or nursing facility for one shift per year to ensure their registration remains in good standing. We found the fact that they must take such positions to be unfair to both CNAs and the assisted living residents who rely on them for assistance as well as an indication that the applicable scope of practice law needs to be reviewed and updated.
- *Protection of complainants to HEALTH from recrimination from reported residences* - The statute governing the State's Long-Term Care Ombudsman program contains provisions protecting complainants from recrimination by a long-term care facility. At this junction, no comparable protection exists for individuals who make complaints and reports about licensed assisted living residents to the Department of Health. This, in turn, may be preventing individuals from filing complaints with the potential to alert the Department of Health about serious problems or regulatory violations occurring in a licensed residence.
- *Supervision of parolees and probationers in assisted living residences* - Currently, there are no parolees in Rhode Island who are subject to electronic monitoring living in licensed residences. An individual who has been assigned to home confinement with electronic monitoring as a condition of probation or parole requires a level of supervision that exceeds the capacity of assisted living staff, and therefore could put other residents at undue risk. However, we found that other current residents who are on parole or probation may not have adequate contact with appropriate supervisory/monitoring personnel from the State's Department of Corrections.

SECTION 3
Assisted Living Assessments: Who gets in and what are their service needs?

In an industry that is highly segmented and that functions on a social rather than medical model – one that by definition provides individualized services rather than standardized medical care -- decisions about whether an individual's service needs can be met in the assisted living setting must by necessity be made on a case-by-case basis. In Rhode Island, as in many other states, assessments have become one of the principal means of making those decisions. At present, assessments are used for screening eligibility for public pay programs, determining the service needs of current and prospective residents, informing decisions about whether those needs can be adequately and appropriately met in a particular residence and in developing care plans that guide the coordination and delivery of services.

Under Rhode Island law, State agencies and licensed assisted living residences have been delegated discrete assessment responsibilities. The State's primary role, which is jointly vested in the Department of Elderly Affairs and the Department of Human Services, is to assess public pay applicants as part of the eligibility process to determine whether they qualify for the SSI-D and/or one of the State's two Medicaid Home and Community Based Services (HCSB) assisted living waiver programs. The chief responsibility of each assisted living residence is to conduct initial assessments of all prospective residents (public and private pay) prior to admission, and to reassess current residents on at least an annual basis. The first chart in this section provides a descriptive summary differentiating the central features of the screenings and assessments conducted by State agencies and licensed assisted living residences.

State Role In Assessing Eligibility

The purposes and procedures for State assessments have not been clearly established.

To be eligible for one of the Medicaid waivers, applicants must need the equivalent of a nursing home level of care and meet several other waiver specific requirements established by the federal government and the State. For example, the RI Housing Financing and Mortgage Corporation (RIHIFMC) waiver was developed as special demonstration project in conjunction with the State's housing authority to increase affordable living options for seniors and is largely reserved for low-income elderly applicants living in one of three assisted living residences that received financing for that purpose. The DEA waiver is intended specifically to serve elders who are making the transition either from nursing facilities back into the community setting or from their homes into assisted living.

In contrast, to qualify for SSI-D, an applicant must be eligible for federal SSI and either seeking admission to or residing in a licensed assisted living residence. Beyond this basic requirement, the authorizing statute for SSI-D says only that the DEA and the DHS are to develop rules establishing the screening and assessment criteria for determining who in this group is appropriate for SSI-D.

DESCRIPTIVE SUMMARY: CENTRAL FEATURES OF STATE AND ASSISTED LIVING RESIDENCES SCREENINGS AND ASSESSMENTS				
	State Public Pay Programs			**Assisted Living Residences (ALRs)**
	SSI-D	**RIHMFC Waiver**	**HCS Waiver**	
Legal Basis	R.I.G.L.§40-6-27 -- Public Assistance for SSI	R.I.G.L.§42-66.8-1 -- RI Assisted Housing Living Waiver	R.I.G.L §42-66.3, Home and Community Services to the Elderly	R.IG.L. §23-17.4 – ALR Licensing Act R 23-17.4 – ALR, DOH Rules.
Target Population	Applicants/recipients of SSI seeking admission to or residing in State licensed ALR;	Elderly and persons w/disabilities eligible or at risk for placement in a SNF.	Medicaid or RIPAE level 1 income eligible seniors needing assistance w/ daily living or an institutional level of care	All prospective and current residents.
Purpose	Determine whether SSI eligible applicants meet eligibility criteria for SSI-D established by DHS rule. *Note: Rule has not been adopted*	Determine whether applicants can receive appropriate level of care in ALR.[22]	Determine whether applicants have functional limitations/level of care needs that can be met in home/community setting like ALR.	Prior to admission, determine compatibility with ALR resident requirements; evaluate level of care needs to determine appropriateness of ALR care setting; develop and update at least annually individualized service plan.
Scope	The DEA & DHS collaborate to adopt rules establishing requirement of/ procedures for conducting screening & assessments. *Note: Rules have not been adopted.*	Must provide the uniform evaluation of health, social & functional needs required to determine level of care needs of individuals with chronic impairments/disabilities necessitating long term care.	Must evaluate functional limitations affecting need for assistance with the activities of daily living or institutional level of care.	Must evaluate cognitive, functional and social needs to determine whether ALR has capacity to provide appropriate level of care and to inform development of service plan.
Procedural Requirements	As required rules have not been adopted, there are no set procedural requirements. Informal routines that have evolved largely dictate how screening and assessment process functions.	Procedural requirements have not been established by law or through administrative rule. As with SSI-D, administrative routines, developed over-time direct the screening and assessment process		ALRs required to use assessment tool developed or approved by Dept. of Health & conduct assessments prior to admission, at least annually and any time resident's care needs change.
Current Process	Professional staff of the DEA evaluate applicants under 65 using the Universal Care Assessment Tool (UCAT) to determine whether ALR care is appropriate.	The DEA has contracted with senior care community providers to conduct the required screening and assessments for applicants 65 and older.		Tends to vary by ALR size, resident focus and service level – i.e., larger ALRs catering to the elderly often conduct more thorough evaluations of need, using their own assessment tools.
Key Issues	The UCAT has not been tested for validity and reliability and as such may not consistently yield information required to determine whether an ALR is an appropriate setting for SSI-D applicants given acuity level and service needs.			Process is inconsistent. ALRs that cater to residents with the most complex care needs are more likely to use the HEALTH assessment and in a manner that meets the minimum requirements set in rule.

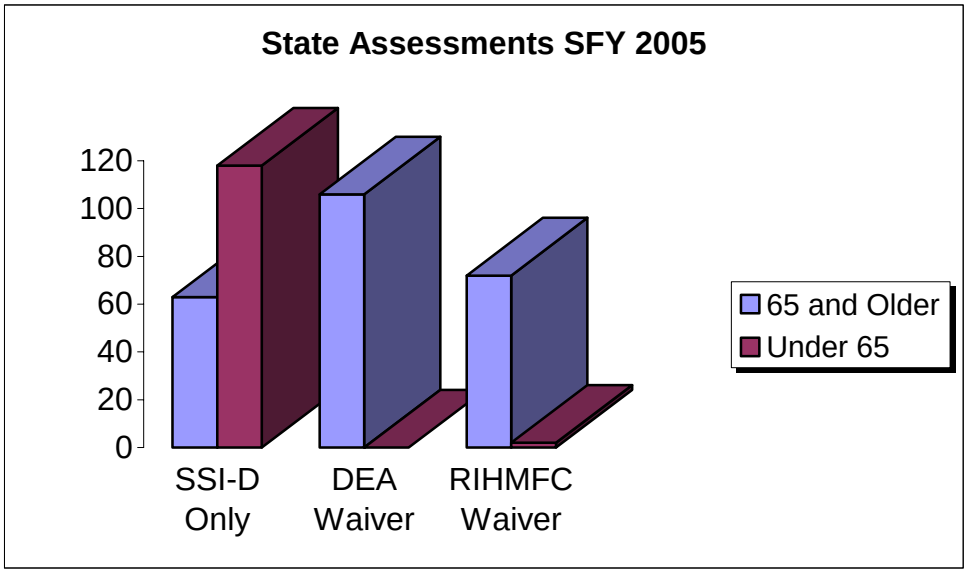
[22] Applies only to those individuals qualifying for government supported LTC – e.g., waiver services. (§42-66.8-4 (a))

The DEA is the State agency that screens public pay applicants for eligibility. To handle the volume of applicants over age 65 and ensure differences in program eligibility requirements are properly applied, the DEA has established a bifurcated process for conducting assessments: the professional staff of the DEA assess public pay applicants under 65, most of whom are seeking SSI-D; community case management providers, under contract with the DEA, conduct the required screening and assessments of individuals age 65 and over applying for either the SSI-D program or for waiver support.

Until recently, the DEA used several different instruments to assess public pay applicants including the Minimum Data Set for Home Care (MDS 2.0), a screening tool used by the DHS to evaluate the care needs of nursing home patients, and the Universal Care Assessment Tool (UCAT). The UCAT was developed by the DEA in 2004 and adopted department wide in May 2005. Figure 8 shows the assessments performed the DEA by population SFY 2005.

During the course of this review, we looked closely at the process for conducting public pay assessments and the various instruments that have been used in the past several years. In general we found that the process now in place does not assess fully an applicant's cognitive, behavioral or functional needs, systematically determine whether assisted living is an appropriate care setting, or evaluate consistently the potential health and safety risks the applicant may encounter or pose once approved for public pay and admitted to a licensed residence.

Figure 8.



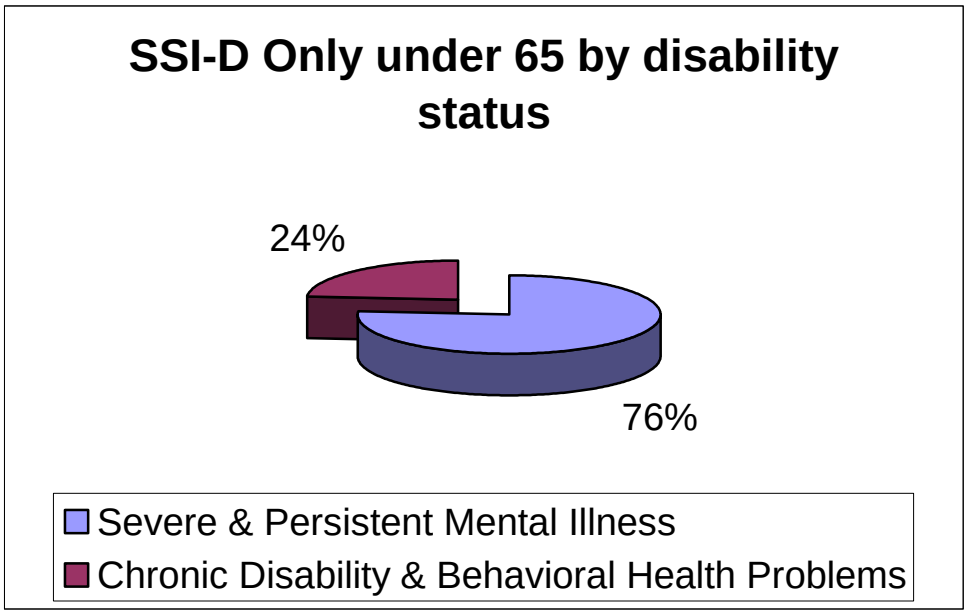
Specifically for residents applying for SSI-D payment, there is considerable confusion about the purposes of the screening and assessment process. Though there is a growing consensus that the DEA process should screen out applicants who require greater supervision than is generally available from assisted living residence staff and/or who pose safety risks, there is no State law or administrative rule authorizing the denial of SSI-D in such instances.

For example, of SSI-D applicants under age 65 assessed by the DEA, 68% (80 of 118) ultimately received SSI-D upon determining that their service needs could be addressed

appropriately within the assisted living setting. Only two were denied SSI-D on the grounds that they required a higher level of supervision than is typically available in assisted living; both of these applicants were referred through the State's Department of Corrections. According to the DEA, the remaining applicants either required a nursing home level of care, or were denied SSI-D upon refusing to enter assisted living. The DEA does not document the cause for such a refusal on a routine basis.

Figure 9 shows the disability status of the 80 assisted living residents under age 65 who ultimately received SSI-D. Residents in this group were referred to the SSI-D program from psychiatric hospitals or in-patient psychiatric units (51); Community Mental Health Centers (15); Assisted living residences (8); Nursing Facilities (3); and Department of Corrections (3). Both disability status and referral source are indicative of the complex array of service needs of the under 65 SSI-D only population. Yet, both of the instruments that have been used to assess applicants in this group during the past year – the MDS for Home Care and the UCAT – were not designed to evaluate individuals with serious mental illnesses or chronic and disabling behavioral health conditions. Additionally, neither instrument has been proven to be a reliable and valid tool for measuring related health and safety risks or the need for structure and supervision. Though the DEA professional staff that administers the assessment are capable and often succeed in acquiring some of this information from other sources, it is not obtained or evaluated in a uniform and consistent manner.

Figure 9.



It is important to note that the prevalence of behavioral disorders in the non-elderly SSI-D only population is not unique to Rhode Island. Twelve other states that provide an enhanced SSI payment for assisted living make it available to adults under age 65 with disabling conditions. All 12 of these states report that the principal diagnosis for enhanced SSI recipients under 65 is also a mental illness or behavioral health-related disability. What distinguishes Rhode Island's SSI-D program from the programs administered by these other 12 states, is the

process for assessing eligibility and for determining whether and what type of assisted living is an appropriate fit.[23]

For example, in California, Massachusetts, and New York, eligibility for the assisted living supplement is determined using an assessment instrument focusing on the full continuum of long term care options. Moreover, in these and several other states, the variation in the services available across assisted living settings is recognized and taken into consideration when deciding whether a particular residence is appropriate for a particular applicant with a specific set of service needs. Most of the other states offering an SSI supplement for assisted living have established distinct categories of licensure that differentiate assisted living residences by the level and/or types of services they provide. In the states where licensure distinctions are not drawn, the state agency that serves as the SSI payer – usually the Medicaid State Agency – certifies residences relative to their service capacity. Thus, the eligibility screening and assessment process looks at both the applicant and the assisted living setting when making a determination of whether SSI payment for assisted living is appropriate.[24]

The State assessment process does not consistently provide the information required to determine the safety and appropriateness of assisted living care.

We found reason to question the usefulness and efficiency of the State's assessment process for public pay residents more generally as well. Specifically, there are no formal procedures or standards that guide how assessments are to be administered or their results evaluated. As a result, SSI-D eligibility screenings and assessments are administered in an inconsistent manner that makes it difficult to discern, from one case to the next, which factors affect an applicant's eligibility for SSI-D and influence determinations of whether assisted living is an appropriate care setting. We found this particularly troublesome given the evidence that there are administrators of smaller residences who consider approval of SSI-D to be both an indication that a resident's level of care needs have been assessed fully as well as an assurance that assisted living is an appropriate and safe care setting.

On the Medicaid waiver side, although the purpose for assessments is more clearly defined than for SSI-D, the process for conducting them is riddled with inconsistencies and no more efficient. For instance, the assessment requirements for the RIHMFC assisted living waiver are more clearly articulated and rigorous than for the DEA waiver, at least under State law and federal regulations.[25] The same assessment tool and process is nevertheless used for both.

The community providers contracted by the DEA to conduct assessments for the State's Medicaid assisted living waivers completed 178 such assessments in SFY 2005. Although exact figures were not available for approvals versus denials during this time period, the providers indicated that about two-thirds of those seeking both the SSI-D and waiver were approved subsequent to the assessment. The majority of those approved were determined to require

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[23] See Social Security Administration Policy Site: POMS SI 01415.035 at http//policy.ssa.gov/poms.nsf and Mollica, Robert and Johnson-Lamarche, Heather. **State Residential Care and Assisted Living Policy: 2004.** U.S. Department of Health and Human Services and National Academy for State Health Policy, March 2005. http://aspe.hhs.gov/daltcp/reports/04alcom.htm.

[24] Ibid.

[25] 42 CFR 441.302(c) and 441.352 (c) define the purposes of and provide guidelines for the evaluation of need in Home and Community Based Service Waivers. The statutory provisions of the RIHMFC waiver that pertain to assessments mirror the federal regulations more closely than the provisions in the State's other HCBS waiver for the elderly, the DEA waiver.

assistance with five or more of the independent activities of daily living or IADLs (e.g., taking medications, managing money, shopping and housekeeping, etc.) and with at least two of the activities of daily living or ADLs (e.g., eating, bathing, toileting, etc.).

The primary reason applicants were denied was reported to be the need for a skilled nursing care. Without the benefit of written procedures and standards, it is not clear how and to what extent assessments of functional status influence such determinations of level of care. Nor is it apparent how and to what extent the eligibility criteria established in the each of waivers affects these determinations.

In short, it is questionable whether the screening and assessment process for the elderly has the capacity to identify public pay applicants with service needs that would be addressed more appropriately and with greater safety in a skilled nursing home setting. This is of particular concern considering that many elderly applicants seeking to reside in assisted living may have serious cognitive impairments like dementia. Neither the assessment instrument now in use nor the process in which it is administered lend themselves to making the finely tuned distinctions required to determine whether an applicant's cognitive limitations are best addressed in assisted living versus a nursing facility.

In addition to the specific concerns noted above, there are a number of other issues worthy of mention that affect the overall effectiveness and efficiency of the State's assessment process:

- *Confidentiality and Privacy Rights* – Public pay applicants are not uniformly advised of their privacy rights or asked to sign releases authorizing disclosure of the confidential health and social service records containing the information required to conduct thorough assessments.
- *Formal Notification and Due Process* – There is no system in place for providing formal notices informing public pay applicants of the specific reasons for a decision to approve or deny assistance and their hearing and appeal rights.
- *Administrative Complexity* – The dual processes for conducting screening and assessments is inefficient and difficult for consumers to navigate and understand.

Industry Role in Assessing Resident Service Needs

Industry assessments do not uniformly address the diverse needs of the diverse assisted living population.

In a service system in which each residence has the flexibility to define its own level of care, assessments play an important role in determining whether an individual's needs and the residence's service capacity are a fit. In other words, the assessment should serve as the nexus between the level of services required by a current or prospective resident, and the range of services the assisted living residence is expected to provide.

As indicated earlier in this report, both State law and Department of Health rules[26] (Section 12.0) establish that it is the responsibility of all licensed residences to conduct initial

[26] R.IG.L. §23-17.4 – Assisted Living Residence Licensing Act and R 23-17.4 – ALR, Rules and Regulations for Licensing Assisted Living Residences.

assessments of all prospective residents, as well as regular follow-up assessments at least annually. Within the broad limits established by the Department of Health's regulations, licensed residences are afforded considerable discretion to decide the focus of the assessments and the manner in which they will be administered. As a consequence, the capacity of the industry assessment process to make the necessary connection between resident needs and services varies significantly from one residence to the next, even when the standardized form developed by the Department of Health is used and the minimum requirements established by rule are met. Among the factors contributing to this variability are the following:

- *Assessment often happens after admission* – We found that contrary to the intent of regulations, an initial assessment is often conducted after a resident has been admitted. Although post-admission assessments are allowable when an "emergency" admission occurs, the purpose for assessments is to determine an individual's level of care needs, inform decisions about whether a particular residence can meet those needs, and assist in the development of an individualized service plan specifying how the residence of choice will do so. An assessment performed prior to admission better serves all of these purposes.
- *Assessment instruments are inadequate* – As is the case with State assessments for public pay residents, the instruments that most residences use – including the model form included in State regulations – are geared toward the functional needs of the elderly. As a general rule, most do not cover the full array of cognitive, behavioral health, functional physical and social needs in the diverse assisted living resident universe.
- *Requirements for reassessment are inadequate* – The State regulatory provisions governing the frequency of assessments do not address the complex and changing needs of residents. Residents may experience subtle changes in cognition and functioning between required annual assessments that signify the onset of a more serious condition or the need for additional services. At a minimum, a targeted screening tool for certain changes (e.g., in cognition or behavioral health) could be used to detect emerging problems that if addressed early might forestall or prevent further decline.

In looking at the implications of these factors more broadly, we found that many of the variations and inconsistencies in the residence assessment are a function of the segmentation in the industry highlighted throughout this report. For example, during our review of the process, it became clear that residences conduct more comprehensive assessments when they have incentive to do so. Not surprisingly, many of those that perform more thorough assessments are larger, market-driven residences that charge high monthly fees and/or for services *a la carte*. In contrast, the smaller residences that cater to the needs of the SSI-D population – and therefore operate with far less revenue – tend to administer the minimum level of assessment required.

Additionally, the reliability and usefulness of industry assessments is affected greatly by the qualifications of the person who administers them and the accuracy of the information obtained from referring (e.g., hospital discharge planners, probation officers) and ancillary sources (e.g., family, friends, health care providers, etc.). Here, too, market-driven residences have the edge. Not only do they have the resources to employ or contract with professionally trained staff to perform the assessments, but they also have a stable revenue stream that affords them the option to deny admission to any prospective resident that might not fit in with the other residents, or that has a questionable background. The residences that operate with less of a financial cushion and serve mostly public pay residents often do not have this flexibility.

In sum, the variability in the scope of assessment tools and in the manner in which they are administered makes it difficult to assure the necessary nexus between care needs and service delivery exists in every assisted living setting. Consequently, both residences and the individuals they serve do not always have a clear sense of what to expect from each other. This in turn leads to considerable confusion over where accountability lies for service quality and the safety and appropriateness of assisted living.

SECTION 4
Assisted Living Public Financing: What the State pays for and how

What happens when the State's assessment of a public pay applicant's needs suggests that a licensed assisted living residence may not be the safest or most appropriate care setting? Are there publicly financed alternatives that provide a comparable living arrangement as well as the more specialized and/or intensive services an applicant's needs require? Will the characteristics of the applicant affect what types of service options are available? For example, does and should it matter whether the applicant is under age 65 or older, a person with a behavioral versus physical disability, or of very limited or more moderate means?

These questions strike at the heart of three financing issues of central importance in the long-term care system in Rhode Island today:

- *Demand and Cost* – The high cost of publicly financed service options for supportive housing affect the capacity of the system to meet the complex and changing needs of the people served.
- *Accountability and Service Delivery* – Existing public financing streams used to support individuals residing in assisted living and other supportive housing arrangements diminish the ability of the State to hold providers accountable for services they deliver.
- *Access and Choice* – The complexity of financing streams reduce the ability of public pay applicants to obtain the services they need and make informed decisions about their care.

Each of these issues is addressed relative to State supported assisted living in the sections below.

An overview of the eligibility criteria for the SSI-D and HCBS waivers – the State's two primary funding streams to support assisted living – is provided in Table 1. It is worth noting here again that public pay residents may be supported by SSI-D only, SSI-D and either the RIHMFC waiver or DEA waiver, or just one of the two waivers.

Table 1: SUMMARY OF PUBLIC PAY PROGRAM ELIGIBILITY CRITERIA		
SSI-D	RIHMFC Waiver	DEA Waiver
• Applicants/recipients of SSI, both elderly and adults w/disabilities, seeking admission to or residing in a State licensed assisted living residences. • Meet income (at or below $1,099 per month) and asset limits (maximum $2,000); and • Needs can be addressed in assisted living, as determined by State administered screening and assessment.	• Elderly and adults w/disabilities eligible or at risk for placement in a SNF; • Meet categorically needy income standards up to 300% of SSI standard; • Requires level of care of individual with chronic impairments or disabilities that ordinarily necessitates long term care but, based State on administered screening and assessment, can be appropriately provided in a licensed assisted living residence.	• Age 65 and over and Medicaid eligible. [27] • Meet Medicaid categorically or medically needy income standards up to 300% of SSI standard[28] • Requires assistance w/ daily living/an institutional level of care; and • Functional limitations/level of care needs can be met appropriately in an assisted living setting, as determined by State administered screening and assessment.

Demand and Cost

State expenditures to support assisted living residents have increased appreciably to meet the continuing growth in demand.

Over the last ten years, the number of public pay residents in Rhode Island has increased in reaction to the expansion in federal and State funding and the growth in the popularity of assisted living as a supportive housing option. Note that in 1997, State lawmakers revised the authorizing statute for SSI-D to raise the amount of the monthly supplement available by $200. Since then, the number of recipients has more than doubled -- from 373 in December of that year to 895 as of September 1, 2005.

Public pay applicants eligible for SSI-D, may receive $1,154 per month, depending on other sources of income: the federal SSI payment of up to $579 per month; and the State enhanced payment for assisted living of up to $575 per month. As noted earlier, of the $1,154, the personal needs allowance for the SSI-D only population is $55 per month. According to the DHS, on average, only about 20% of the SSI-D population receives the full $1,154; the monthly SSI-D payment for the remaining 80% is lower due to adjustments for other sources of income.

Growth in the number of residents for each of the State's Medicaid waivers for assisted living has not changed as dramatically as the SSI-D program due to limits imposed by either enrollment caps or restricted budget appropriations. The RIHMFC waiver currently has an enrollment cap of 200 slots. Although eligibility under the RIHMFC waiver also extends to adults with disabilities as well as to seniors, since FY 2003, all but two of the public pay residents covered have been 65 years of age or older. All public pay residents covered by the DEA waiver are 65 or older. The income of DEA waiver residents tends to be higher than that of both the SSI-D only and RIHMFC waiver group, as Medicaid categorically and medically needy standards apply.

[27] The statute also provides eligibility for homebound individuals who are Medicaid ineligible.

[28] If Medicaid-ineligible, applicants must meet the income standard at level 1 of RIPAE ($17,155 individual/$21,455 couple). Public pay residents that qualify on the RIPAE standard must make a co-pay.

Until recently, there was a waiting list for both the RIHMFC and DEA waivers. Many of the individuals on the waiting list were already residing in the assisted living setting and using the SSI-D payment to fund their stay. In SFY 2004, the State decided to address the waiting list issue by increasing budget appropriations for the DEA waiver to expand the number of available slots. Consequently, since SFY 2004, the number of public pay residents covered through the DEA waiver expanded from 30 to 82 in SFY 2005 to the current total of 110.

The payment amounts for the DEA and RIHMFC waivers differ significantly from SSI-D. The State pays residences directly a flat rate of $35.54 a day for the Medicaid covered services they provide to each waiver-eligible public pay resident they admit. As is explained in greater detail below, these public pay residents must pay for room and board with other income or resources; since the majority of these residents also receive some or all of the $575 per month available through SSI-D, the State is thus paying a share of room and board costs as well. There are a small number of *waiver only* public pay residents that do not receive SSI-D. For example, at present, all but 37 of the 310 waiver-eligible public pay residents are also receiving State-funded SSI-D.

Table 2 provides an overview of the characteristics of the public pay residents receiving support today through SSI-D only, SSI-D and a waiver, and a waiver only, based on information provided by the DHS, the DEA, and the industry. The principal distinctions between the two groups are age and income and, more importantly, the nature of their disabilities/conditions. All of these factors affect the level of financial support public pay residents receive, the types of residences where they live, the scope of services they are provided and, ultimately, the costs of the State's assisted living programs.

Table 2: SELECTED CHARACTERISTICS OF PUBLIC PAY RESIDENTS: SSI-D ONLY V. WAIVER/SSI-D AND WAIVER ONLY

	SSI-D Only	Waiver & SSI-D /Waiver Only
Average Age	62	84
Average Monthly Income of Resident	$512	$711
Qualifying Characteristic, Disability or Condition	Disabling behavioral health and/or physical condition and functional limitations including serious and persistent mental illness.	Cognitive, functional and physical limitations associated with aging-related condition.
Referral Source	Psychiatric hospital, hospital, community health care center, home, or correctional facility	Home, nursing facility, assisted living residence, or hospital.
Discharge Location	Home, community health care setting, nursing facility	Hospital or nursing facility.
Average Length of Stay	Five years or more	Eight years or more
Type of Licensed Residence	Small, congregate residence w/double occupancy, community bath, few amenities	Larger market-driven residences, private or semi-private room, full amenities

As of September 1, 2005, the breakdown of public pay recipients by funding source is as follows[29]:Sixty-nine percent (69%) -- SSI-D only; thirty percent (30%) -- SSI-D and either the DEA or RIHMFC waiver; and one percent (1%) -- DEA or RIHMFC *waiver only*.

State financing of assisted living centers on funding streams rather than on public pay residents. This makes it difficult to assess and track overall costs per resident.

Examining the overall cost of the State's programs and services supporting assisted living residents proved to be a challenge as there is not a single "assisted living" budget item, and multiple funding streams and agencies are involved. This is due in part to State budgeting and accounting practices, as well as to the manner in which financing for assisted living public pay residents is appropriated across health and human services departments.

Specifically, the State's two HCBS waivers for assisted living are funded through the annual appropriations of separate departments: the RIHMFC waiver through the Department of Human Services and the DEA waiver through the Department of Elderly Affairs. The SSI-D program is also funded through DHS, though personnel costs for conducting eligibility screening and assessments for both waivers and the assisted living supplement are allocated to the DEA. In addition, adult day care utilized by assisted living residents is a Medicaid State Plan serviced financed through the DEA. SSI-D only recipients are eligible for adult day care services. As certain social activities are included as waiver services, decisions about whether a waiver supported resident qualifies for adult day care are made on a case by case basis. Behavioral health services, on the other hand, are largely paid for with Medicaid funds allocated to the Department of Mental Health, Retardation, and Hospitals (MHRH); most other non-waiver Medicaid services provided to public pay residents are paid for through the DHS.

Complicating matters further, each of the departments involved uses different payment/reimbursement strategies and methods for projecting and tracking annual expenditures. Moreover, the percent of total Medicaid costs the federal government pays – known as FFP or the federal financial participation rate – changes from year to year and, in some instances, by service and coverage group.

Despite the accounting obstacles, we found it possible to make several generalizations about overall costs for public pay programs supporting assisted living:

- *State costs are increasing.* Expenditures for public pay residents covered by the two Medicaid waivers have increased by between 2% and 5% per annum over the last five years, when adjusted for the increase in the overall number of individuals covered due to expansion in the DEA waiver. This is comparable to the rise in Medicaid costs for services provided to the elderly more generally.
- *The federal share of total costs has begun to decline.* The federal participation rate for SFY 2006 has decreased and is expected to drop even further over the next several years as a result of federal fiscal constraints and ongoing efforts at the national level to reform Medicaid to reduce reimbursement levels to the states.

[29] These percentages differ somewhat from those included in Figure 1 on Page 1. The information provided in Figure 1 was developed by representatives of the industry and are based on the 2004 calendar year. The figures noted in this section of the report were provided by the DHS and were included as part of a broader budget analysis conducted for other purposes.

- *The SSI-D caseload is affecting State costs.* Since SFY 2003, the SSI-D caseload has been rising at a faster rate – about 8% -- than at any time in the recent past. It is difficult to assess how this has affected State costs per recipient because available figures do not routinely adjust for reductions in the $575 supplement resulting form outside income. However, the overall cost to the State for SSI-D has been rising steadily.
- *Total expenditures for assisted living include a variety of other services.* Actual expenditures for publicly financed assisted living include costs for a variety of services that are not part of the SSI-D and waiver program appropriations – e.g., primary care, adult day care, mental health services, etc. When the costs of these services are taken into account, total expenditures more than double.

Table 3 shows expenditures for assisted living public pay programs over the last two years, excluding costs for any additional publicly financed health and human services. The table shows both State and federal expenditures with a FFP rate of 55% and reflects the general trends in total program costs noted above – i.e. general growth patterns in caseload and costs from one year to the next, including the sharp rise in both for the DEA waiver as more SSI-D recipients on the waiver waiting list have been moved into the program.

Table 3: SFY 2004-2005: EXPENDITURES FOR ASSISTED LIVING PUBLIC PAY PROGRAMS		
	State Fiscal Year 2004	**State Fiscal Year 2005**
State Dollars		
State SSI-D	$4,956,500	$5,023,775
State RIHMFC Waiver	1,000,154	1,039,883
State DEA Waiver	36,515	74,249
Total State Expenditures	**$5,993,169**	**$6,137,907**
Federal Dollars (FFP/SSI)		
Federal SSI	$2,739,888	$3,066,336
Federal RIHMFC Waiver	1,276,075	1,323,488
Federal DEA Waiver	55,502	94,613
Total Federal Expenditures	**$4,071,465**	**$4,484,437**
Total State Expenditures	**5,993,169**	**6,137,907**
Total Federal & State Expenditures	**$10,064,643**	**$10,622,344**
Average Residents Per Month	**750**[30]	**806**[31]

Note that the figures in Table 3 are presented in aggregate annual costs rather than in per recipient per month costs. We found we were unable to readily obtain this information because the DHS does not track how much of the total SSI and SSI-D payment of up to $1,154 a month

[30] ***521 SSI-D only; 197 Waiver & SSI-D*** (170 RIHMFC +27 DEA)***; 32 Waiver only*** (30 RIHMFC +2 DEA)

[31] **517 SSI-D only; 250 Waiver & SSI-D** (170 RHIMFC + 80 DEA); ***39 Waiver only*** (30 RIHMFC +9 DEA) During SFY 2005, appropriations for the DEA waiver were increased to accommodate the growing number of seniors on the waiting list for assisted living. As many of the seniors on the waiting list were SSI-D only recipients, the small decline in the number of public pay residents in this group was a result of transfers to the DEA waiver.

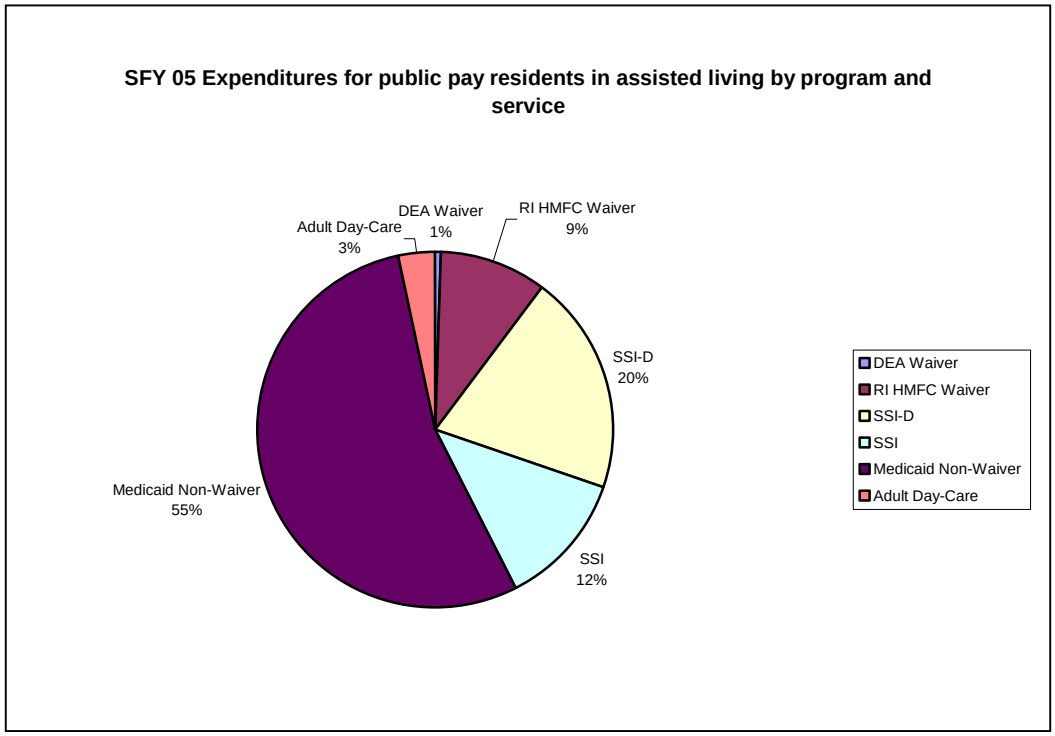
each resident receives, once that amount is adjusted for other sources of income and/or support through one of the Medicaid assisted living waivers.

Table 3a shows total expenditures for SFY 2005 when the $13,482,522 non-waiver Medicaid costs for health and adult day care services are included. The figures in Table 3a indicate the total amount of dollars that the State and federal government spent for assisted living in SYF 2005. Note that program costs increase by over 133 percent once expenditures for non-waiver Medicaid services are added to the total.

Table 3a: SFY 2005 TOTAL EXPENDITURES FOR PUBLIC PAY RESIDENTS	
Total State SSI-D and Waivers	$6,137,907
Total State Non-Waiver Medicaid [32]	$5, 932,310
Total State Expenditures – All Services	**$12,070,217**
Total Federal SSI-D and Waivers	$4,484,437
Total Federal Non-Waiver Medicaid	$7,550,212
Total Federal Expenditures – All Services	**$12,034, 649**
Total Federal and State Expenditures	**$24,104,866**

Figure 10 shows how overall costs break down by program and type of service.

Figure 10.



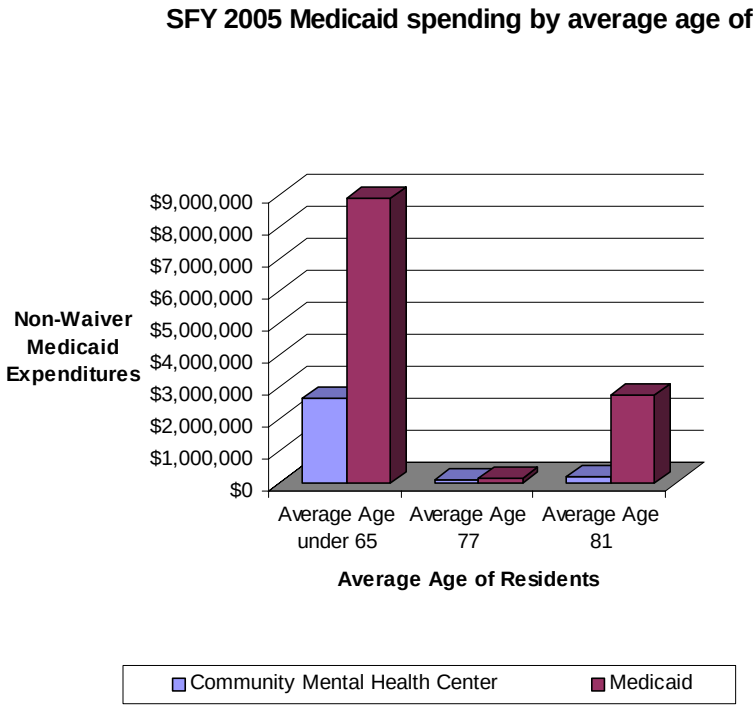
SYF 2005 Total Overall Value= $24.1 Million

[32] Figures are estimated as they are based on an analysis of Medicaid claims data conducted by the DHS for a one year period --from 4/2004 to 5/2005 – that covers portions of both the 2004 and 2005 fiscal years. Figure includes adult day care as well other health care services including primary care, behavioral health services, etc.

We found that when the costs for Medicaid services are broken down further several important patterns emerge. Specifically, the DHS analyzed claims data comparing costs for all Medicaid services versus those provided through the State's Community Mental Health Centers (CMHC) by the age of public pay residents receiving some portion of the SSI-D supplement over a year period approximate to SFY 2005. The findings of this analysis indicate:

- *Medicaid costs for non-elderly, SSI-D only public pay residents are the highest.* Nearly 66% of non-waiver Medicaid expenditures in SFY 2005 were for services provided to SSI-D recipients with disabilities under age 65.
- *Costs for behavioral health services are significant*. About 23% of the $13.5 million in non-waiver Medicaid expenditures over a year period were for behavioral health services provided through the CMHCs. Particularly noteworthy is the fact that, during a one year period, 20% of the public pay recipients living in residences catering to the SSI-D only population received Mobile Team Treatment (MTT) Services. MTT is a comprehensive and costly bundle of services provided by CMHCs and is reserved for individuals who have the most serious behavioral health needs.
- *Non-elderly public pay residents utilize the greatest share of behavioral health services*. As indicated in Figure 11, almost 86% of the $3,053,184 in Medicaid claims for CMHC services was for non-elderly SSI-D only residents. Here too, MTT utilization is telling: all but five of the eighty-six residents receiving MTT between May of 2004 and May of 2005 were under age 65 and living in more modest, congregate housing type residences.

Figure 11.



Non-elderly SSI-D only public pay residents utilize the greatest share of behavioral health and all Medicaid services.

Some of the differences in Medicaid costs shown in Figure 11 can be explained, at least in part, by the fact that over half of the elderly receiving SSI-D are also covered by one of the State's two assisted living waivers. Licensed residences admitting waiver supported residents must meet standards requiring that they provide a bundle of mandated services, the costs of which are covered by the $35.54 per diem fixed rate paid by the State. Some of the services the State pays for a la carte for SSI-D only public pay residents are covered under this fixed rate, including case management and social activities tantamount to adult day care.[33]
For example, according to the DHS claims data for May 2004 to May 2005, of the 102 public pay residents that received offsite adult day care services, only two were covered by one of the waivers. In both cases, the waiver-supported residents were required to obtain special permission from the DEA to obtain the additional, off-site adult day care services.

Overall, we found the Medicaid claims data provided by the DHS to be indicative of both the scope and complexity of the service needs of the SSI-D only population, particularly those with disabilities under age 65. We also found these data to be compelling evidence that the methods the State uses to support public pay residents do not facilitate the level of accountability rising expenditures require and demand.

Accountability and Service Delivery

The payment methods used by the State do not adequately ensure accountability or promote equal access to services across programs.

Issues of accountability are particularly pronounced on the SSI-D side. Once determined eligible, SSI-D payments are typically sent to the public pay resident in check form. Most residents who receive only SSI-D support make monthly payment arrangements directly with the administrator or manager of the residence.

We found that some assisted living residences request residents to name them as the *payee* for SSI/SSI-D checks. At present, federal policy specifically prohibits providers from requiring a SSI recipient to name them as payee as a condition of admission or service. During the course of our review, we found that there is considerable confusion among many members of the industry over this point. There appear to be a fair number of licensed residences in Rhode Island that have instituted a requirement to be named as the payee. Several we spoke with indicated that they did so out of necessity because many residents lost or misplaced their monthly checks or simply refused to pay what they owe.

As SSI and SSI-D payments are made directly to recipients, the payment levels set by the federal and State government influence rather than dictate the monthly rates charged by residences. Indeed, to ensure their beds are full, residences serving the SSI-D only population seldom charge more than the SSI standard of $1,104 per month. We found this to be potentially problematic for two reasons.

[33] As noted earlier, adult day care is a Medicaid State Plan Service and is not include among the waiver services covered by the $35.54 per diem flat rate.

Unlike many other states, RI does not require special licensure or certification for residences serving the SSI-D recipients.

First, as we have pointed out repeatedly in this report, assisted living residences that provide different types of living environments, cater to particular populations, or provide specific types of specialized services or higher levels of coordination are not differentiated by State law or licensure regulations beyond the fire-safety, medication administration and dementia levels of licensure. As a consequence, licensed residences in the State have considerable flexibility to define themselves within the parameters of existing law, and to determine, through assessments conducted prior to admission, whether they have the capacity to meet the service needs of a prospective resident.

Licensed residences have both the discretion and the responsibility to make reasoned decisions about the types of public pay residents they can safely and appropriately serve. We found evidence that some of the residences serving the SSI-D only population are struggling to remain solvent and, as a result, are hesitant to deny admission to a resident, no matter how inappropriate the fit or great the potential safety risks to others, because their survival depends on filling every possible bed.

Second, in the course of this review, many of the industry representatives and other stakeholders we consulted stated that the SSI standard barely covers the cost of the minimum services licensed residences are required to provide under State law and regulations. In their view, this greatly limits the choice of assisted living residences open to public pay residents who are supported through SSI-D only.

The commitment and actions of administrators and staff of residences influence service access and quality.

We did find indications that many of the residences serving the SSI-D only population are financially strained, particularly those serving non-elderly adults with disabilities. However, several we visited routinely provide residents with access to the coordinated high quality services they need. We found, in general, that it is the extraordinary commitment of owners, administrators and staff that distinguish the residences with the reputation for providing the best service and living environment from their counterparts in this segment of the industry. The key decision makers in these residences are less likely to admit individuals with needs that exceed their service capacity and/or pose safety risks. Just as importantly, they interact with and monitor the activities and health status of existing residents on a regular basis to ensure emerging problems are detected early and promptly addressed.

That these residences have achieved this level and quality services on their own initiative is praiseworthy, but also a reason for concern, because they are the exception rather than the rule. Moreover, as the SSI-D payment is made to the individual recipient, the State has not taken advantage of its leverage as *payer* to raise the bar and require all residences serving this population to provide same level and quality of services.

At present, Rhode Island is one of 15 states that provide financial support to low-income assisted living residents through SSI.[34] Of the 15, Rhode Island's state-funded enhances payment is the highest. As there are states with much more expensive housing costs in this group, including California, New York and Hawaii, the amount of the combined SSI and SSI-D monthly payment is clearly not the only factor limiting the choices and range of services available to public pay residents. As noted earlier in the report, we found that Rhode Island is one of the few states with an SSI supplement that does not utilize a licensure level or payment certification process as a mechanism for identifying and setting minimum standards for residences that admit non-elderly adults with disabilities who receive SSI-D.

The State has not fully utilized its leverage as a principal payer for assisted living.

Additionally, Rhode Island is the only State in this group that does not conduct comprehensive behavioral/mental health assessments as part of the eligibility screening process for applicants under age 65 who apply for SSI-D. Several states, including Massachusetts, Maryland and New Jersey, perform an initial screen to detect for behavioral/mental health conditions and then a full assessment similar to the PASARR, the evaluation tool required by the federal government for nursing home patients, to determine whether assisted living is an a safe and appropriate service environment.[35]

Under the State law authorizing the SSI-D program, the DHS and the DEA are delegated the responsibility for establishing the regulations for determining eligibility for payment within the boundaries set under federal law. The DHS and the DEA thus have the authority to adopt administrative regulations that require a more comprehensive behavioral health assessment and set the minimum standards that any assisted living residence admitting an SSI-D recipient must meet. Also, as is discussed later in this section, the State could explore using different payment methods that provide greater accountability to substitute for or augment all or a portion of the SSI supplement for public pay residents with complex behavioral health needs.

Public pay residents supported by the State's Medicaid waivers are guaranteed access to a bundle of high level services, including comprehensive case management.

The State does currently certify assisted living residences that admit public pay residents covered under the waivers. However, the State's two waivers differ from one another and from SSI-D in several important respects.

First, under the DEA's Medicaid Section 1915(c) Home and Community Services Waiver, assisted living is actually defined as one of several community-based services rather than as a distinct care setting or housing option. As a result, eligibility for waiver services rests on whether the covered services available in the community – including assisted living – provide an adequate and appropriate care for an applicant who would otherwise need to

[34] Information derive from the Social Security Administration Policy Site: POMS SI 01415.035, "Federally Administered Optional Supplementary Payment Program – 1/05 Payment Levels," http://policy.ssa.gov/poms.nsf/inx/0501415037

[35] The Pre-admission Screening and Annual Resident Review (PASARR) process for nursing home patients is defined at 42 C.F.R. 483, Subpart C. The PASARR has two components. First, prior to admission, the state must determine if the individual with serious mental illness or mental retardation requires nursing facility care. Second, the state must conduct an annual review to determine whether nursing facility placement for the resident remains appropriate. For those identified by the screening as having serious mental illness, the next step depends on the resident's physical and mental treatment needs and their length of stay in the facility.

be in a skilled nursing facility. By contrast, the State's RIHMFC waiver was established as part of a demonstration project designed specifically to increase the affordable assisted living options for low-income elders and adults with disabilities. Eligibility for the RIHMFC waiver is thus tied directly to assisted living as a specific community-based service setting with the capacity to meet or mitigate the need for skilled nursing facility care.

To meet the eligibility criteria for both waivers, public pay residents must have functional limitations and/or health needs that would require skilled nursing home care were it not for assisted living services. The acute needs of applicants meeting these criteria typically require a higher level of service than the minimum provided for in the State's assisted living statute – a level blending elements of the medical and social models. Thus, to receive certification from the DHS and the DEA to admit a prospective resident eligible for either Medicaid waiver, a licensed residence must have the resources and capacity to offer an array of waiver required services, many of which exceed the standards for assisted living residence licensure.

The scope of required waiver services is summarized in Table 4. We found that many of these services are routinely available in the assisted living residences on the market track that cater to elderly private pay residents, if only on an *a la carte* basis. Conversely, we also found that few of the smaller, more modest residences that generally serve public pay residents supported by SSI-D offer such a wide range of services.

Moreover, as income eligibility for the waivers is set at a significantly higher level than for SSI and Medicaid more generally, waiver supported residents often have the resources to pay the balance for room and board on their own. Due to room and board limits established in conjunction with the waivers, residences receive up to $1,802 per month for each DEA waiver eligible resident and up to and $2,206 per month for each RIHMFC waiver-eligible resident, excluding the $100 per month personal needs allowance. Thus, the coverage requirements of the DEA and RIHMFC waiver afford the public pay residents they support access to licensed residences that are out of the financial reach of their counterparts – the lower income residents who rely on SSI-D only for assistance.

To illustrate the point more fully, Table 4 includes the minimum requirements for the SSI-D program. It is important to emphasize here that the eligibility determination process, income standards, and scope of services covered by the two waivers were designed to comport with federal requirements. The State has considerably greater flexibility in setting its own requirements for SSI-D. Indeed, our review of State and federal laws and regulations indicated that aside from base eligibility requirements,[36] there are no minimum standards for the SSI supplement that cover service access, quality, safety or appropriateness of placement. However, the State has the leverage to establish standards for residences serving the SSI-D only population that address the inequities and service gaps resulting from the differences in assisted living funding streams.

[36] The U.S. Social Security Administration has established policies that indirectly deal with certain safety issues. For example, under federal policy, an SSI recipient that violates probation or parole is no longer eligible for either SSI or the supplement. There are also restrictions related to Medicaid that state's must follow. For example, SSI and SSI-D are not available to otherwise qualified individuals residing in health facilities or other settings where more than 50% of the costs are paid through Medicaid. This excludes residential settings like assisted living in which a resident receives individual rather than a package of Medicaid services, whether paid for on a fee for service basis or through some form of managed care.

Table 4: PAYMENT METHOD AND REQUIREMENTS ASSISTED LIVING PUBLIC PAY PROGRAMS			
	RIHMFC WAIVER	**DEA WAIVER**	**SSI-D ONLY**
Payment Method	Flat rate paid directly to residence	Flat rate paid directly to residence	Check sent to resident who makes payment arrangements w/ residence
Rate	$35.54 per diem $1,102 per month	$35.54 per diem $1,102 per month	About $1,100 per month
Rate Set By	State	State	Residence
Medicaid Services Covered	Case management Personal Care Attendant Care Meal Preparation Housekeeping 24 Hour staffing	Case management Personal Care Attendant Care Minor Assistive Devices Homemaker/Housekeeping	None. Residences typically provide personal care assistances services required by regulation and, in some instances, low to moderate service coordination.
Room & Board	Not covered	Not covered	Covered
Limits on Room & Board Charges by Residences	Charges may not exceed the SSI standard of $1,104 per month. Must be a single room/apartment with private bath	Charges may not exceed $700 per month. Rooms may only be shared at resident's request.	None
Allow Family Supplement	No	No	Yes
Personal Needs Allowance	$100	$100	$55

The State's flat rate payment approach does not serve the interests of public pay residents or the industry.

In addition, we also found reason to question the effectiveness and responsiveness of the State's flat rate payment approach for Medicaid and SSI-D compared to the alternatives. As indicated in Table 5, the chief advantage of a flat payment approach is that it is a relatively straightforward on an administrative level. Assisted living residences certified to accept waiver recipients are paid the $35.54 per day flat rate per eligible resident irrespective of their individual service needs. Although SSI-D payment is adjusted for income and is sent to recipients, the effect is about the same: residences serving SSI-D only residents expect no more than the SSI and SSI-D monthly maximum, less the required personal needs allowances, regardless of the residents services needs.

The flat rate payment is more advantageous on the Medicaid waiver side, but only insofar as residents have SSI-D or other resources or sources of income to pay room and board costs, which vary between an additional $600 for the DEA waiver to over a $1,000 for the RIHMFC waiver. In addition, whatever the flat-rate approach gains in administrative ease is lost in terms of both accountability and the disincentives it provides to the industry to accept residents with more complex and potentially costly service needs.

Our review of the payment methods employed by other states that have an SSI supplement and/or HCBS waivers for assisted living revealed that most have opted to use a combination of approaches. We found that states that license multiple levels or sub-categories of assisted living, or that certify residences or the programs they institute for payment, have established fairly complex reimbursement strategies that adjust compensation levels based on the number or functional needs of residents served and the range of specialized services or living arrangements available.

For example, Vermont has established a tiered payment approach that complements the state's multi-level licensure system, which draws distinctions between residences based on their capacity to serve individuals with varying functional limitations or acuity needs. The state has adopted a single, comprehensive assessment tool that evaluates the cognitive, behavioral health, physical and social limitations of all prospective assisted living residents – both public and private pay – and then identifies the type of licensed assisted living residence authorized to provide the services required to address those limitations. Residences capable of meeting the rigorous service and staffing standards set by the state for the type of licensure required to serve residents with the greatest functional limitations are paid the highest per diem rate.

Residences seeking to admit non-elderly public pay residents with serious behavioral health needs must meet the applicable licensure requirements as well as a separate set of payment certification standards developed jointly by the state's mental health and Medicaid agencies pertaining to minimum levels of service coordination, supervision, and staff qualifications and training. An appropriately licensed residence that obtains this certification is paid an additional setting-specific flat rate if they provide single occupancy rooms or apartments with private baths.

As suggested in our discussion of the disparities in the level of services available to public pay residents supported through the Medicaid waivers versus SSI-D only, the State has the capacity as a principal *payer* to set minimum quality and safety standards and hold assisted living residences accountable for meeting them. At present, the State is not using this leverage to the extent that it can or should, particularly with respect to the residences that cater to the SSI-D only non-elderly public pay resident.

We found that many of Rhode Island's neighboring states confronted with similar service inequities are reforming their systems for financing assisted living for public pay residents. Several that currently use a flat rate approach are in the process of, or at least contemplating, revamping their payment strategies to follow Vermont's lead and create different payment levels for assisted living based on the functional capacity or specialized services needs of the individuals residences serve. In order for Rhode Island to follow suit, the State must establish a more comprehensive and efficient eligibility screening and assessment process, set minimum quality and safety standards, and then institute a mechanism via licensure or certification for payment that ensures that assisted living residences have both a strong incentive and the resources required to rise up to meet them.

Table 5: ASSISTED LIVING RATE PAYMENT APPROACHES: ADVANTAGES AND DISADVANTAGES[37]				
Approach	**Description**	**Advantages**	**Disadvantages**	**Impact**
Flat or Flat – Setting Specific	All residences receive same payment irrespective of resident needs/level of services provided. May vary depending on double v., single occupancy, and apartment v. room.	Administrative Ease If varies by setting, rewards residences that maximize space of each resident – e.g., incentive for single occupancy room	May provide disincentive for residences to accept/retain residents w/high cost health needs. Disconnect between payment & resident's functional needs/actual utilization	Does not require extensive data about resident health status. Accountability suffers as ease of payment makes it difficult to assess resident status, service utilization.
Tiered	Different payment levels based on functional capacity of residents – e.g., # ADLs limitations; type or severity of disability	Provides higher payment to residences that cater to populations with greater/more complex functional needs	Provides incentive for residences to accept/retain individuals w/greater functional & service needs.	Requires universal assessment to establish tiers & determine appropriate payment rates. Once accomplished, offers high level of accountability.
Case Mix	Acuity-based system incorporating payment formula often used in SNF – e.g., multiple complex payment levels	Multiple payment levels to reflect specific types of resident service needs. Similar to method used for SNF.	May establish too many payment options given that assisted living residents have fewer functional/acuity needs that most SNF residents.	Some residences would not be able to manage complex data needs & thus may accept residents w/narrow range of high functional needs.
Care Plan/ Fee-for-Service	Payments based on cost of each unit of service performed	Payments based on actual cost of services utilized by each resident.	Administratively complex. Difficult to track individual service costs; also, may underestimate/overvalue certain ancillary costs of care – staff licensing, etc.	Requires uniform assessment updated on a regular basis

Access and Choice

In Rhode Island, non-elderly public pay residents have limited access to other types of supportive housing.

Over the last decade, assisted living care has been primarily characterized as the supportive residential living option of choice for seniors with moderate functional and/or cognitive impairments. This view has not only been reinforced by industry marketing, but by State and federal policies as well. In general, we found this to be a fairly accurate depiction of the role assisted living plays for elderly residents, both private and public pay.

[37] Adapted from a comparison located in *State Assisted Living Practices and Options*, by Robert L. Mollica and Robert Jenekens. (Coming Home Project: 2002): p.37.

We have noted throughout this report that for adults with disabilities under age 65, assisted living is often the only available supportive housing option rather than the living arrangement of choice.

In seeking to explain why non-elderly residents have so few options, we looked at the range of alternative supportive residences currently available in the State that serve individuals with similar types of disabilities and service needs. To validate the accuracy of the widely held view that the majority of these residents have behavioral health related conditions, we reviewed the data about types of disabilities identified in the assessments conducted by the DEA, an analysis of Medicaid claims data prepared by the DHS, as well as other surveys and studies of assisted living residents in the State. This information confirms that the overwhelming majority of non-elderly residents either self-report or have been diagnosed with a behavioral health related disability or utilize services suggesting the presence of such a disability.

The DHS claims data showed that nearly 70% of non-elderly public pay residents utilized a service associated with a psychiatric diagnosis; additionally, about 36% used services designated for individuals with severe and persistent mental illness (SPMI); and, as shown earlier in this section, residents under 65 account for over two-thirds of the total expenditures for CMHC services provided to the assisted living population. We also took note of information provide by industry representatives, residence administrators and Department of Corrections officials indicating that a significant portion of the non-elderly residents with behavioral conditions have criminal backgrounds.

The existing alternative settings are few in number, tend to have limited capacity, and are considered to be much more costly than assisted living.

In general, we found that the alternative supportive residential settings that exist are not always an appropriate fit and that, even in those instances when an individual's needs, eligibility and residence services are properly aligned, high costs and limited capacity pose serious obstacles to access. Specifically, the chief alternative supportive setting for non-elderly adults with behavioral health conditions are the CMHC affiliated group home residences and supervised apartments licensed by the Department of Mental Health, Retardation and Hospitals as behavioral health organizations.

Though licensed supportive residences and supervised apartment are treated as distinct living options, the chief difference between them is the level of staff oversight. In a group home, staff is on-site; in some supervised apartments, staff must be available within five minutes from any unit in the building. Otherwise, both the group homes and the apartments provide similar types and levels of services. At present, eligibility for MHRH residential group homes and apartments are primarily reserved for individuals who meet the requirements for the State's Community Support Program or CSP. To qualify for the CSP, an individual must have an SPMI and serious functional impairments that require intensive services unavailable in an outpatient setting, at least once in his or her lifetime.

There are a variety of other factors that also pose obstacles to access. First, due to archaic Medicaid rules requiring the states to bear the lion's share of financial and administrative responsibility for mental health services provided to adults between ages 19 and 64, MHRH licensed behavioral health residences must have fewer than 16 beds to qualify for FFP.

Second, as the operating costs of MHRH licensed residences are high and are typically covered by departmental appropriations, there are relatively few of them as well. Although department regulations allow residences financed by other sources to obtain licensure if they meet applicable standards, the department currently only licenses residences that it funds. Third, department officials reported that they have an obligation to fill the limited space in these residences with individuals in the priority populations they are bound by law to serve, including individuals residing in or being discharged from publicly operated hospitals and health care facilities.

Aside from the MHRH licensed and funded alternatives noted here, there are not any other supportive residential care options currently available in Rhode Island for non-elderly individuals with behavioral health needs and, in some case, histories with the criminal justice system. Importantly, the State is the only one in New England that does not fund a correctional step down or passage residence or license mental health residences that serve individuals who are ineligible for the CSP, but need supportive services to remain living in the community.

In our meetings with stakeholder and members of the industry, the absence of and need for such alternatives was a common theme. Discussions with agency officials indicated that these options have been considered in the past and were not pursued because they are service alternatives considered as too costly given the State's limited resources.

The State has not systematically assessed the aggregate costs and benefits of publicly financed assisted living services.

In an effort to compare the costs of services for public pay residents with the both existing and possible alternatives, we aggregated and analyzed data about assisted living costs from all available resources, including annual expenditures for SSI-D and each of the two Medicaid waivers as well as claims data for adult day care, community-based substance abuse and mental health services, acute hospitalizations and medical interventions, and other ancillary public pay supports. We then gathered similar information about MHRH licensed supportive residences and correctional step-down and passage residences in Maryland, Massachusetts and New Jersey.[38]

With this information in hand, we compared the costs for providing services to a public pay resident under age 65 with an SPMI diagnosis that, although manageable through medication, needs regular monitoring. To assess what the maximum cost would be for providing the same package of services in the three different residential settings selected, we calculated figures as if the resident had no outside income or resources, a history of incarceration and was eligible for the CSP. Though the available data indicates that there are a significant number of public pay residents with similar conditions and characteristics, there are many adults with disabilities in the assisted living setting who require less intensive services and lower public subsidies due to higher income. In short, our analysis is based on a *most expensive case scenario*. The results of this analysis are presented in Table 6.

[38] We spoke with officials in all three States, reviewed budget materials and each state's Medicaid State Plan as well as the following and the following articles and reports: Maryland Department of Health and Mental Hygiene, "Maryland's Assisted Living Program," January 19, 2004; National Association of State Mental Health Program Directors, "Maryland Community Justice Treatment Program," April 2001; Kupersaning, Eve, "Program Helps Mentally Ill Move from Cell to Community," **Psychiatric News**, December 01, 2000;Commonwealth of Massachusetts, Governor's Commission on Corrections Reform. **Strengthening Public Safety, Increasing Accountability, and Instituting Fiscal Responsibility in the Department of Correction**. Final Report, June 30, 2004; and Ziedonis, D and Violette, Nancy, "Reentry into the Community after Addiction Treatment within NJ's Prisons and Jails," State of New Jersey, January 24, 2003.

Table 6: COMPARISON OF ASSISTED LIVING COSTS V. ALTERNATIVE SUPPORTIVE RESIDENTIAL CARE/HOUSING OPTIONS			
	Assisted Living SSI-D Only Residence	**MHRH Supervised Apartments**	**Correctional Step Down/Passage Residence**
Principal Funding Source	SSI and SSI-D	Medicaid Community Support Program and SSI	Medicaid Private Non-Institutional State Plan & SSI
Base Monthly Rate	$1,100	$3,510	$1,860
Services Covered	As required by State regulation, personal care assistance and assistance with or administration of medications. Varying degrees of service coordination	Case management, Psychiatric evaluation, Medication monitoring, Nutritional services, Support/education with ADLs, Rehabilitation services, Family support and counseling, Employment counseling, Group and/or individualized therapy Social interaction, Monitoring of mental health status	Care plan development and monitoring, Transition planning, Personal care assistance, Case management, Medication monitoring, Family and group therapy, Employment counseling, Crisis intervention, Social re-integration and related activities, On-site supervision
Room and Board Included	Yes – two meals a day and semi-private room	No – Residents contribute 65% of their monthly SSI payment of about **$360** at present	Partly – Residents are typically required to contribute up to **$300** per month of SSI to cover meals
Additional Service Costs Per Month	**$3,263** $2,263 MTT[39] $500 Adult Day Care $500 RN-MD	**$110** Adult Day	**$1,000** RN, MD, Individual Psych
Total Monthly Costs – Including R&B costs	**$4,363**	**$3,980**	**$ 3,160**

As the figures presented in the table make clear, the cost of services provided to non-elderly public pay residents can, and often do, exceed monthly expenditures for the principal alternatives in Rhode Island – i.e., MHRH licensed group residential homes and supervised

[39] Figures based on an analysis of the DHS claims data for public pay residents for a one year period indicating a SPMI diagnosis and reflect calculation of average costs per unit of services most frequently utilized. MTT is the CMHC's Mobile Treatment Team service at cost of $73 per day per month for a minimum of 8 hours of service the first month, and 5 hours of service the second and third months. MTT is a comprehensive and intensive service reserved for individuals determined to have high risk, serious conditions and includes case management, crisis intervention, and an array of other interventions many other residents receive piecemeal. More than half of the non-elderly adults in assisted living receive MTT. Adult day care is $37 per day for an average of 13.5 days per month; the rates for psychiatric RN and MD services vary by type of service and length from $25 a quarter hour to $122 for a 50 minute individualized session.

apartments -- as well the passage/step down type of residence established by many other states. We recognize that the comparison of alternatives presented here is on the service and cost high end and does not take into consideration a variety of important factors such as start-up costs, expenditures for the maintenance of the residences physical structure and so forth. However, in spite of these limitations, we were struck by the fact that supportive housing options that routinely provide the level of service, structure and supervision to handle this scenario have somewhat lower monthly costs than assisted living.

The State has not utilized all the available sources of funding for services provided in the assisted living setting.

During the course of our review, we surveyed the various ways states across the nation provide financial support for assisted living as well as alternative housing options like MHRH licensed residences and the step-down/passage residences included as an example in Table 6. In general, we found that the State has not examined nor taken full advantage of the different funding sources that could be used to support assisted living or alternative supportive residential options.

Table 7 provides a listing of the funding sources and options available and/or used by other states to finance assisted living and alternative supportive residential service settings. With respect to the financing of services, we found that there are a wide range of Medicaid state plan options that could be used to cover services in assisted living that provide greater accountability than SSI-D alone. For example, several neighboring states use several of these options along with housing funds to cover costs and assure access to and the quality of residential care. Massachusetts is a case in point.

At present, Massachusetts finances services provided to non-elderly individuals in the assisted living category referred to as “adult foster care” using Medicaid managed care for behavioral health services and the personal care state plan option along with an SSI supplement to cover lodging costs. According to state officials overseeing this program, the personal care option provides residences in this category a flat rate of just under $38 per day to cover service coordination, personal and attendant care, medication administration, minor assistive devices, meal preparation, 24 hour staffing and house keeping. Behavioral health services provided through the Massachusetts managed care carve out are paid at the rate of $125 per month. The SSI enhanced payment for public pay residents living in this supportive housing option was up to $454 per month in calendar year 2005. In short, the state uses this mix of financing methods and funding streams to make about $1,750 available per month for each public pay recipient living in adult foster care.

Officials of the Department of Human Services interviewed during our review informed us that they are currently reviewing both the Medicaid state plan and waiver options available to support services provided to public pay assisted living residents. The DHS indicated that anticipated changes in federal Medicaid state plan options, funding and program requirements may affect the State’s ability to implement these strategies in the near future, however.

Rhode Island has explored more of its options on the housing finance side, though most efforts have focused on the elderly. The RIHMFC demonstration waiver falls into this category. RIHMFC support the development of assisted living residences under the waiver through the federal low-income tax credit, which is more restrictive than several other financing options currently available through the U.S. Department of Housing and Urban Development (HUD). The low-income housing tax credit does not allow a residence to offer psychiatric services or admit individuals with a high level of need for them; prospective residents with a criminal background must also be denied admission. The requirements for the tax credit also dictate the scope of common areas and provide that each low-income resident has a single occupancy room/apartments with a private bath.

Given that most non-elderly assisted living residents have behavioral health conditions or disabilities, and that as SSI-D only recipients they seldom have the excess income/resources to pay the higher costs for private rooms, few have qualified for the RIHMFC waiver services since its inception. Several other assisted living residences in the State have received re-development or conversion funding secured through U.S. Department of Housing and Urban Development Programs that provide greater flexibility – e.g., Section 202 program or Assisted Living Conversion Program – but they too target services toward the elderly.

The federal government has established tenant and project-based programs that make funds available to support individuals with disabilities and the development of residence based living options to serve them – HUD Section 8 and 811 Vouchers.

Briefly, the Section 8 Designated Housing program provides vouchers to Public Housing Authorities (PHAs) that have an approved HUD Allocation Plan for their federal public housing units to: (1) implement “elderly only” housing policies; (2) implement “disabled only” housing policies; or (3) implement “mixed elderly/disabled” housing policies. Only non-elderly people with disabilities (under 62 years old) can receive vouchers from this set-aside, which are intended to expand the supply of Section 8 housing opportunities for non-elderly people with disabilities who may have been negatively impacted by PHA designation policies. Because they can only be issued to people with disabilities, these vouchers are a potential source of funding for supportive housing. PHAs must submit Allocation Plans to HUD in order to designate a number of units as "elderly only," "disabled only," or "mixed." Across the country, many PHAs have chosen to implement "elderly only" housing, thereby diminishing the supply of affordable housing options for people with disabilities. Mainstream Housing Opportunities for Persons with Disabilities program vouchers are set-aside exclusively for people with disabilities.

Section 8 rules limit a resident’s payment for rent to a maximum of 40% of income. Subsidy rates generally do not factor in cost and access to common areas, support spaces and security. At present, most Section 8 vouchers allocated to the State by HUD that fall into one of the categories listed here are for the elderly or families that include a person with disabilities. Officials of the MHRH indicate that there are a number of individuals with mental health disabilities who are receiving Section 8 vouchers at this time. However, as individuals with a history of substance abuse or criminal activities are often ineligible for Section 8 support, vouchers are not an option for a significant number of the assisted living residents with disabling conditions under 65. Among the seniors with Section 8 vouchers, a small percentage is also receiving SSI-D only and utilizes the vouchers to offset assisted living room and board costs.

The Section 811 voucher program is targeted specifically at non-elderly adults with disabilities. HUD makes Section 811 funds available for the development of supportive housing for very low-income members of this population and provides vouchers to subsidize rent. The goal of the program is to increase the number and kind of residential care alternatives that enable adults with disabilities maintain as much independence as possible while living in the community. HUD provides interest-free capital advances to nonprofit sponsors like the State's Community Mental Health Centers to assist them in financing licensed group homes and residences. The rental assistance vouchers provided to individuals program also provides project rental assistance, which covers the difference between the HUD-approved operating costs of the project and the tenants' contribution toward rent. Both Section 811 project and tenant based financial supports have been used exclusively by the CMHCs.

Table7: FUNDING SOURCES FOR ASSISTED LIVING/SUPPORTIVE HOUSING	
Sources	**Used/Allowed in RI?**
1. Supplemental Security Income	
Federal	Yes
Special State Supplement for assisted living residences	Yes, SSI-D
- *Applicable to alternative supportive housing options?*	Not allowed under State law, though may be extended to "residential care" as SSI-D category.
- *Separate rate for non-elderly adults w/disabilities?*	Not used at present, though permitted by State law and federal policy.
2.General/State Special Funds	No
3. Community Development Block Grant	No
4A. Medicaid – State Plan Options	
Personal Care Option	Not presently; under review by the DHS.
Private Non-institutional Care Option	Same as Above
Targeted Case Management	No
Rehabilitative Service Option	No
Managed Care	Medicaid managed care plan covering adults with disabilities is now being developed by the DHS.
4B. Medicaid – Waiver Options	
Cash and counseling/direct care options -- Under federal law, assisted living residents are not eligible at present.	Pilot project currently being implemented by the DHS.
HCBS Waivers	Yes, RIHMFC and DEA
5. HUD: Housing Choice vouchers	
- *Tenant-based*	
• Designated for elderly only	Yes
• Mainstream for adults with disabilities	Yes, but very limited.
• Section 811 Non-elderly adults w/disabilities	Yes, but only for those without a chronic substance abuse or criminal history
- *Project-based*	
• Section 8/202 Elderly-only	Yes
• Section 811-Non-elderly adults w/disabilities	Yes, but only to finance MHRH licensed behavioral health residences

PART III

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Our review of assisted living in Rhode Island today revealed that it is an appropriate and safe supportive housing option for the overwhelming majority of residents the industry currently serves. More affluent seniors who need supportive services to remain more independent have the greatest choice in selecting an assisted living residence, as there is a licensed assisted living residence in the State with the capacity to meet virtually any need or preference. Although there is a narrower range of options for the low-income elderly who qualify for one of the State's two Medicaid waivers, the residences certified by the State to admit these individuals provide the full spectrum of mandated services single occupancy or semi-private rooms, and baths and as well as a host of other, often high end, amenities.

We did find that there are areas for improvement for the industry (e.g., more thorough and frequent assessments, more training for residence administrators, etc.) and the State's chief licensing authority (e.g., better oversight using a more resident-centered approach) and payer (e.g., more flexible and accountable payment strategies). We also have serious concerns about the safety of "locked" dementia units and about the capacity of some residences to monitor and deliver necessary services to residents with progressive cognitive impairments more generally. Overall, however, we concluded that for private pay and most public pay elderly assisted living residents, the quality of services and the living environment closely approximates the image that the industry projects to seniors, their families and the general public.

Our review also indicated that for a small, diverse and growing number of low-income individuals with complex disabling conditions, assisted living is something quite different. For SSI-D only public pay residents, particularly those under age 65 with behavioral health-related disabilities, assisted living is the default rather than preferred supportive housing option. We found several licensed residences that cater to the SSI-D only population that provide exemplary services in a safe, high quality living environment. However, as many of the industry representatives and stakeholders we met during our review were quick to point out, residences with minimal services, variable living conditions, inadequately trained staff, and more safety risks than safeguards are more often the rule.

What makes these residences different is less the way the look than the fact that most do not have the capacity to routinely provide either the appropriate level of services or a safe living environment. In short, we found that, although licensed as assisted living, many of the residences housing the State's most vulnerable public pay recipients – SSI-D only -- bear little resemblance to their market driven counterparts in the industry that serve private pay and waiver eligible seniors.

We found the inequities in level of services and safety for SSI-D only public pay residents to be particularly troublesome and thus worthy of the State's immediate attention.

Specifically, the ostensible goal of the SSI-D program, and both of the State's Medicaid waivers, is to make assisted living more affordable for individuals who need supportive housing, but do not have the necessary income and resources. The State's Medicaid waivers, when supplemented with SSI-D, have largely achieved this goal. Yet, the assisted living residences that are affordable for SSI-D only recipients sometimes do not adequately address the complex behavioral health and physical disabilities that make supportive housing a practical necessity. Thus, it is clear that assisted living, as it exists today, is not always the best or most appropriate supportive housing option for SSI-D only recipients.

We found that the lack of alternatives for SSI-D recipients was due, at least in part, to the State's system for licensing and providing financial support for assisted living. On the licensure side, it was apparent that the existing levels of licensure – i.e., fire, medication and dementia-related – do not adequately differentiate assisted living residences in terms of either the scope of services or type of living environment they provide for populations other than frail elderly. The lack of such distinctions makes it difficult for the State, as payer, and for all prospective residents – public and private pay – to determine whether a particular residence is an appropriate service fit. Though industry assessments should play an instrumental role in guiding decisions about whether a licensed residence has the capacity to meet a prospective resident's needs, we found evidence indicating that they do not effectively do so on a consistent basis.

With respect to the State's public pay system for assisted living, we found several areas that warrant further review and/or action. Among those that should be revisited as soon as possible are the eligibility screening and assessment process, payment strategies, and alternative funding opportunities. Also meriting immediate attention is our finding that Rhode Island is one of the few States that has not established certification standards for residences serving individuals receiving a supplement to SSI. This is particularly problematic given the absence of a license category that differentiates between residences based on the scope of specialized services they provide. Additionally, we took note of the fact that the State has not fully explored the costs and benefits of expanding existing supportive housing options or developing new ones.

Last, but no less important, we found that many of the safety issues we detected were related to problems areas already noted as well as to obstacles in the flow and quality of information available to prospective and current residents. In the health service market place, as in most, access to reliable information is the key to making informed and reasoned choices. Similarly, accountability and information are inextricably intertwined -- without information there can be no accountability. We found there to be lapses in the scope and quality of information available from all sources – the industry and individuals and families it serves, the organizations and facilities that refer residents, and the State agencies that assess service needs, oversee how they are provided, and bear a significant portion of the financial responsibility for them.

Recommendations

Our review indicated that the most pressing challenges confronting the State in assisted living today fall into three overlapping areas: service, safety and transparency. In this section of the report, we lay out a series of recommendations designed to assist the State in meeting these challenges. Some of these recommendations can be implemented immediately by one or two State agencies working in tandem. There are also several recommendations necessitating extensive interagency coordination and collaboration and thus may require a longer time frame to fully implement.

Wherever a recommendation identifies a need for interagency coordination, we suggest that the OHHS lead a task force to develop policies that maximize the use of resources, avoid duplication, and that are consistent with the State's goals for improving the long-term care system in Rhode Island more generally. The OHHS task force, consisting of representatives of State health and human service agencies, the Department of Corrections and various other stakeholders, should be charged with ensuring all the recommendations set forth below are pursued in an open, transparent, timely and effective manner.

Services: Raising the Bar and Expanding the Options

The Managing Director of the Office of Health and Human Services should convene an interagency task force to assist and advise the Department of Health in developing the requirements for a new level of licensure for residences serving individuals who have needs that extend beyond personal care assistance due to a condition or impairment requiring specialized services or living arrangements. The Department should be prepared to implement the new level of licensure by no later than October 1, 2006.

Some assisted living residents in Rhode Island today have disabling conditions or impairments requiring the coordination of specialized services, and/or a level of supervision and attendant care that, although still consistent with a social model, are more intensive than is the norm industry wide. There should be a mechanism for distinguishing licensed residences that cater to individuals with particular or higher acuity needs, and hold them accountable for coordinating and ensuring access to the array of services necessary to meet them.

In the Department of Health's current licensure schema, the fire-related and medication-related levels of licensure help to define, in part, the service needs of the resident population -- e.g., residents in an F1-licensed residence must be able to self-preserve in case of an emergency. Residences obtaining the newly established level of licensure would be classified further by the higher degree of service coordination they provide, just as residences that have a dementia care level of licensure provide additional relevant services.

Establishing a separate level of licensure for residences with higher-need populations will make it easier for prospective residents to identify and evaluate their choice of assisted living residences in Rhode Island.

In addition, differentiating between residences in this manner will create a framework on which the State can build if the public pay financing system is retooled to adjust the compensation for those that serve eligible individuals with acuity needs requiring a broader and/or more intensive service coordination.

One of the chief challenges associated with developing a new level of licensure centers on how to define its scope and purpose relative to the broader context of residential care settings licensed by the State. Thus, it is critical that the Department of Health work closely with other State agencies licensing residential care settings and key stakeholders to ensure the new level of licensure serves a unique purpose and one that is consistent with the intent of Assisted Living Licensing Act.

The Department of Health will also need to set forth requirements in regulation for residences that obtain the new level of licensure. These requirements could specifically identify staffing and appropriate services that residences catering to populations with specific characteristics or needs must provide. Alternatively, a more minimal strategy would be to require residences to self-report to the Department the services they provide or arrange to meet resident needs. This, in turn, would obviate the need for the Department to adopt a separate set of regulations and standards applicable only to residences seeking the new level of licensure. A middle strategy would be to require residences to self-report the services they provide or arrange, as well as have specific structure or process requirements that ensure they have the capacity to provide the specialized services they plan to deliver.

By no later than March 1, 2006, the Department of Human Services and the Department of Elderly Affairs should use their joint authority under current law to establish a payment certification process for licensed assisted living residences now admitting recipients of SSI-D.

In the public finance section of the report, we noted that the State has not taken full advantage of its leverage as a payer to ensure that SSI-D only recipients are afforded appropriate services in a safe living environment. Given the severity of the health conditions observed in the SSI-D only population, the assisted living residences in which they live would be appropriate candidates for obtaining the new level of licensure proposed above.

While the development of regulations for a new level of licensure is underway, the DHS and the DEA should immediately pursue the interim step of adopting an administrative rule setting forth minimum payment certification standards for the residences that serve SSI-D only recipients. These standards should inform and eventually be incorporated into the licensure requirements for residences that serve populations with specific characteristics or needs.

Within 180 days from when the rules take effect, all residences admitting SSI-D only public pay residents must meet certification standards similar to the following:

- *Assessments and Care Planning*. Assessments of prospective and current residents and the development and monitoring of individualized care plans must be conducted by appropriately qualified professionals. The State's Nursing Practice Act requires that assessments and care planning be performed by properly trained licensed nurses. Residences seeking certification must also show evidence that the

assessment instrument used by nursing professionals engaged for such purposes provides a comprehensive evaluation of a resident's behavioral health needs and identifies any potential safety risks.

- *Staff qualifications and resident monitoring*. There must be staff on-site for a minimum of 12 hours a day who have successfully completed training in how to monitor behavioral health status and identify subtle changes in attitudes, actions or medication compliance that may be indicative of a decline in health status, the emergence of safety risks, and/or the need for medical interventions or a higher level of care.
- *Service Coordination.* Residences must provide evidence that there is a service coordination system in place that enables residents to access needed services and assures they are provided in a timely and effective manner.
- *Risk disclosure and reporting*. Residences must have a mechanism for informing prospective and current residents of any safety risks in the living environment posed by other individuals on the premise. They must also show that they have developed protocols for averting and managing safety issues, handling complaints and reports about violent or threatening speech/behaviors, and notifying the appropriate mental health and law enforcement authorities when such incidents occur.

To ensure compliance with these certification standards, the DHS should use the interagency task force to direct staff professionals from the DEA, MHRH, the Department of Health, and the DOC, to make initial on-site visits of residences and to conduct follow-ups every two years thereafter. Additionally, as some of the residences that serve the SSI-D only population may have financial difficulty meeting the new certification standards, the State should consider providing them with monetary incentives or other compensation via Medicaid or in the form of small one-time grants.

By no later than July 1, 2006, the authorizing statute for the SSI-D program, R.I.G.L.§40-6-27, should be amended to allow the State to use the flexibility permitted under federal law to expand the supportive housing options covered under SSI-D.

Although the provisions of R.I.G.L.§40-6-27 limit SSI-D payment to eligible applicants residing or seeking to reside in a licensed assisted living setting, the State defined the category for federal Social Security Administration purposes as "Residential Care/Assisted Living." An amendment should be made to Chapter 40-6-27 that allows the State to take full advantage of this broader definition.

We found that the supportive housing options available in Rhode Island are quite limited, particularly for the non-elderly population under 65 with disabling behavioral health conditions. The principal alternative for members of this group is the MHRH funded and licensed behavioral health residences, operated by the CMHCs, which primarily serve the department's priority populations.

We found that the MHRH has the authority to license residential care settings that are not funded by the department, but offer the range of behavioral health services that public pay residents need. The growing number of individuals requiring these services who are in assisted living because they have no other choice is a clear indication that there is a gap in the continuum of care available in Rhode Island.

Changing the authorizing statute for SSI-D to also define MHRH licensed residences as "appropriate residential care living arrangements" for the supplemental payment will provide the State with the opportunity to begin filling that gap without creating a parallel service system.

Existing residences, irrespective of how they are funded, should be afforded the option of obtaining MHRH licensure if they meet the applicable standards. To participate in the SSI-D program, they should also be required to comply with the SSI-D certification for payment standards called for in the previous recommendation. Making SSI-D available to MHRH licensed residences will also give the community of providers an incentive to establish additional supportive housing. Those currently licensed by the State are prohibited from admitting SSI-D recipients under federal law because more than half of their funding is provided through Medicaid.

We recognize that expanding the supportive housing options under SSI-D may require additional funding on the front-end. Thus, it is critically important that State agencies work together with nonprofit organizations and assisted living residences and pursue the tenant and project-based funding streams available through the federal government. Additionally, plans to pilot or more effectively use various funding sources and/or payment strategies in conjunction with or as a substitute for SSI-D should consider the implications for both MHRH licensed behavioral health residences and assisted living as well as for the public pay residents they serve. Likewise, in moving forward on the recommendations in this report related to sub-categories of assisted living licensure, it is essential that all parties involved take into account MHRH's licensure authority and responsibilities with respect to behavioral health and avoid developing a parallel service system.

The Department of Human Services should to also use the flexibility allowed under federal law for SSI-D to recognize the unique needs and specialized service requirements of non-elderly residents with disabilities.

As an additional step, the State should use the flexibility it now has under federal law to create separate SSI-D payment levels for the elderly and adults with disabilities. We found that most of the states that provide an SSI enhanced payment established different payment levels for adults with disabilities. Several states in the region, including Massachusetts, Vermont, and New York, have created distinct categories of SSI-D that provide a separate enhanced payment for adults with disabilities living in smaller, congregate housing settings. This payment is used in conjunction with the Medicaid state plan personal care or private non-institutional care services to assure residences serving non-elderly adults with disabilities have a steady stream of revenue and the resources required to provide quality services.

The Department of Human Services has indicated that the financing options for the SSI-D only population are now under review. The Department noted that the Federal Social Security Administration has informed the State that SSI-D categories and rates can be changed, provided that the monthly payments do not fall below the amount set when the assisted living program was established in the early 1990s – i.e., $352. Even with this limitation, there is sufficient flexibility to revise SSI-D to make the payment system more responsive to the diverse needs of the population it serves.

The OHHS-led interagency task force should undertake the effort to designate a single point for screening and assessing the eligibility of public pay applicants. In addition, the DHS should collaborate with the DEA in adopting joint administrative rules that establish and standardize the procedures for the screening and assessment process and ensure that the rights of applicants are protected and observed. Both tasks should be completed by July 1, 2006.

The differences in the eligibility criteria for the SSI-D and Medicaid waiver programs have effectively divided the universe of public pay applicants into two distinct groups: the low-income frail seniors, age 65 and over, with physical or cognitive functional limitations who might otherwise require a nursing home level of care and thus qualify for waiver services; and the diverse range of disabled adults, under age 65, living at that financial margins who are eligible for SSI-D as the result of one or more of disabling chronic physical or behavioral health conditions. The DEA's complex dual screening and assessment process does not adequately evaluate the needs of public pay residents in either group on a consistent basis. This, in turn, may have unintentionally contributed to the inequities in the scope and quality of services the SSI-D and Medicaid waiver populations are each able to access. Establishing a single point for screening and assessing public pay applicants will not alone compensate for these inequities. What it will do is ensure members of both groups are treated equitably and make the process more efficient and easier for applicants to navigate and understand.

The absence of formal rules and written guidelines establishing the eligibility criteria for public pay programs and standardizing the procedures used to determine whether they are met is also problematic. We found that both have not only contributed to the general confusion about the purposes of public pay assessments, but the inconsistent manner in which they are performed, and the potential for the results to be mischaracterized and misused as well – e.g., by the assisted living residences where they seeking admission. Thus, to clarify the role of the process and ensure it functions more efficiently, the DHS and the DEA should work together with stakeholders to develop rules that reflect the general consensus about the role of public pay eligibility screening and assessments, how they are administered and to what end.

The State should adopt a standardized, and easy to administer assessment tool with the capacity to be used across long-term care settings.

Over the last several years, State policymakers have advanced several initiatives that call for the established of a coordinated long-term care entry system that utilizes a uniform assessment to determine an individual's level of care, screen eligibility for publicly financed benefit and services, and evaluate the appropriateness and safety of services provided in the home and community v. institutional setting.[40] The OHHS is uniquely position to lead the five health and human services departments in a collaborative effort to develop a universal screening/assessment tool with this goal in mind. (Several states – including Virginia, Maryland and Maine – have been successful when undertaking similar efforts.) The assessment tool should have the capacity to identify any cognitive, mental health, substance abuse, medical or functional impairments that require a more comprehensive evaluation.

A set of assessment forms that provide this more intensive evaluation of health status and service needs should also be developed. To ensure they are performed in a consistent and uniform manner, training on the applicable procedures and standards should be required for any individuals administering both the universal assessment tool and the more focused evaluations.

The Department of Health should adopt rules requiring licensed residences to conduct standardized comprehensive screening and assessments that cover cognitive, behavioral health and functional impairments both prior to admission and at six-month intervals.

The purpose of resident assessments conducted by assisted living residence personnel is essentially three-fold: to determine an individual's level of care needs, to inform decisions about whether a licensed residence can meet those needs, and to assist in the development of an individualized service plan specifying how the admitting residence will do so. In other words, the assessment should serve as the nexus between the care a current or prospective resident requires and the range of services an assisted living residence is expected to provide. When the assessment process fails to provide the information necessary to make this link, access to and the quality of needed services suffers.

Although some licensed residences conduct comprehensive assessments that address the full range of an individual's potential services needs, it is generally by choice and in their economic interest to do so. As we noted in the report, the assessment form required by the Department of Health, which a significant number of residences use, was not designed to fully evaluate the diverse needs of the assisted living population.

[40] See for example: R.IG.L. §42-66.6

As a result, the variability in the scope and effectiveness of industry assessments makes it difficult to assure the necessary nexus between needs and services exist in every assisted living setting, regardless of the number of beds, the mix of public versus private pay residents, or the physical environment and service offerings. In short, it is not clear that the needs of prospective and current residents are being either identified or addressed on a routine basis prior to admission.

By standardizing the industry assessment process and broadening its focus, both residents and administrators will have access to the information required to make reasoned decisions about the appropriateness and safety of the assisted living service setting. As the assessments administered by the State serve a similar function at the pre-admission stage, the Department of Health should ensure that the standardized assessment forms and guiding procedures adopted complement those being developed by the health and human services departments for public pay applicants under the direction of the OHHS.

The Department of Health should include service coordination as one of the "residential services" that all assisted living residences are required to provide.

Assisted living residences serve a population seeking a supportive community-based residential arrangement because of a physical, cognitive or behavioral health limitation or condition that makes independent living no longer a viable option. Accordingly, residences should have the capacity to routinely monitor the status of the people they serve to detect changes indicative of an early decline (e.g., dementia), the worsening or a condition, or the onset of any other illness or disability that could be alleviated or controlled if addressed promptly and managed properly. It is also incumbent upon residences to identify residents capable of attaining a higher functioning level (e.g., younger residents and full time employment) and assist them in arranging activities and obtaining services that will help them become more self-sufficient and/or independent.

Pro-active service coordination of this kind may appear to be a fundamental departure from what has traditionally been conceived as the appropriate role of assisted living. Indeed, one of the chief marketing points of the industry has long been that, unlike health care settings operating on a medical model which provide extensive supervision and observation, assisted living is a service setting that supports the independence of residents. Although still evident in the State's regulations, this minimalist concept of assisted living has become dated and is thus no longer consistent with the needs and expectations of residents or the views of the wider public.

The OHHS-led task force should develop and adopt payment options that are more responsive to the variable needs and service requirements of public pay residents and the licensed residences where they live.

Moreover, we found that in the growing number of residences in both segments of the industry that now already provide some degree of service coordination, residents appear to enjoy a better quality of life. As redefining "residential services" to include service coordination will have the effect of mandating that it be provided industry-wide, it is worth noting that many of the residences currently providing the highest level of coordination have the fewest resources.

One of the most striking features of the State's public pay programs is the lack of accountability for services rendered, more so on the SSI-D only side, but with respect to Medicaid waiver services as well. The principal issue with SSI-D is that after the DEA conducts its initial assessment of a prospective public pay resident, the State does not systematically track health status or the costs for Medicaid and other health and human services.

The Department of Human Services is the designated "single state agency" for Medicaid purposes. Although Medicaid funds are appropriated through other departments (e.g., funds for the DEA waiver are allocated to DEA), the DHS is the principal payer for the program and, in this capacity, oversees and tracks claims. We noted in the report that a special claims analysis of Medicaid expenditures for the SSI-D population prepared by the Department of Human Services provided useful insights into the types of services – both waiver and state plan -- that were being utilized and reimbursed. However, the data the DHS was able to make available did not lend itself to an analysis of how effectively Medicaid dollars were being spent vis-à-vis other assisted living services. For instance, we could not determine whether higher than average per person costs for Medicaid was an indication that residents had greater acuity needs and were receiving the level of service coordination required to ensure those needs were met, or a sign that outside providers were delivering services that a residence should be offering on-site. The data required for such an analysis, although available, is difficult to extract and thus not accessible on a routine basis.

The area of concern with the Medicaid waivers is the use of a flat rate payment methodology. The problem with using this payment approach is that residences receive the same amount irrespective of the public pay resident's services needs. Thus, a residence participating in the waiver has a clear incentive to cherry-pick on the front end (i.e., admit residents that are likely to have fewer high cost services needs) and to discharge quickly on the back end (i.e., initiate transfers to nursing homes when residents become high cost). Additionally, though the flat rate payment methodology provides greater accountability than the SSI-D approach, the limits set do not take into consideration the great variation in service needs across the assisted living population.

As the Medicaid services provided to public pay residents flow through different State agencies (e.g., DEA, MHRH, and DHS), it is important that all are involved in discussions about exploring new payment options. Among the alternative approaches the OHHS should lead the departments in evaluating are: a tiered payment system, based on acuity needs; managed care for populations or in service areas where Medicaid spending is high; and a cash-and-counseling strategy in which eligible individuals are provided with a budget to be used to pay for the services they need on their own.

Vermont currently utilizes a combination of a tiered and flat rate approach that centers on level of acuity, which is also used to determine licensure level. Although complex, Vermont's acuity-based reimbursement system ensures public pay residents have ready access to the services they need. Moreover, it also provides fair compensation to residences willing to coordinate or arrange for the delivery of either the very specialized services or a broad continuum of services residents with multiple functional limitations often require.

Several states have developed managed care carve outs for assisted living public pay residents with common services needs. Maryland, for example, has established both managed care program for individuals with serious behavioral health and high cost chronic conditions (e.g., congestive heart failure and diabetes) that can be successfully controlled or moderated with certain kinds of intensive services. Oregon has also instituted a managed care approach that provides case management and an array of social, behavioral health and medical services for Medicaid eligible public pay residents with mental health and cognitive impairments. Both states indicate that managed care has improved service quality and access.

The Department of Human Services is currently utilizing a cash-and-counseling approach as part of grant. At present, federal policy prohibits use of the grant for assisted living. However, the prohibition is expected to be lifted soon. This will make it possible to expand the grant to include all or certain segments of the assisted living population.

The OHHS-led task force should develop a plan to ensure the State utilizes all of the available sources of funding for assisted living.

For many public pay residents, assisted living is the only affordable supportive living arrangement available. The recent growth in both housing and health costs is a statewide problem that has had consequences for all Rhode Islanders, but particularly for low-income seniors and adults with disabilities. During the course of our review, we surveyed the various ways states across the nation provide financial support for assisted living as well as comparable residential-based care settings. In general, we found that the State has not examined nor taken full advantage of the different funding sources that could be used to support assisted living or alternative supportive residential options.

On the housing side, the State has advanced several initiatives to expand the living choices for the elderly, to the virtual exclusion of adults with disabilities. The RIHMFC demonstration waiver is a case in point. The mechanism used to finance development of the three residences, the federal low-income housing tax credit, imposes requirements that limit the types of residents who gain access (e.g., residences are prohibited from admitting individuals needing psychiatric services) and the manner in which space is allocated (e.g., residents must be provided private rooms/apartments with baths and only a limited amount of space can be designated as common or social areas).

Given that most non-elderly assisted living residents have behavioral health conditions or disabilities, and that as SSI-D only recipients they seldom have the excess income/resources to pay the higher costs for private rooms, few have qualified for the RIHMFC waiver services since its inception. Several other assisted living residences in the State have received re-development or conversion funding secured through U.S. Department of Housing and Urban Development Programs that provide greater flexibility – e.g., Section 202 program or Assisted Living Conversion Program – but they too target services toward the elderly.

The federal government has established tenant and project-based programs that make funds available to support individuals with disabilities and the development of residence based living options to serve them – HUD Section 811 Vouchers.

Thus far, approval by and the involvement of the Department of Mental Health, Retardation and Hospitals (MHRH) have been required to mine this source of funds. There is no federal or State law or regulation requiring decisions about Section 811 vouchers for tenants or residences to be the sole province of a state's mental health authority. There are several states that have utilized Section 811 funds to support correctional step down facilities (e.g., Maryland and New Jersey) and supportive housing for adults with behavioral health problems (e.g., Massachusetts and Maine). In short, the State needs to develop a comprehensive plan for increasing the availability of affordable housing that considers options such as these and takes into account the needs of both adults with disabilities and seniors.

Additionally, our review found that the Department of Human Services has begun evaluating the Medicaid state plan and waiver options available to support services provided to public pay residents. With extensive changes in federal Medicaid funding and program requirements expected in the near future, it is essential that the Department work closely with other health and human services agencies and the Department of Corrections and the State's various housing authorities when examining the benefits and consequences of alternative financing mechanisms. Again, the OHHS should play a role in coordinating this effort.

By February 1, 2006, the OHHS should submit a report to the Governor that compares the cost and effectiveness of providing publicly financed services to adults with disabilities in assisted living versus other residential settings with the capacity to offer a comparable array of community-based services and supports.

To fully appreciate the State financial support for public pay residents in assisted living, it is important to keep in mind that between May 2004 and May 2005, the total (including federal and State contributions) Medicaid costs for state plan services provided to residents receiving SSI-D and waiver support exceeded $13.5 million. This does not include SSI-D payments made directly to public pay residents, nor the flat rate of $35.54 per diem for Medicaid personal care and related services that the State provides to residences through the waiver programs. The combined cost to the State alone, excluding federal financial contributions for all three funding streams (Medicaid waiver, SSI-D and Medicaid state plan), was approximately $12.6 million dollars in SFY 2005. The State needs to scrutinize whether these funds are being spent in a cost-effective and efficient manner in view of the possible alternatives. As noted above, many states have found that by re-allocating existing funding sources and taking advantage of alternative financing schemes, the capacity and range of residential supportive living options can be greatly expanded.

Again, given that federal funds for Medicaid state plan services are likely to be cut significantly over the next several years, it is imperative that the State undertake a comprehensive study of the publicly-financed assisted living in comparison to comparable alternatives. This too should be a task in which the OHHS facilitates and coordinates as part of a broad-based initiative.

Safety: Assuring a Quality Living Environment

The Department of Health should immediately amend the definition of a "resident" to exclude convicted felons on probation or parole that are subject to electronic monitoring from residing within assisted living residences.

State policymakers, the industry and the general public agree that assisted living residences do not provide the appropriate living environment for individuals subject to electronic monitoring by the Department of Corrections. Based on this broad consensus, it is both necessary and appropriate for the Department of Health to amend the definition of assisted living resident accordingly.

The Department of Corrections should ensure immediate full implementation and continuous monitoring of recently developed protocols strengthening oversight of and the exchange of information about individuals on probation and parole that are residing in the assisted living setting.

The Department of Corrections instituted protocols requiring that proper notification is provided to each licensed residence about any convicted felons on probation or parole seeking admission to or already living in the residence. Such notification is to include information about how and under what circumstances a residence should contact the felon's probation/parole officer. As of September 2005, supervising probation and parole officers will contact residents who are offenders, and the administrator of the residence where they live on a monthly basis. Residences will also be notified when an offender is no longer on probation or parole status. Additionally, the protocols require that the Department increase the level of supervision over residents on parole/probation that have been convicted of violent crimes.

It is imperative that the Department assures that the protocols are fully implemented immediately and that their efficacy is monitored on a continuing basis. In addition, the Department should also regularly evaluate the effectiveness of procedures for community notification about probationers and parolees more generally.

The Department of Health should modify the assisted living regulations to ensure residents are informed about the role and responsibilities of the State Long-Term Care Ombudsman in protecting their rights and advocating on their behalf.

Under the assisted living regulations currently in effect, licensed residences are required to provide contact information about the State's Office of the Long-Term Care Ombudsman (LTCO) in resident agreements as well as in public postings. The Department of Health should incorporate specific language in the regulations for assisted living requiring residences to inform prospective and current residents and their families about the important role the LTCO is authorized to play in ensuring their safety and rights are protected.

This information should be disclosed in written form upon admission and at regular intervals thereafter, and should specify clearly that the LTCO is by statute an advocate for assisted living residents and that residents, staff, and families who cooperate with the Ombudsman are protected from retributions.

The Department of Health should develop a more "resident centered approach" for ensuring licensed residences comply with regulations and provide appropriate services as well as a safe living environment.

The Department of Health's current practice is to exercise oversight by conducting inspections in a manner similar to the process used for skilled nursing homes. As noted in the report, this approach is labor-intensive, time-consuming, high-cost and, in some respects, ill-suited for the assisted living setting. To maximize limited resources allocated towards oversight of assisted living residences, other states have developed alternatives to the nursing facility inspection model.

For example, in Colorado, inspectors monitor compliance with regulations using a process that centers on the observation of residents, the delivery of services, and the physical environment. Colorado's regulatory agency has also developed a system for targeting limited resources to address problem areas common industry-wide -- e.g., inadequate social activities or medication errors. Another strategy states have use to maximize resources is to prioritize complaints and reports according to their seriousness or potential to cause harm and reduce the time spent focusing on minor violations. In Wisconsin, inspectors give a "notice of findings" to assisted living residences when they identify for violations that do not pose immediate harm to residents. These notices are used to inform residences about the minor infractions detected by compliance staff and serve as a substitute for the more cumbersome task of citing and responding to a deficiency.

Inspectors in Wisconsin also use an abbreviated process for residences with a record of few deficiencies. Minnesota has adopted a similar approach for conducting inspections that waives the required inspection for any residence providing "consistently high quality services" to residences. Like Colorado, Minnesota has adopted a "resident-centered" compliance strategy that considers the prevalence of deficiencies to be an ancillary indicator of service quality.

In a 2002 study of state assisted living monitoring and enforcement systems nationwide, officials mentioned the following oversight strategies as the most effective: conducting follow-up visits when violations are detected or complaints received, and having a range of enforcement actions available that can be applied progressively based on a residence's ability to comply with regulations when compliance problems are detected.[41] Given that State law gives the Department of Health wide latitude in determining the procedures for monitoring assisted living residences, the Director should explore and pilot-test resident-centered oversight strategies that incorporate some of the strengths of those mentioned here and/or that have worked successfully in other states.

[41] Mollica RL. State Assisted Living Policy 2002. Portland, ME: National Academy for State Health Policy, November 2002. Available at: http://www.nashp.org/store/prodpage.cfm?CategoryID=5#16

The Department of Health should take the appropriate legal steps required to adopt whistle-blower protection for staff, residents, and family members who report problems about assisted living residences to a government agency.

The Department of Health's ability to assure that assisted living residences are providing a safe and appropriate services rests in part on the complaints and reports it receives from residents, their family members and the professional staff who work in the assisted living setting. Fear of recrimination is one of the central reasons all concerned are reluctant to report service and quality issues.

The Department of Health could expand its regulatory presence by implementing protections removing this barrier. It is not clear whether the Department has sufficient legal authority at present to establish whistleblower protection by regulation. If not, the Department should propose legislation that will indemnify and protect individuals who, in good faith, make reports or complainants about assisted living residences to a government agency.

The Department of Health should strengthen and broaden the staffing and service requirements for the dementia level of licensure.

Assisted living residents in Rhode Island today should expect that the residence where they live to take an early intervention aimed at preventing or forestalling the potential health effects of an unchecked decline in cognition. Most dementias decline progressively rather than abruptly. Consequently, any assisted living residence that admits or retains an individual with a dementia diagnosis should be prepared to monitor and handle worsening dementia symptoms.

The following recommendations for dementia care practice in assisted living residences developed by the Alzheimer's Association[42] should be incorporated into Department of Health regulations for the "dementia care" level of license:

- *Staffing* – All staff (temporary and permanent) should demonstrate an understanding of "dementia, including the progression of the disease, memory loss, and psychiatric and behavioral symptoms"; have training in "specific aspects of care, such as pain, food and fluid intake, and social engagement; and have continuing education in dementia-related care practices.
- *Assessment* – The comprehensive admission assessment and reassessment for residents who exhibit dementia-related symptoms should: include items in areas such as sensory capabilities, decision-making capacity, and communication abilities; take into account variations in resident function at different times of day; provide additional screening for nutrition, pain, and social engagement; and be conducted every ninety days or upon significant change in condition.

[42] Alzheimer's Association, Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes, 2005.

- *Service plans* – Service plans should address provisions for specific areas of dementia care practice, such as assuring adequate food and fluid consumption, pain management, and social engagement.

The Department of Health should revise the assisted living regulations to strengthen training requirements and continuing education requirements for all assisted living staff, including Administrators.

The scope and quality of services an assisted living residence provides is greatly affected by the qualifications and training of its staff.

Over the last five years, states across the nation have been looking for ways to meet the growing and changing needs of the assisted living population. Ensuring that assisted living staff have the qualifications and training necessary to recognize and address these needs has become one of the principal objectives of many of these state efforts. In this respect, Rhode Island should not be an exception. To confront the challenges in assisted living in the State today, and successfully pursue the goals set forth in this report, the Department of Health should work together with stakeholders to review the role of assisted living staff and qualification and training requirements. At a minimum, the regulations should be revised to clarify the responsibilities of direct care and managerial staff (e.g., administrators, medication administration aides, nurses, etc.) and strengthen the base qualifications and training requirements to make them more comparable to the level achieved in neighboring states. In addition, the regulations should establish that all direct care staff obtain a specific number of hours of continuing education at least annually.

In residences that cater to or serve residents with specialized needs or particular conditions (e.g., dementia, behavioral health needs, etc) all direct care and managerial staff should be required to obtain continuing education focusing on those needs/conditions. To ensure that assisted living staff are able to provide the level of service coordination necessary, relevant continuing education and training for staff in this area should also be required.

Additionally, to enable assisted living administrators to better identify the needs of residents of all ages, the Department of Health should identify particular areas in which all administrators should demonstrate competence. These areas should extend beyond familiarity with aging-related concerns, such as: resident rights, behavioral health disorders and signs of decline or instability in mental health conditions, dementia-related symptoms, communication with and managing behaviors of residents with dementia, aging-related conditions, resident safety, service plans, and reporting requirements.

The Department of Health should develop standards for the oversight of medication administration aides as well as a state-wide registry identifying, at a minimum, the date of certification.

Rhode Island is one of the few states in the region that has not instituted a mechanism for identifying appropriately trained medication administration aides. Members of the industry and other stakeholders have indicated there is a clear need for the Department of Health to establish a state-wide registry listing the names of all medication administration aides who have passed the state-approved course in drug administration, and, if feasible, their current employer.

Other states, like Virginia, have taken steps to require personnel that help administer medications to register with the Board of Nursing.[43] In Maine, "medication technicians" must have eight hours of continuing education every two years.[44] Other steps that could strengthen oversight of medication administration aides in the State include revising the regulations to require specific types of continuing education and to mandate assisted living residences to maintain both the qualifications of their medication administration aides and record of their Continuing Education Units (CEUs) on file.

The State should reduce the required 30 days of notice before discharging residents, while preserving the right to due process and maintaining the provisions pertaining to life-threatening emergencies and nonpayment of fees and costs.

According to industry members, residents and their families sometimes use the 30 day notice for discharge requirement to remain in assisting living as long as possible even though it is not an appropriate care setting or living arrangement. Licensed residences that primarily serve the elderly indicate that this increasingly occurs when family members are seeking to delay moving a resident to a more costly skilled nursing facility. Residences that cater to the population with disabilities under age 65 report that the 30 day notice poses safety risks as it prohibits the timely discharge of residents who are disruptive and/or who need a greater level of supervision or care, but are reluctant to leave because of lack of alternative housing options.

Adopting a shorter timeframe for giving notice will sufficiently protect the rights of individual residents who cannot be adequately or appropriately served in the assisted living setting. At the same time, it will also allow residences to be more responsive to other residents who have needs that can be more readily addressed or concerns about the safety of the living environment.

[43] Code of Virginia, 54.1-3041.

[44] Regulations Governing the Licensing and Functioning of Assisted Housing Programs: Assisted Living Programs. State of Maine, Department of Human Services, Bureau of Elder and Adult Services, Assisted Living Licensing Services. September 1, 2003.

Problems with the time requirements for resident discharges are not unique to Rhode Island. States across the nation are exploring alternative strategies for striking a fairer balancing the rights of residents requiring discharges or transfers with those of their fellow residents and the operators of the facilities that serve them. For example, Oregon adopted a provision that establishes involuntary discharge/transfer criteria as part of a broader effort to deal with this issue. Under this provision, assisted living residences are permitted to provide 14 days written notice when a resident is reevaluated subsequent to "a sudden change in condition that requires medical or psychiatric treatment outside the facility" and determined to have needs exceeding the level of service available in the assisted living setting. Additionally, less than 14-day notice is allowable with written consent from the appropriate licensing agency in the state.[45] In Maine, involuntary discharge is allowable when a consumer's intentional behavior results in damage to the residence, or to residents or staff.[46] As these examples from other states show, a shorter time frame than the 30 days notice currently required is not without precedent.

The Department of Health should prepare legislation that adds assisted living residences that have at least one full-time registered nurse on staff to the list of settings in which Nursing Assistants are authorized to practice. In addition, the Department should revise its regulations to include assisted living residences as a setting in which Nursing Assistants may demonstrate continued employment for purposes of renewing their certification.

Certified Nursing Assistants (CNAs) are trained to provide the personal care and assistance that residents in assisted living need and depend upon. By definition in statute, however, they must be supervised by nurses and other appropriate staff in a health facility, or by a physician.[47] Although many of the staff in assisted living residences may be CNAs working under registered nurses, they may not renew their license unless they have worked for a minimum of eight hours in a health care facility, according to the Department of Health's regulations regarding nursing assistants. Because assisted living residences are not health care facilities, full-time employment in an assisted living residence does not contribute to this minimum, even if the Nursing Assistant's work was directly supervised by a registered nurse.

By amending State law to add assisted living residences as a setting in which CNAs may demonstrate continued employment, one barrier to recruiting trained staff to work in assisted living residences may be removed, thereby benefiting residents. CNAs will also benefit, as those already working in the assisted living setting will not have to seek temporary, one-time shifts at health care facilities elsewhere to meet the conditions of certification renewal.

[45] Mollica, RL and R Jenkens. State Assisted Living Pracies and Options. September, 2001. A publication of the Coming Home Program, funded under a grant from The Robert Wood Johnson Foundation. Available at: http://www.ncbdc.org/ncbdc/contents.nsf/docname/CHStatePolicyManual/$file/CHPPolicyManualPDF.pdf

[46] Regulations Governing the Licensing and Functioning of Assisted Housing Programs: Assisted Living Programs, Section 5.3. State of Maine, Department of Human Services, Bureau of Elder and Adult Services, Assisted Living Licensing Services. September 1, 2003.

[47] R.I.G.L. 23-17.9-2.

Transparency: Expanding Access to Information

The Department of Health should adopt regulations standardizing the required form that residences use to disclose: services and costs; criteria for admission, discharge, and continued stay; and any particular types of residents or specialized populations the residence admits or serves. To assure consumers have ready access to the information on the form, the Department of Health should also make a summary available at a single location on its website.

Adoption of a standardized form would provide a checklist that residences use to make public certain types of information they must already disclose under existing regulations such as level of license, admission and discharge criteria, services available, and financial terms. Additionally, the Department of Health should expand the disclosure requirements to mandate that additional information be reported on the form, such as whether the residence caters to individuals with particular disabling conditions (e.g., mental health or HIV-AIDS) and/or admits residents who are on parole or probation for a violent crime. For this approach to disclosure to be effective, all prospective residents should be required to sign the form prior to admission to acknowledge that they have read and understood the information it contains. A signed disclosure form of this type is required in Texas, and is used on a voluntary basis in New Hampshire and Vermont.

Both tracking the information on the form and maintaining a website making it readily available to the public are labor-intensive tasks that may sap the Department of Health's already limited resources. Accordingly, we recognize that additional resources may need to be appropriated to the Department of Health for such purposes.

The Department of Health should propose legislation that will require licensed health care providers and facilities making referrals to assisted living residences to disclose in writing all available information about the health status of prospective residents to the full extent confidentiality and privacy laws allow.

Individuals enter assisted living through many different doors. Consequently, one of the challenges licensed residences face is obtaining the information about a prospective resident's history and health status required to determine whether assisted living is an appropriate and safe fit. Before admission to an assisted living residence, most elderly residents were living independently in their own homes or apartments. The decision to live in an assisted living setting is thus typically made by the elderly resident, or family members acting on their behalf, subsequent to an acute episode requiring hospital or nursing home care or the gradual decline of functional and/or cognitive status. For those assisted living residences serving the elderly, cognitive impairments can cloud a resident's recall and family members are not always a reliable source of information about loved ones.

The pool of adult residents with disabilities under age 65 are drawn from a far more diverse range of venues, including their own homes as well as psychiatric inpatient facilities, mental health centers, residential treatment programs, correctional institutions, and homeless shelters.

Often, members of this group are seeking admission because there is no other available supportive living arrangement. The assisted living residences serving this population have even greater difficulty accessing information about history and health status not only because there are fewer ancillary sources (e.g., family and friends), but because referral entities anxious to find an acceptable living arrangement/placement have little incentive to disclose complex, serious health issues and services needs. Adopting regulations that require licensed health care providers and facilities to provide accurate and complete information when making referrals will help assisted living residences overcome at least one of the obstacles limiting the thoroughness of the assessment process.