Health Innovation Subcommittee

Tuesday, February 19, 2013
3:00 PM - 5:00 PM
306 HOB

Will Weatherford
Speaker

John Wood
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Innovation Subcommittee

Start Date and Time:	Tuesday, February 19, 2013 03:00 pm
End Date and Time:	Tuesday, February 19, 2013 05:00 pm
Location:	306 HOB
Duration:	2.00 hrs

Workshop on Assisted Living Facility Regulation:

--Presentations on Assisted Living Facility Regulation by the Agency for Healthcare Administration
--Presentation on the Recommendations of the Florida Assisted Living Facility Workgroup by Larry Polivka, Chair
--Panel Discussion on Industry Recommendations for Improvements in Assisted Living Facility Regulation

NOTICE FINALIZED on 02/12/2013 16:10 by Iseminger.Bobbye

AHCA - Assisted Living
Facilities (ALFs) Presentation

Assisted Living Facilities in Florida

Agency for Health Care Administration

Molly McKinstry

Deputy Secretary Health Quality Assurance

February 19, 2013

Assisted Living Facilities

- Provide full-time living arrangements in the least restrictive and most home-like setting
- Range from individual apartments or rooms that a resident has alone or shares
- Least restrictive setting
- Maintain independence to extent possible
- Regulations must be flexible to allow aging in place

Assisted Living Facility
Basic Services

- Housing, nutritional meals and special diets
- Assistance with the activities of daily living
- Assisting residents to take their own medications
- Supervising residents
- Arranging for health care services
- Providing or arranging for transportation to health care services
- Health monitoring
- Respite care
- Social and leisure activities

Assisted Living Demographics

- No Limitation on Licensure
- Decade of Significant Growth
- 3,044 Facilities / 85,427 Beds
- No Federal "Certification"
- Limited Medicaid Funding
- Aged & Disabled
- Mental Health
- Developmentally Disabled

Florida Assisted Living Trends

State-wide

- 32% increase since 2003
- 80% increase Limited Mental Health
- 52% have six beds or less
- Smallest ALF size = 2 beds
- Largest ALF size = 495 beds

Miami-Dade

- 30% of all ALFs in State
- 80% of Miami-Dade ALFs have six beds or less
- 75% of Miami-Dade ALFs are Limited Mental Health

ALF License Types

- **Standard**-Assistance with or supervision of activities of daily living and self-administration of medications
  - Appropriately licensed personnel may administer medications
- **Limited Nursing Services** – Allows for the provision of certain "nursing" services
- **Extended Congregate Care** – Allows for the provision of more complex services (highest acuity)
- **Limited Mental Health** – Required if the ALF has more than two mental health residents receiving OSS or social security disability

Assisted Living Specialty Licenses

- 1,073 Limited Nursing Services ALFs
- 277 Extended Congregate Care ALFs
  15,284 ECC beds
- 1,084 Limited Mental Health ALFs

Assisted Living Residents

- Eighteen years of age or older
- Be able to transfer, with assistance
- Be able to take his/her own medication, with assistance from staff
- Be free from signs and symptoms of any communicable disease
- If a resident requires administration of medication, a nurse provided by the facility (as an employee or under contract), or the resident, or the resident's representative, contracts with a third party to provide this service
- Need routine, simple nursing services but not 24-hour nursing services
- Exceptions for Extended Congregate Care residents

Resident Assessment and Contracts

Resident Health Assessment

- Completed by a health care practitioner
- Addresses the needs of the resident
- Verifies needs can be met in an ALF

Facility / Resident Contract

- Each resident must have a contract
- Facility must adhere to the contract

Assisted Living
State & Local Government Roles

- Agency for Health Care Administration
  - Licensure and Regulation
  - Medicaid – Assisted Care Services, Various Waiver
- Department of Children and Families
  - Adult Protective Services
  - Mental Health Clients in ALFs
  - Specific Medicaid Waiver
- Agency for Persons with Disabilities
  - Developmentally Disabled Clients in ALFs
- Attorney General
  - Medicaid Fraud Control
  - Patient Abuse, Neglect and Exploitation (PANE)
  - Operation Spot Check
- Health Department
  - Health and Sanitation Inspections

Assisted Living
State & Local Government Roles

- Department of Elder Affairs
  - Rule Development for Assisted Living, Adult Family Care Home, Adult Day Care, Hospice
  - Comprehensive Assessment and Review of Long-Term Care Services (CARES)
  - Long-Term Care Ombudsman Program
  - Statewide Public Guardianship Office
  - Assisted Living Trainer Certification
  - Specific Medicaid Waivers
- Local Authorities (ALF)
  - Fire Authority – Fire and Life Safety Approval
  - Zoning / Building Code Approval and Enforcement

Regulatory Standards

- Resident Care Standards
- Medication Assistance
- Dietary Standards
- Appropriate Supervision
- Staffing
- Education
- Facility and Resident Records
- Limited Physical Plant

Common Assisted Living Violations

- Elopement drill requirements
- Medication record errors or incomplete
- Staff health checks/screenings
- Incomplete health care assessment
- Staff training incomplete or not documented
- Background screening of staff not conducted
- Resident contracts incomplete

Regulatory Process

Regulatory compliance is verified during:

- License application process
- Information arising between biennial licensure
- During inspections, complaint investigations and monitoring

When violations are identified, deficiencies are cited and correction is expected. For inspection violations:

- Follow up visits are conducted to verify compliance
- Off site follow up may occur for documentation violations where correction can be verified

ALF Inspections and Monitoring

- Biennial Licensure Inspections
- Complaint Investigations
- Quarterly ECC Monitoring
- Twice a Year LNS Monitoring
- Inspection Process
  - Regulatory and Complaint History
  - Adverse Incidents
  - Abuse Reports
  - Ombudsman Reports

Other Agency Visits

- Long-term Care Ombudsmen Visits
- Annual Fire Inspections – Local Authorities
- Annual Sanitation Inspections – DOH
- Adult Protective Service Investigations
- Medicaid Waiver Support Coordinators

Assisted Living Complaints and Visits

Complaint Investigations

- Complaint increase of 24%
- Prioritize based on risk to residents
- Serious and immediate threats investigated within one day
- All complaints investigated on average within 22 days

Total ALF visits	Fiscal Year	Number of Visits
	07/08	6,892
	08/09	6,060
	09/10	6,455
	10/11	6,327
	11/12	6,600

ALF Resident Centered Survey Process

Revised survey process focus on identified CORE areas:

- Resident Rights
- Resident Care and Services
- Nutrition and Food Services
- Physical Environment and Safety
- Staff Training
- Medication Management

Licensure Violations

Deficiencies are classified

- Class I deficiencies
- Class II deficiencies
- Class III deficiencies
- Class IV deficiencies

ALF Inspections & Violations

	FY 2007/08	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
All Inspections/Visits	5,274	4,735	5,826	6,367	6,859
Inspections/Visits with Deficiencies	1,897	1,725	2,114	2,105	2,354
Class I	41	55	25	109	107
Class II	242	260	215	351	746
Class III	12,025	10,262	12,506	11,696	8,846
Class IV	2,362	1,257	1,577	731	261
Total Violations Cited	14,670	11,834	14,323	12,887	9,960

Regulatory Sanctions

- Emergency Actions – Limited to Serious Ongoing Issues (Imposed Immediately)
  - Moratorium
  - Suspension
- Sanctions for Violations (Due Process Before Imposition)
  - Fines - Class I, Class II, Uncorrected Class III
  - Denial of License Renewal or Initial Application
  - Revocation of License
    - Closure during Litigation

Regulatory Sanctions

- Due Process for Sanctions
  - Opportunity to Challenge
  - Actions Pend during Litigation
  - Imposed by Final Order
    - May Also Be Challenged
    - Court Can Enjoin Agency Imposition

Assisted Living Enforcement Actions and Affiliated Closures

	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	Total
Suspensions	0	2	1	2	5	10
Revocations	5	4	12	7	17	45
Denials	6	11	7	5	9	38
Closed/ Failed to Renew during Legal Case	34	37	40	46	38	195
Total	45	54	60	60	69	288

Assisted Living Fines

	# of ALFs	# of Cases	Fines Imposed
FY 2006/07	276	373	$872,860.16
FY 2007/08	351	500	$819,916.77
FY 2008/09	354	471	$685,392.83
FY 2009/10	243	324	$627,055.50
FY 2010/11	406	519	$783,247.18
FY 2011/12	426	546	$1,615,105.15

Recent Changes

- Enhanced Partner Communication/Coordination
- Consumer Information and Outreach
- ALF Enforcement Team
- Revised Survey Process
- Enhanced Surveyor Training and Survey Oversight

Assisted Living Workgroup

- Governor Scott directed AHCA to examine regulation and oversight of ALFs
- Focus on Monitoring of Safety and Resident Well-being
- Diverse Sixteen Member Panel
- 2011 Phase I Meetings, Online Report
- 2012 Phase II Meetings, Online Report
  - Included behavioral health managed care
  - Sub-committee Summit and Continued Dialogue

ALF Workgroup
Recommendations

Recommendations from ALF Workgroup

for

2013 Legislation

Larry Polivka, Ph.D.
Claude Pepper Center, Florida State University

February 19, 2013

ALF Workgroup Reports

- The Assisted Living Workgroup met from August 2011 to October 2012 (7 meetings) and produced two Reports (Phase I and Phase II) with 125 recommendations.
- I've always been very sensitive to regulatory over reach in assisted living and opposed the imposition of a NH like regulatory framework in assisted living since the 1980s.
- I've supported increasing Assisted Living Facilities capacity to allow aging in place (admission and retention of more impaired residents) since directing the development of the ECC License in 1990/91.
- I've also felt, however, that we (policymakers, advocates, media) should monitor the growth and changes in assisted living (residents and services) from a public policy perspective, including regulation.
- As more impaired residents live in assisted living and age in place we need to ensure that the regulatory framework continues to be effective--responsive to resident needs for an adequate quality of care and life.
- I think I shared this perspective with other members of the Assisted Living Workgroup, all of whom were very conscientious and thoughtful in all workgroup deliberations and the development of final recommendations. It was an honor to be able to work with them.

ALF Workgroup Reports

- Many Phase I recommendations were included in 2012 ALF legislations (2 senate bills—most of the higher priority recommendations were in both bills and other were in one or the other bill). I hope these recommendations are also included in any 2013 legislation.
- I have identified the following recommendations from the work group Phase I and Phase II Reports for priority attention in the development of 2013 Legislation.
- I did not include any from the 24 training recommendations, several of which were addressed in the DOEA negotiated rule for assisted living. I am inclined to defer to AHCA, DOEA and others in identifying the other training recommendations that should be included in any 2013 Legislation.
- These selected recommendations reflect my own sense of ALF regulatory priorities. I do not pretend to speak for the work group as a whole.

ALF Administrator Qualifications

Raise standards to become an ALF administrator including:

- Take core training and pass competency examination, and
- Be at least 21 years of age, and
- Have an associate degree or higher from a accredited college (in a health care related field) and (one year experience) working in a health care related field having direct contact with one or more of the client groups or,
- A bachelor's degree in a field other than in health care from an accredited college and (one year experience) working in a health care related field having direct contact with one or more of the client groups or,
- A bachelor's degree in a field other than in health care from an accredited college and one year experience working in an ALF or,
- At least two years experience working in a health care related field having direct contact with one or more of the client groups or,
- A valid nursing home administrator's license, or
- A valid registered nurse license, or
- Grandfather existing administrators with certain training and experience, and no Class I or Class II deficiencies in their past.

Resident Discharge

- Reduce the resident discharge notice from 45 to 30 days and provide an option for the resident to appeal with a decision within 10 days. The entire appeal process should take no longer than 45 days.

- Mandate that social workers and discharge planners provide a completed AHCA 1823 Form to the assisted living facility administrator to ensure appropriateness of the resident's admission.

Resident Admission, Quality of Life, Discharge, Safety and Rights

Hold state and local hospitals accountable for discharge planning that matches individual needs and desires to an appropriate and available setting that best integrates individuals into the community. Modify Chapter 395, F.S., to require hospital document consideration of an individual's choices in discharge placements.

ALF Information and Reporting

- Require minimal online data submission to the Agency on a quarterly basis. ALFs currently submit data to the agency in a variety of online applications including adverse incident reporting, monthly liability claim reporting and participation in the Emergency Status System (over 85% of ALF have online accounts). ALF data submission to the Agency should include:
- Number of residents (census)
- Number of residents requiring specialty license services: Limited Nursing Services (LNS), Limited Mental Health (LMH), Extended Congregate Care (ECC)
- Number of residents on Optional State Supplementation (OSS)
- Number of Medicaid recipients whose care is funded through Medicaid by type of waiver

Enforcement

- Require AHCA to assess certain administrative penalties such as increasing sanctions for recurrence of serious deficiencies affecting resident' health, safety, or welfare or failure to pay fine.

- Require a mandatory moratorium for serious violations (Class I or II), when an ALF fails to correct all outstanding deficiencies and reach full compliance at the time of a follow up visit or by the mandatory correction date.

Resident Advocacy

Ensure volunteers have the right to visit licensed programs at any time for purposes of monitoring as well as for complaint resolution. All observations and findings should be submitted to AHCA and acted on in an expedited manner.

Mental Health

Require a Limited Mental Health (LMH) license for ALFs with any mental health residents. The current definition of LMH license is an ALF that serves three or more mentally ill or disabled residents must obtain a limited mental health (LMH) specialty license.

For the purposes of assisted living licensure, a mental health resident is defined as an individual who receives social security disability income (SSDI) due to a mental disorder or supplemental security income (SSI) due to a mental disorder, and receives optional state supplementation (OSS). This definition is limited as there may be other assisted living facility residents with sever and persistent mental illness who have a case manager but do not meet this specific definition.

Mental Health (Continued)

- Require the ALF's administrator, or designee, who acts to have a resident involuntary examined pursuant to Chapter 394, F.S., to document in the resident record the steps taken to prevent the Baker Act within five business days after the initiation of the Baker Act. The presence of the documentation within the timeframe permitted shall be sufficient to satisfy the requirement.
- Improve case management services and advocacy for residents by offering residents choice of case managers and living arrangements.
- Prohibit targeted case management from being provided by an assisted living facility.
- Increase the monitoring of case managers.
- Clarify roles and responsibilities of LMH ALFs and make appropriate changes through a collaborative process including AHCA, DOEA, DCF and any other appropriate agencies.
- The Phase I recommendation to require a Limited Mental Health License for ALFs with any mental health residents (one or more) should not be lost sight of.

Multiple Regulators

Require in law that AHCA staff and other agencies involved in ALF's report knowledge or suspicion of any resident abuse, neglect or exploitation to the central DCF abuse hotline.

Multiple Regulators (Continued)

Form a workgroup of all agencies involved in ALF regulation and stakeholder groups to develop a new organizational structure streamlining the regulatory process.
Designate AHCA as the lead agency for all regulatory activities in the interim.

Multiple Regulators (Continued)

Allow AHCA discretion to use DCF Adult Protective Services findings and pursue sanctions for verified abuse and neglect findings in a facility.

ALF Policy Review Council

Establish an ALF Policy Review Council with broad representation from AHCA, DCF, DOEA and ADP, from the ALF industry, ALF residents and family members, aging and disabled adults, mental health and developmentally disabled advocates and other policy experts. The council should have 15-20 members appointed by the Governor for terms of two and three years and meet at least three times a year. Several other high priority ALF Workgroup recommendations could be among the first issues addressed by the Council.

ALF Policy Review Council (Continued)

The ALF Policy Review Council could evaluate the ALF enforcement process beyond a punitive approach. Although the punitive approach is necessary for chronically poor performing facilities, it is not the best way to elevate quality across the ALF community. Examine the Wisconsin model for ALF regulation which is similar to the AHCA abbreviated survey with the addition of a consultative/collaborative regulatory model.

Consultative Model Pilots

Establish pilot projects to test consultative health quality initiatives in Florida. The pilot projects should include criteria for quality improvement plans and a means of measuring progress towards implementation of plans. These pilot projects should include data collection requirements regarding resident satisfaction, quality of care indicators and use of best practices by frontline caregivers.

Cost of Care Study

AHCA should conduct a cost of care study that would establish cost of care to meet all the requirements associated with the care of a resident in a licensed LMH ALF, a standard licensed facility, a licensed LNS and ECC facility.

Consumer Information

- Develop an independent Medicaid consumer choice counseling hotline for patients, their families or medical professionals to access information on making informed decisions about appropriate ALF placement.
- The hotline should be operated by a third party to eliminate the possibility of referrals to facilities motivated for reasons other than resident needs.

AHCA - ALF Initiatives and Updates

Agency for Health Care Administration
Assisted Living Facility
Initiatives and Updates

Molly McKinstry

Deputy Secretary Health Quality Assurance

February 19, 2013

Agency Initiatives

- Assisted Living Workgroup
  - Phase I Recommendations
  - Phase II Recommendations
  - Public Comment and Workgroup Discussion
- Senate 2011 Interim Report: Review Regulatory Oversight of Assisted Living Facilities in Florida
- Stakeholder Comments and Suggestions

Outreach and Communication Providers and Consumers

- Statewide joint training for administrators, providers and survey staff
- Enhanced FloridaHealthFinder
  - Medicaid services provided by the facility
  - Smartphone apps to locate facilities faster
  - Sanctions and emergency orders
  - Link to all Agency final orders (legal actions – Medicaid and licensure)
- Monthly press releases regarding sanctions, closures, and other actions – all provider types
- Collaborative training with other departments and agencies (provider and staff training)

Outreach and Communication Partner Agencies

- Weekly facility actions meetings to address licensure and Medicaid issues
- Joint inspections with Medicaid Program Integrity
- Access to systems and data used by partner agencies
- DOEA partner in the negotiated rulemaking process
- ALF awareness training for waiver support coordinators and Agency staff (Joint venture between licensure and Medicaid)

Outreach and Communication Partners

- Monthly Interagency Meetings with Agency Partners
  - Long Term Care Ombudsman
  - Department of Elder Affairs
  - Department of Children and Families
  - Agency for Persons with Disabilities
  - Department of Health
  - Medicaid Program Staff
  - Medicaid Program Integrity
- Developed Online Partner Observation Tool
  - Regulators and Advocates
  - Health Care Providers
  - Managed Care Plans

Outreach Results

- Awareness of Concerns
- Coordination of Actions
  - Licensure
  - Monitoring
  - Medicaid Participation
- When and How to Report Problems

ALF Enforcement Team

- Team of ten ALF surveyors
- Functionally separate from the local survey management staff but are physically located in each of the eight Agency field offices

- Primary functions include:
  - Conducting high priority complaints
  - Collaborating with other agencies and law enforcement
  - Participating in unlicensed activity investigations
  - Performing off hours or weekend inspections and monitoring activities
  - Conducting quality assurance reviews

Assisted Living Surveyor Training

- 16-week comprehensive orientation program
  - Review of relevant rule, statutes, and regulations
  - Performance of the survey process, Principles of Documentation
  - Field experience with a qualified mentor/preceptor

- Validation field survey with ALF Enforcement Supervisor for final readiness determination

Revised AHCA Quality Assurance

- Existing supervisor review of all survey reports
- Field Office sample review
- ALF Enforcement Team sample review
- Onsite training for each Field Office by ALF Enforcement Team

Revised Assisted Living Survey

- Enhanced focus on residents
- Concentration on interviews, observations, and record review
- Improve consistency/revised regulation (tags)
- Abbreviated review as authorized by law
    - two survey periods (four years)
    - consistent ownership
    - survey history
    - licensure complaint history
    - ombudsman complaint history
- Largely based on Wisconsin model

Assisted Living Facility Abbreviated Survey

Implemented abbreviated surveys for ALFs with compliance histories as defined in s. 429.41(5), Florida Statutes

- No class I or II
- No uncorrected class III
- No confirmed Ombudsman or licensure complaints within two licensing periods (4 yrs.)
- Must have two survey periods under the current owner

Assisted Living Facility
Abbreviated Survey

- Focus on resident and family feedback
- Observations by the surveyor
- Record reviews based on observations and interviews
- Concerns identified result in expanded sample selection up to standard survey

Medicaid Actions

- Coordinated Medicaid termination when license is revoked, denied, closed
- Long Term Care managed care coordination
  - DOEA Nursing Home Diversion Waiver providers
  - Managed Care Plans – Network Provider status
  - Provider Network Verification Software
- Monthly transparency
  - Press release of terminations / legal actions with closures
  - SB 1986 status report

Assisted Living Sanctions

- Centralized evaluation of sanctions based on inspections
- Consolidate cases when appropriate
- Track and monitor case status in concert with license renewals

Assisted Living Fines

	# of ALFs	# of Cases	Fines Imposed
FY 2006/07	276	373	$872,860.16
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Assisted Living Enforcement Actions and Affiliated Closures

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Closed/ Failed to Renew during Legal Case	34	37	40	46	38	195
Total	45	54	60	60	69	288

Legislative Opportunities

- Clarify case management oversight in limited mental health facilities
- Revise inspections to focus on regulatory problems
- Remove subjective criteria from fines and focus fines on severe violations
- Simplify emergency moratoria criteria
- Require data submission for consumer information and regulatory oversight

Legislative Opportunities

- Specify requirements for infection control and sanitation
- Medication assistance and standards
- Trainer standards
- Administrator qualifications
- Adverse incident reporting
- Elopement prevention policies

Contact Information

Assisted Living Workgroup Site:
ahca.myflorida.com/SCHS/CommiteesCouncils/ALWG/index.shtml

www.ahca.myflorida.com
www.floridahealthfinder.com

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Office of Program Policy
Analysis (OPPAGA) Research

OPPAGA Research on Assisted Living Facilities

Assisted Living Facilities

- Section 429, *Florida Statutes,* defines an assisted living facility (ALF) as "*any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.*"
- The Agency for Health Care Administration (AHCA) licenses and regulates ALFs. ALFs must reapply for licensure every two years. AHCA inspects ALFs upon licensure and when they receive a complaint.
- The departments of Children and Family Services, Elder Affairs, and Health also have regulatory responsibilities.

Assisted Living Facilities

- As of June 30, 2012, there were 3,293 Licensed ALFs in Florida.
- In addition to a standard license, ALFs can apply for specialty licenses, depending on the type of services they provide or populations they serve. There are three types of specialty licenses.
- 1,761 ALFs have a specialty license[1]
  - 1,082 ALFs have a Limited Mental Health (LMH) license
    - Required by ALFs serving three or more mental health residents
  - 274 ALFs have an Extended Congregate Care (ECC) license
    - Allows facilities to offer enhanced services delivered by licensed nurses and other health care professionals to care for residents as they become more impaired
  - 1,062 ALFs have a Limited Nursing Services (LNS) license
    - Allows facilities to offer residents additional nursing services, otherwise not allowed under a standard license

[1] Of these ALFs, 654 have multiple specialty licenses.

OPPAGA Research Questions

- What are the indicators of an unmanaged population with mental illness and what factors contribute to this?
- What challenges do ALFs face when caring for residents with mental illness?
- What strategies or practices do ALFs use to effectively manage this population?

What are the indicators of an unmanaged population with mental illness and what factors contribute to this?

AHCA Deficiency Data on ALFs

- OPPAGA analyzed ALF license and survey data for Fiscal Years 2009-10, 2010-11, and 2011-12
- Included deficiencies from AHCA licensure inspections, complaint investigations, and change of owner inspections.
- Analyzed deficiency data by license type

Deficiency Data Exhibits

Exhibit 1: Deficiencies by License Type

Exhibit 2: Number of Facilities by License Type and Licensed Beds

Exhibit 3: Deficiencies by License Type and Licensed Beds

Exhibit 4: Number of Facilities by License Type and OSS Beds

Exhibit 5: Optional State Supplemental Beds Comprise a Larger Percentage of Total Beds at Facilities with a Limited Mental Health License

Exhibit 6: Deficiencies by License Type and OSS Beds

Exhibit 7: Top Deficiency Categories by License Type

Exhibit 8: Specific Deficiencies by License Type

Exhibit 9: Unsafe Environment Deficiencies

Exhibit 10: Medication Deficiencies

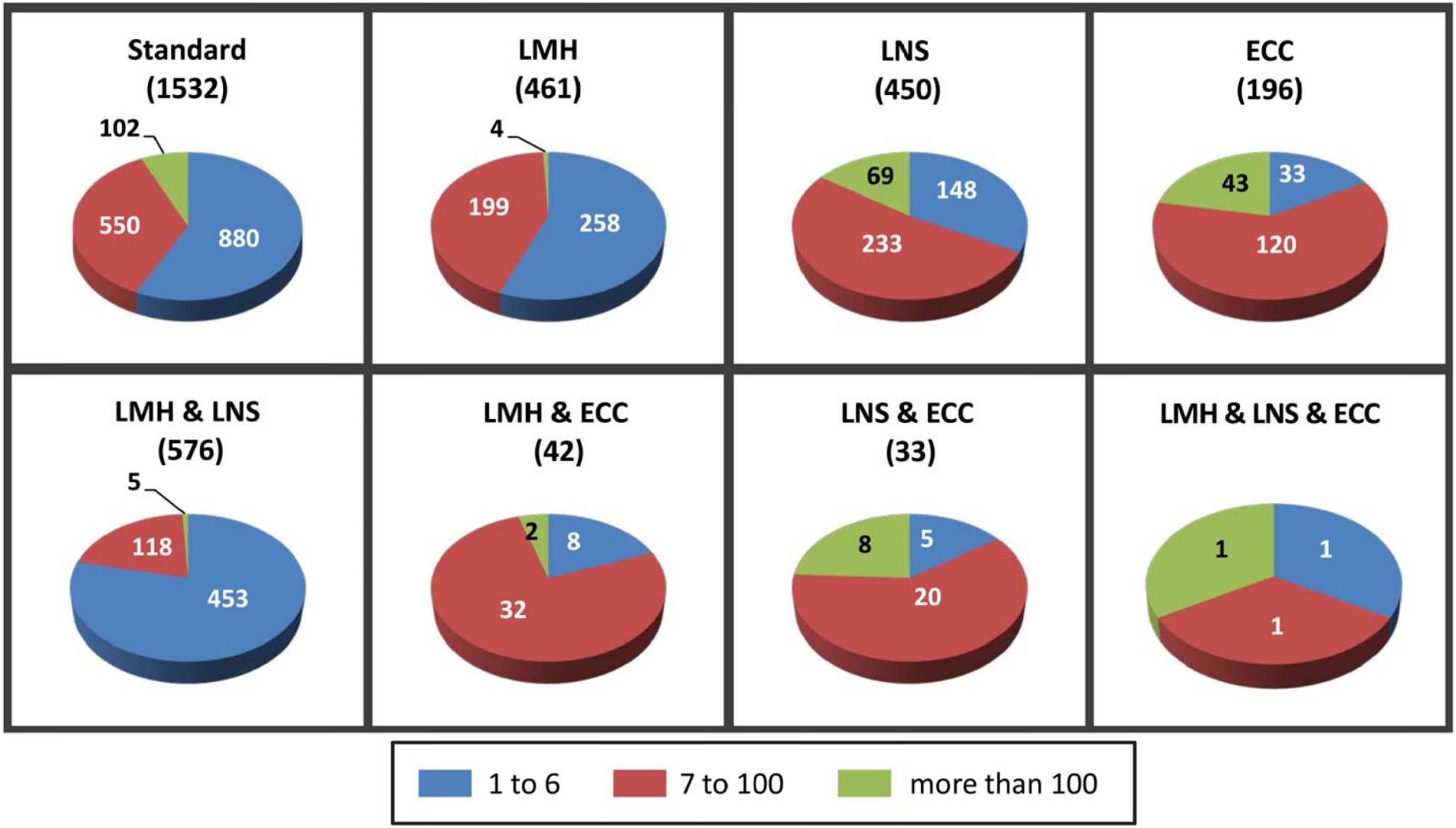
Exhibit 11: Elopement Deficiencies

Exhibit 1
Deficiencies by License Type

License Type	Number of Facilities by License	Percentage of Total Facilities	Number of Deficiencies by License	Percentage of Total Deficiencies	Average Number of Deficiencies per Facility
Standard	1,532	46.5%	28,157	40.3%	18.4
Limited Mental Health (LMH)	461	14.0%	11,697	16.7%	25.4
Limited Nursing Services (LNS)	450	13.7%	10,389	14.9%	23.1
Extended Congregate Care (ECC)	196	6.0%	4,348	6.2%	22.2
LMH & LNS	576	17.5%	13,430	19.2%	23.3
LMH & ECC	42	1.3%	1,184	1.7%	28.2
LNS & ECC	33	1.0%	626	0.9%	19.0
LMH & LNS & ECC	3	0.1%	62	0.1%	20.7
Total	**3,293**	**100%**	**69,893**	**100%**	**21.2**

Source: OPPAGA analysis of AHCA inspection data from Fiscal Years 2009-10, 2010-11, and 2011-12.

Exhibit 2
Number of Facilities by License Type and Licensed Beds[1,2]



[1] Licensed beds indicates the total number of beds authorized by AHCA for the ALF license; it is not an indicator of utilization.

[2] The distribution of licensed beds for all facilities was 54.2% for ALFs with 1 to 6 beds, 38.7% with 7 to 100 beds, 7.1% with more than 100 beds.

Source: OPPAGA analysis of AHCA inspection data from Fiscal Years 2009-10, 2010-11, and 2011-12.

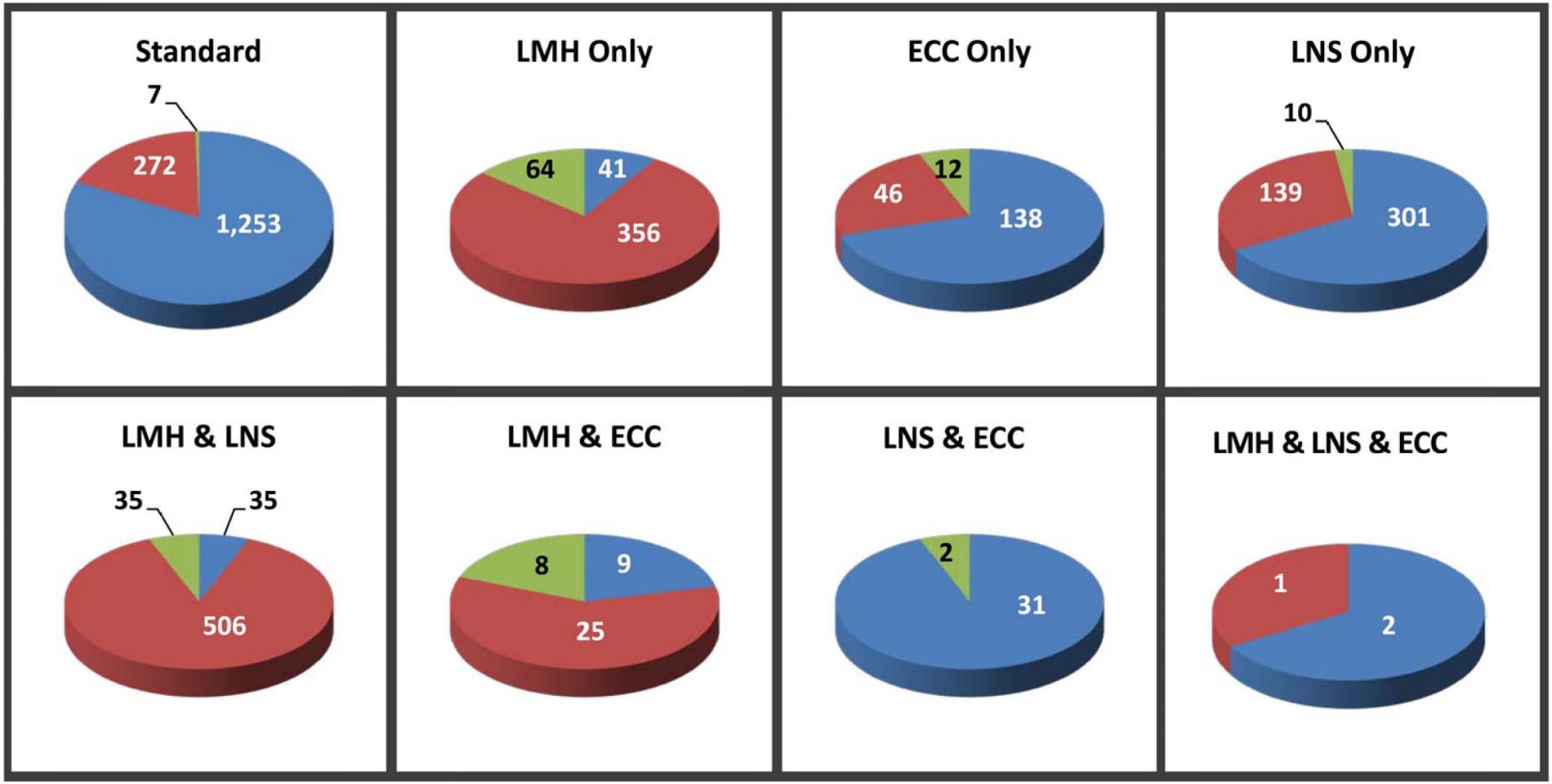
Exhibit 3
Deficiencies by License Type and Licensed Beds

License Type	1 - 6 Beds		7 -100 Beds		101+ Beds	
	Percentage of License Type[1]	Percentage of Deficiencies	Percentage of License Type[1]	Percentage of Deficiencies	Percentage of License Type[1]	Percentage of Deficiencies
Standard	57.4%	49.3%	35.9%	41.3%	6.7%	9.4%
Limited Mental Health (LMH)	56.0%	47.6%	43.2%	50.2%	0.9%	2.2%
Limited Nursing Services (LNS)	32.9%	26.2%	51.8%	53.1%	15.3%	20.7%
Extended Congregate Care (ECC)	16.8%	12.4%	61.2%	58.5%	21.9%	29.1%
LMH/LNS	78.6%	71.7%	20.5%	26.0%	0.9%	2.3%
LMH/ECC	19.0%	9.8%	76.2%	85.2%	4.8%	5.0%
LNS/ ECC	15.2%	6.2%	60.6%	65.2%	24.2%	28.6%
LMH/LNS/ECC	33.3%	19.4%	33.3%	25.0%	33.3%	55.6%

[1] This is a percentage of the total beds in the bed category for the license type and should equal 100% across the three categories. For example, of ALFs with a standard license, 57.4% have 1-6 beds, 35.9% have 7 - 100 beds, and 6.7% have more than 100 beds.

Source: OPPAGA analysis of AHCA inspection data from Fiscal Years 2009-10, 2010-11, and 2011-12.

Exhibit 4
Number of Facilities by License Type and Optional State Supplemental (OSS) Beds[1,2]

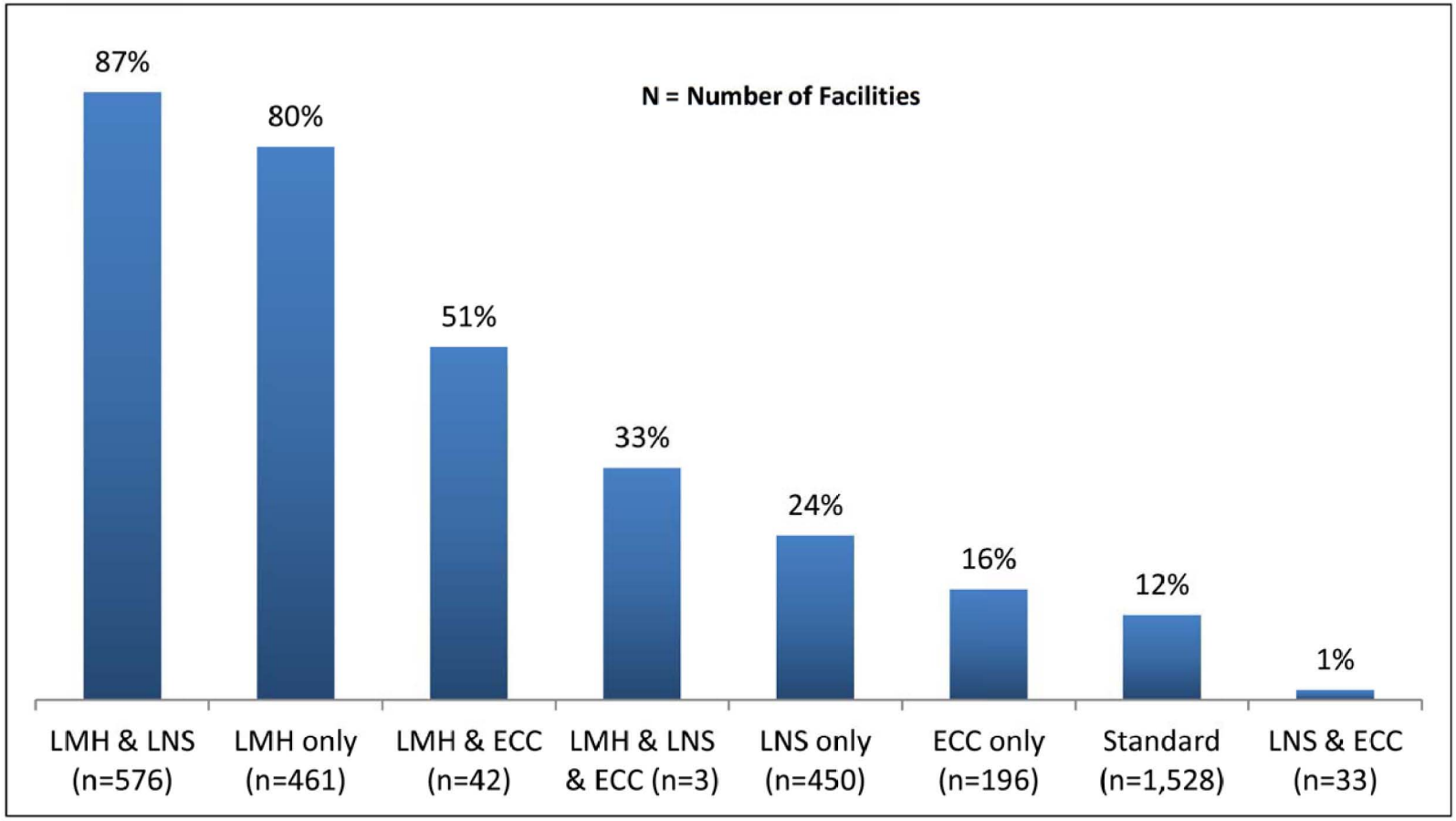


[1] Optional State Supplementation(OSS) beds are a designation of someone receiving OSS funds, who has been certified by the Department of Children and Families as needing placement in a licensed facility. A mental health resident is defined as a person who is receiving SSI or SSDI due to a mental disability and is also receiving OSS funding. OSS beds are the total number of OSS beds that AHCA authorizes for the ALF.

[2] The distribution of OSS beds for all facilities was 55.0 % for ALFs with no OSS beds, 40.8% with 1 to 20 OSS beds, and 4.2% with more than 20 OSS beds.

Source: OPPAGA analysis of AHCA inspection data from Fiscal Years 2009-10, 2010-11, and 2011-12.

Exhibit 5
Optional State Supplementation Beds Comprise a Larger Percentage of Total Beds at Facilities with a Limited Mental Health License



Source: OPPAGA analysis of AHCA inspection data from Fiscal Years 2009-10, 2010-11, and 2011-12.

Exhibit 6
Deficiencies by License Type and Optional State Supplemental Beds[1]

License Type	No OSS Beds		1 - 20 OSS Beds		21+ Beds	
	Percentage of License Type	Percentage of Deficiencies	Percentage of License Type	Percentage of Deficiencies	Percentage of License Type [1]	Percentage of Deficiencies
Standard	81.8%	81.0%	17.8%	18.6%	0.5%	0.5%
Limited Mental Health (LMH)	8.9%	6.0%	77.2%	75.8%	13.9%	18.2%
Limited Nursing Services (LNS)	66.9%	65.3%	30.9%	30.3%	2.2%	4.4%
Extended Congregate Care (ECC)	70.4%	69.3%	23.5%	23.6%	6.1%	7.2%
LMH/LNS	6.1%	4.5%	87.8%	84.4%	6.1%	11.0%
LMH/ECC	21.4%	20.1%	59.5%	65.4%	19.0%	14.5%
LNS/ ECC	93.9%	83.2%	0.0%	0.0%	6.1%	16.8%
LMH/LNS/ECC	66.7%	80.6%	33.3%	19.4%	0.0%	0.0%

[1] This is a percentage of the total OSS beds and OSS bed deficiencies in the bed category for the license type and should equal 100% across the three categories. For example, of ALFs with a standard license, 81.8% have no OSS beds and were cited for 80.4% of the deficiencies , 17.8% have 1-20 beds and were cited for 19.2% of the deficiencies, and 0.5% have more than 20 beds and were cited for 0.4% of the deficiencies.

Source: OPPAGA analysis of AHCA inspection data from Fiscal Years 2009-10, 2010-11, and 2011-12.

Deficiency Categories

- OPPAGA combined a number of related deficiencies to provide categories of deficiencies for comparison
- **Staff Requirement** deficiency category is a composite of 10 individual deficiencies related to background screenings, staffing levels, and staffing records.
- **Records and Policies** deficiency category is a composite of 13 individual deficiencies related to staff records, reporting requirements, resident records, facility policies, and inspection records.
- **Medication** deficiency category is a composite of nine individual deficiencies and relate to medication records, proper assistance with medication administration, and safekeeping of medication.
- **Care and Coordination of Care** deficiency category is a composite of 19 individual deficiencies related to resident care, supervision of residents, health assessments, and the coordination of care with tools such as the community living support plan.
- **Admissions and Discharge** deficiency category is a composite of nine individual deficiencies related to admission eligibility, discharge standards, and admissions processes in the facilities.
- **Physical Plant** deficiency category is a composite of eight individual deficiencies related to building code violations, and fire safety standards.

Exhibit 7
Top Deficiency Categories by License Type[1]

License Status	Percentage of Staff Requirement Deficiencies	Percentage of Records and Policy Deficiencies	Percentage of Medication Deficiencies	Percentage of Care and Coordination of Care Deficiencies	Percentage of Admissions and Discharge Deficiencies	Percentage of Physical Plant Deficiencies	Percentage of the Six Deficiency Categories[2]
Standard	33.9%	18.2%	12.3%	12.2%	7.4%	5.3%	**89.3%**
Limited Mental Health (LMH)	35.1%	18.0%	8.7%	12.7%	5.0%	8.1%	**87.6%**
Limited Nursing Services (LNS)	30.1%	17.1%	15.8%	17.4%	7.1%	4.4%	**91.8%**
Extended Congregate Care (ECC)	27.6%	16.0%	16.6%	19.3%	7.4%	5.4%	**92.3%**
LMH/LNS	36.4%	17.9%	9.7%	12.5%	6.8%	6.6%	**89.9%**
LMH/ECC	26.6%	14.1%	16.6%	14.7%	9.8%	10.2%	**92.0%**
LNS/ ECC	28.4%	13.3%	15.3%	25.7%	5.4%	3.8%	**92.0%**
LMH/LNS/ECC	53.2%	9.7%	12.9%	3.2%	17.7%	0.0%	**96.8%**

[1] These six deficiency categories comprise multiple deficiencies and are the six most cited categories of deficiencies for each license type.

[2] This is the percentage that six deficiency categories represent of total deficiencies. For example, for standard licensed ALFs, these six categories comprise 89.3% of their total deficiencies.

Source: OPPAGA analysis of AHCA inspection data from Fiscal Years 2009-10, 2010-11, and 2011-12.

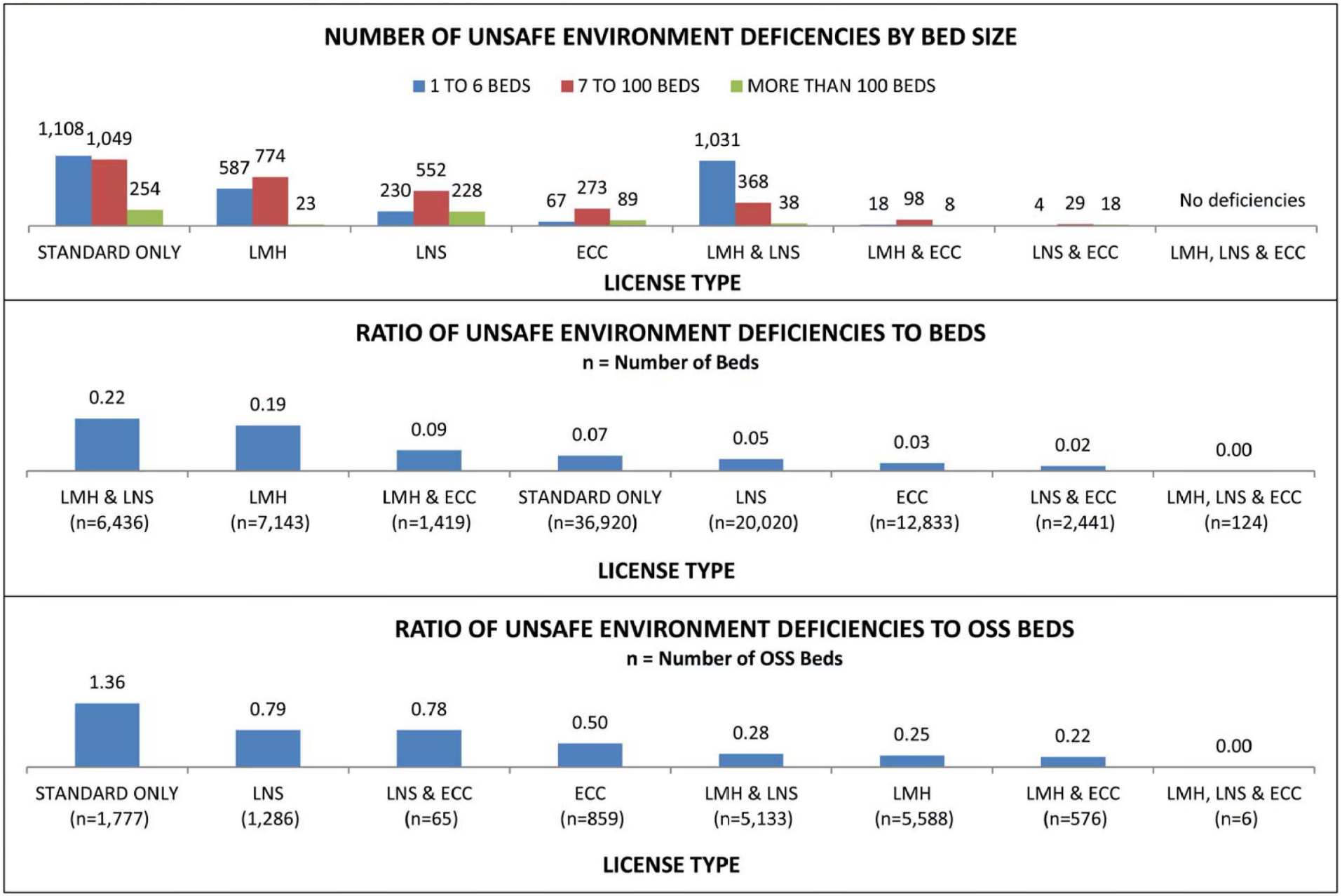
Exhibit 8
Specific Deficiencies by License Type[1]

License Status	Percentage of Total Facilities	Percentage of Unsafe Environment Deficiencies	Percentage of Elopement Deficiencies	Percentage of Medication Deficiencies
Standard	46.5%	35.4%	41.9%	41.0%
Limited Mental Health (LMH)	14.0%	19.5%	19.6%	12.1%
Limited Nursing Services (LNS)	13.7%	15.8%	22.3%	19.4%
Extended Congregate Care (ECC)	6.0%	6.4%	4.1%	8.6%
LMH/LNS	17.5%	20.2%	8.1%	15.4%
LMH/ECC	1.3%	1.8%	1.4%	2.3%
LNS/ ECC	1.0%	0.9%	2.7%	1.1%
LMH/LNS/ECC	0.1%	0.0%	0.0%	0.1%
Total	**100%**	**100%**	**100%**	**100%**

[1] The table shows the percentage of specific deficiencies by license type of all deficiencies across the facilities. For example, deficiencies for unsafe environments for facilities with a standard license comprised 35.4% of unsafe environment deficiencies for all facilities. Unsafe environment and medication categories include multiple deficiencies.

Source: OPPAGA analysis of AHCA inspection data from Fiscal Years 2009-10, 2010-11, and 2011-12.

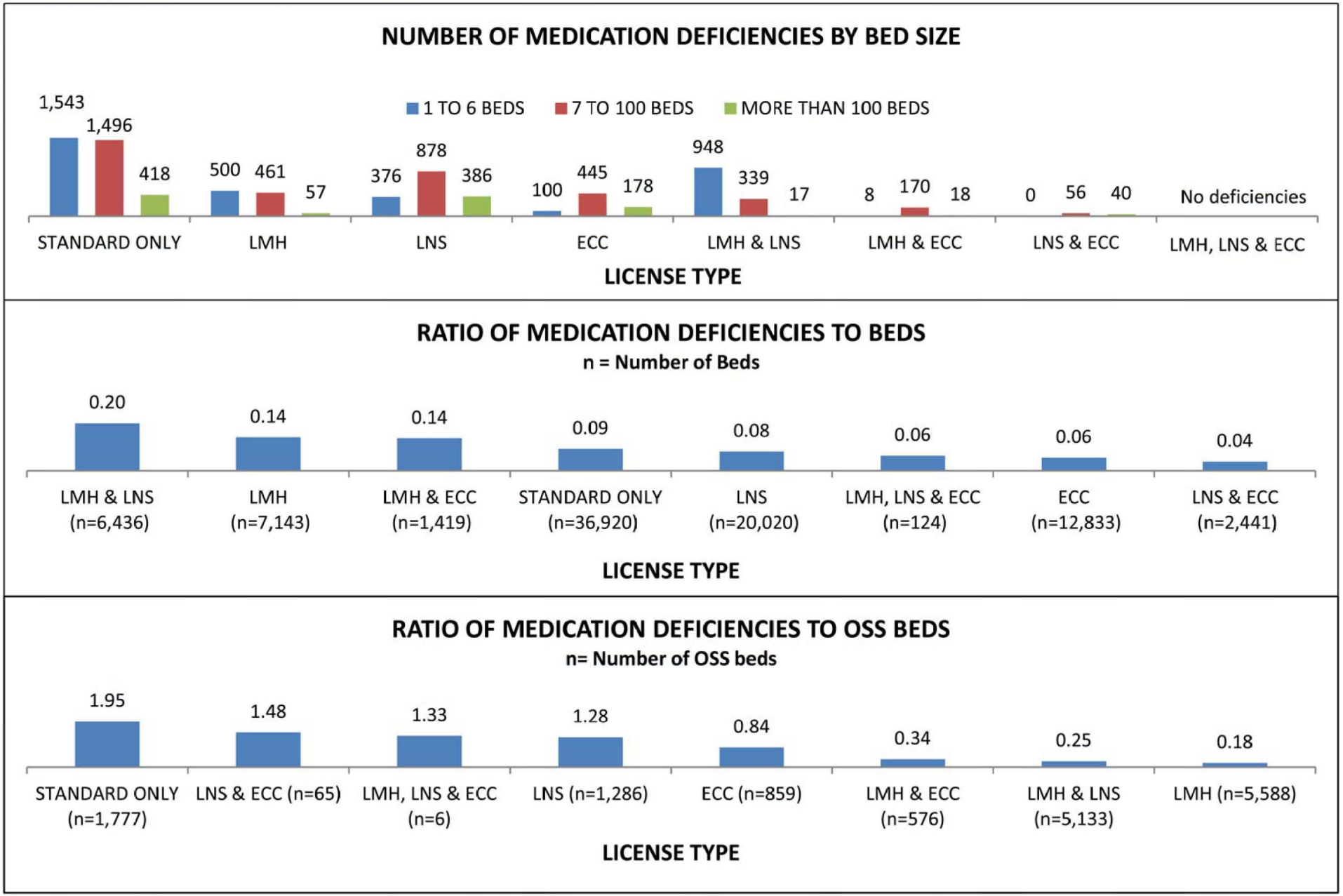
Exhibit 9
Unsafe Environment Deficiencies[1]



[1] Unsafe environment deficiencies is a composite of 19 individual deficiencies that would cause a safety concern in areas such as admissions, training, supervision, food services, staffing standards, and background screenings.

Source: OPPAGA analysis of AHCA inspection data from Fiscal Years 2009-10, 2010-11, and 2011-12.

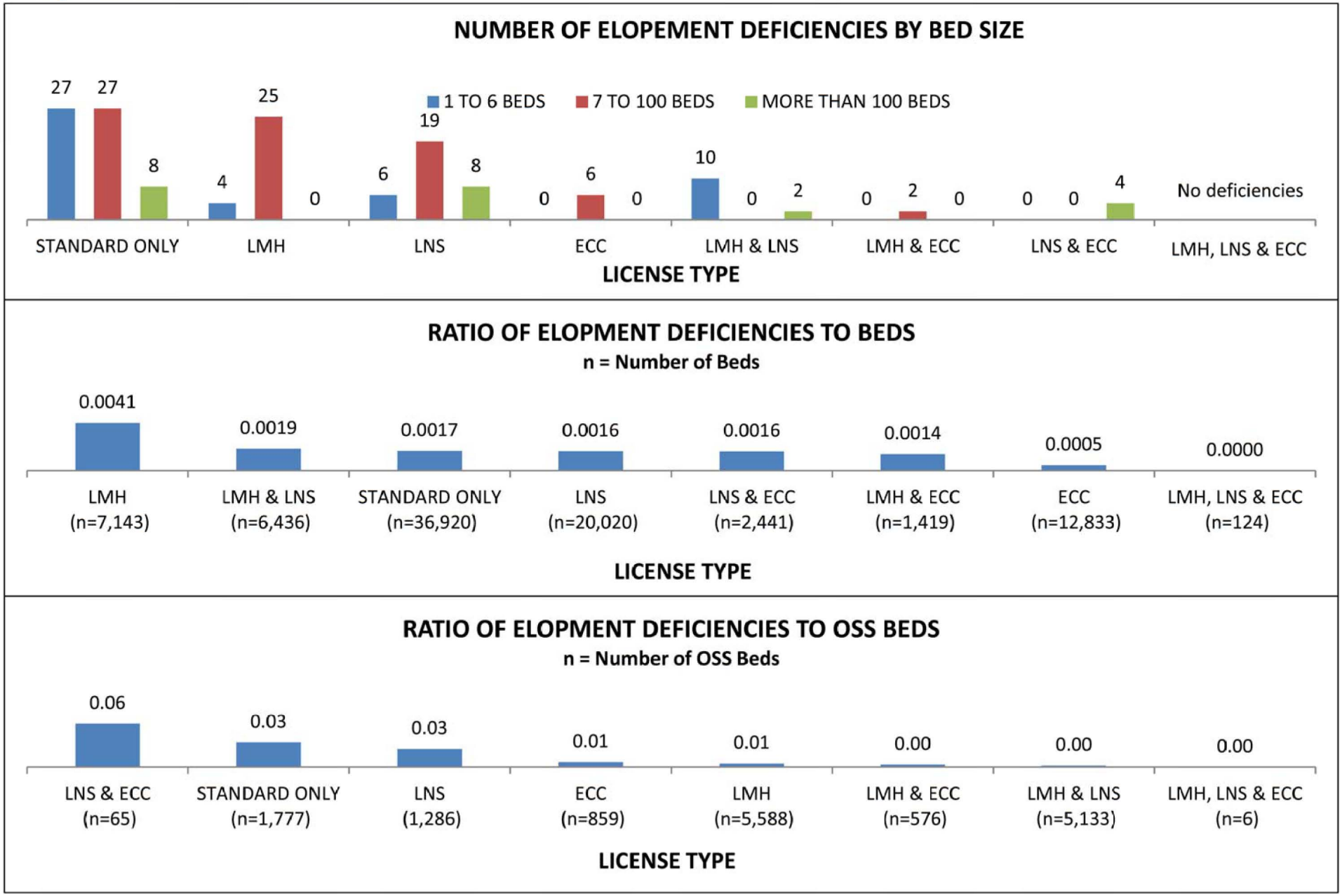
Exhibit 10
Medication Deficiencies[1]



[1] Medication deficiencies is a composite of nine individual deficiencies and relate to medication records, proper assistance with medication administration, and safekeeping of medication.

Source: OPPAGA analysis of AHCA inspection data from Fiscal Years 2009-10, 2010-11, and 2011-12.

Exhibit 11
Elopement Deficiencies[1]



[1] Elopement deficiencies relate to policies and planning to prevent resident elopement.

Source: OPPAGA analysis of AHCA inspection data from Fiscal Year 2009-10, 2010-11, and 2011-12.

Other Potential Indicators of an Unmanaged Population

- High Staff Turnover
  - Consistently high staff turnover can occur because staff do not have the knowledge, experience, or ability to effectively manage residents' specific mental health issues.
- High Resident Turnover
  - When residents have difficulty getting their needs met or remaining stable, they may move to a new facility or the facility may require those residents to leave the facility.
- Baker Acts and Hospitalizations
  - When residents are not properly managed, signs of deterioration and instability are not addressed. This can develop into a crisis and, subsequently, the need for emergency services, such as Baker Acts and hospitalizations.
- Frequent Medication Changes
  - Frequent changes to residents' medication typically indicate that a resident is having difficulty remaining stable; lack of stability could be a function of an unstable environment or lack of medication compliance.

What challenges do ALFs face when caring for residents with mental illness?

Severe and Persistent Mental Illness (SPMI) and Alzheimer's/Dementia

- Stakeholders revealed that the most significant issues involve the SPMI population rather than the Alzheimer's/dementia population.
- The two populations have different needs and issues.
- Stakeholders generally agreed that mixing the SPMI and Alzheimer's/dementia populations can potentially create problems if they are not properly managed. The SPMI residents can create a dangerous and confusing environment for elder populations with Alzheimer's and dementia.

Challenges to Managing Mental Illness

The goal for persons with mental health illnesses is to ensure stability. Challenges to managing residents' mental illness include:

- **Assisting residents with medical care**
  - Without assistance and monitoring, residents often do not take medication or take it improperly. In addition, physical ailments can trigger mental health issues.
  - Helping residents make and keep appointments and coordinating transportation can be difficult.
- **Identifying problems early**
  - If residents who are having problems are not identified early, it may develop into a mental health crisis.
  - Careful observation and evaluation of residents is necessary to identify problems early so that there is opportunity to intervene.

Challenges to Managing Mental Illness
(continued)

- **Preventing harm/disruption to other residents**
  - Residents with mental illnesses can become argumentative and aggressive, which can result in a harmful and disruptive environment for the other residents, especially for residents with Alzheimer's/dementia.
- **Obtaining adequate case management**
  - The case managers at the community mental health centers are responsible for developing and monitoring residents' community living support plan. Stakeholders reported that there often is limited involvement by the case managers.
- **Providing sufficient on-site programming**
  - When programming is insufficient and residents are unengaged, they decompensate or leave the ALF, where they are unsupervised and can create problems in the community and with law enforcement.

What strategies or practices do ALFs use to effectively manage this population?

Strategies and Best Practices

- **Ensure appropriate placement**
  - Assessing resident information to develop a thorough understanding of residents' needs assists ALF administrators in determining whether they will be able to meet the resident's needs and how to best do so.
    - Conduct resident interviews prior to admission:
      - What happened at the last facility?
      - What are the resident's likes/dislikes?
      - Will the resident take their medication?
      - Are there any aggression issues?
    - Review medical information (e.g., AHCA form 1823 or other health information) and interview health care providers, discharge planners, and case managers
    - Interview administrators at past facilities and family members
    - If placement does not seem appropriate or is unsuccessful, work with case managers to identify alternative housing options

Strategies and Best Practices
(continued)

- **Assist residents with medication management**
  - While ALF administrators cannot enforce medication compliance, they can utilize a number of strategies to facilitate medication compliance.
    - Use prepackaged prescriptions by dosage
    - Incorporate medication into the resident's daily routine, such as during meal time or at daily activities
    - Use community resources to assist in medication management (training and consultations by health care providers)
    - Include taking medication as a term in the resident contract

Strategies and Best Practices
(continued)

- **Provide Sufficient Staff Support/Resources**
  - To effectively manage persons with mental illness, ALF administrators need to provide staff with effective resources and support.
    - Training
      - Complete training requirements as soon as possible . Staff have six months to complete training, but it should be completed as soon as possible. (As of December 2012, community mental health centers or the managing entities provide training at least once every six months. However, DCF plans to offer on-line training that could be accessed at any time by July 2013.)
      - Provide on-site mentoring by ALF administrator and experienced staff
    - Documentation
      - Develop and enhance documentation practices to ensure that staff have updated information about changes in resident conditions and potential problems
    - Staff -Resident Relationships
      - Foster individual relationships (e.g., assigning staff to specific residents)
    - Resident Activities
      - Use community resources to provide on-site activities - mental health related (e.g., in-house therapy) and general (social, religious, holiday)

Strategies and Best Practices
(continued)

- **Establish and maintain effective relationships with community stakeholders**
  - Developing effective working relationships with key stakeholders in the community facilitates ALF administrators' access to information that assists in meeting resident needs and getting help when a resident begins to have problems.
    - To have immediate points of contact, develop and maintain relationships with health care providers, such as psychiatrists, case managers, and hospitals
    - Develop relationships with local law enforcement to increase knowledge and awareness of mental illness and to assist during resident crisis

Florida Assisted Living Workgroup, Phase II Recommendations

November 26, 2012

Final Report of the Assisted Living Workgroup

On January 31, 2012 Governor Rick Scott directed the Agency to go forward with Phase II of the Assisted Living Workgroup (AL Workgroup) to continue the examination of issues related to assisted living facilities (ALF). Phase I of the AL Workgroup made recommendations to the Governor and Legislature to improve the monitoring of safety in ALFs. Phase I took place between August 8, 2011 and November 8, 2011, and a report of initial (Phase I) recommendations was issues in November 2011.

In the 2011 report, the AL Workgroup recommended that a Phase II workgroup be appointed to continue to address assisted living policy and regulation in a comprehensive manner. Phase II Assisted Living Workgroup meetings were held on June 25th in Jacksonville, July 27th in Fort Lauderdale, September 10th in Orlando and October 3rd through the 5th in Tallahassee as well as two conference calls that took place on August 31st and September 21st. The AL Workgroup heard testimony and presentations from a wide spectrum of the stakeholders, including: assisted living resident advocates, operators, owners, administrators, state agency staff, managed care organizations, and community mental health centers.

The workgroup included the State Long-Term Care Ombudsman, assisted living facility representative, advocates, health care association representatives, policy experts as well as Senator Rene Garcia and Representative Matt Hudson. Dr. Larry Polivka, Director and Scholar in Residence at the Claude Pepper Foundation, served as Chairman of the workgroup and Agency Secretary Elizabeth Dudek and representatives from the Governor's Office participated in each meeting. State agency leadership participation included representatives from each Agency involved in assisted living facility oversight.

Phase II of the AL Workgroup was designed to utilize the information and recommendations gathered during Phase I and develop recommendations for Legislative proposals for the 2013 Legislative session.

Dr. Larry Polivka, Chair, identified three major priorities of the Phase II Workgroup:

- Identification and discussion of mental health related assisted living issues.
- Evaluation and discussion of issues raised during Phase I relating to organizational infrastructure for regulation.
- Evaluation and discussion of issues related to administrative qualifications, licensure, resident admission/discharge, staffing, resident rights and safety issues.

Throughout Phase II, twenty-one public comments were heard and eleven state agency presentations were made. Additionally, due to the amount of public testimony and potential mental health recommendations, the AL workgroup dedicated two full days to mental health issues, October 4-5, 2012. Prior to that meeting, an Assisted Living Facility/Limited Mental Health and Community Mental Health Center Summit conference call was held September 21, 2012 and a follow-up Summit was held in Tallahassee October 3, 2012. Workgroup member Bob Sharpe, President and CEO, Florida Council for

Community Mental Health, chaired the Summit and presented specific recommendations from the Summit to the Al Workgroup for consideration at the October 4-5, 2012 meeting.

All of the written resources used by the workgroup along with the minutes for the meetings and the Phase I Final Report & Recommendations are available to view at http://ahca.myflorida.com/SCHS/CommiteesCouncils/ALWG/index.shtml.

WORKGROUP MEMBERSHIP AND PARTICIPATION

Public officials, policymakers, advocates and members of the provider community participated on the workgroup as follows:

Larry Polivka, PhD., Chair, The Pepper Center Florida State University
Senator Rene Garcia, The Florida Senate
Representative Matt Hudson, The Florida House of Representatives
Larry Sherberg, Florida Assisted Living Association
Steven P. Schrunk, Florida Health Care Association
Charles Paulk, Florida Life Care Residents Association (FLiCRA)
Jack McRay, AARP-Florida
Jim Crochet, Long Term Care Ombudsman
Bob Sharpe, Florida Council for Community Mental Health
Scott Selis, Esq., The Florida Bar, Elder Law Section
Brian Robare, The Villa at Carpenters
Roxana Solano, Villa Serena I-V
Michael Bay, Eastside Care, Inc.
Martha Lenderman, Lenderman and Associates
Luis E. Collazo, MSW, Palm Breeze ALF
Darlene Arbeit, LeadingAge Florida

The Office of the Governor was represented by Danielle Scoggins and Michael Joos.

State Agency Representatives serving as resources to the AL Workgroup consisted of:

Elizabeth Dudek, Secretary, Agency for Health Care Administration
Molly McKinstry, Deputy Secretary for Health Quality Assurance, Agency for Health Care Administration
Polly Weaver, Bureau Chief, Field Operations, Agency for Health Care Administration
Anne Avery, Operations and Management Consultant, Bureau of Field Operations, Agency for Health Care Administration
Darcy Abbott, Bureau of Medicaid Services, Agency for Health Care Administration
Carol Barr Platt, AHCA Administrator, Managed Behavioral Health, Legislative Analysis & Special Projects Unit, Bureau of Managed Health Care, Agency for Health Care Administration
David Oropallo, Bureau Chief, Health Facility Regulation, Agency for Health Care Administration
Shaddrick Haston, Esq., Assisted Living Unit Manager, Agency for Health Care Administration
Susan Kaempfer, Operations and Management Consultant Manager, Assisted Living Unit, Agency for Health Care Administration
Marisol Novak, Government Operations Specialist, Bureau of Health Facility Regulation, Agency for Health Care Administration

Charles Corley, Secretary, Department of Elder Affairs
Susan Rice, Assistant General Counsel, Department of Elder Affairs
Jackie Beck, Bureau Chief, Mental Health Services, Department of Children and Families
Robert Anderson, Director Adult Protective Services, Department of Children and Families
Cynthia Holland, Bureau Chief, Substance Abuse and Mental Health Services, Department of Children and Families
Mary Beth Vickers, Division Director, Children Medical Services, Department of Health
Robin Eychaner, Environmental Supervisor II, Bureau of Environmental Health, Department of Health
James Varnado, Director, Medicaid Fraud Control Unit, Attorney General's Office
David Bundy, Chief Assistant Attorney General, Medicaid Fraud Control Unit, Office of the Attorney General
Captain Chuck Jordan, Medicaid Fraud Control Unit—Central Florida Region, Office of the Attorney General
Captain William Avery, Medicaid Fraud Control Unit, Office of the Attorney General
Captain David Brockmeier, Medicaid Fraud Control Unit, Office of the Attorney General
George Cooper, State Fire Marshall, Department of Financial Services
Fred Chaplin, Regional Supervisor, Bureau of Fire Prevention, Department of Financial Services
Tom Rice, Operations Review Specialist, Agency for Persons with Disabilities
Gerry Driscoll, South East Region Manager, Agency for Persons with Disabilities

EXECUTIVE SUMMARY

The assisted living community in Florida has witnessed exponential growth over the past eight years, increasing by 30 percent. As a largely consumer choice driven industry, assisted living continues to be a home-like, residential model that thrives in the Sunshine State. Pursuant to section 429, F.S., ALFs should be operated and regulated as residences with supportive services and not as medical or nursing facilities. Furthermore, regulations governing ALFs must be flexible enough to allow the facilities to adopt policies enabling residents to age in place while accommodating theirs needs and preferences—creating more complex care. The challenge is balancing the provision of appropriate care without compromising the concept of a social or residential model.

The changing landscape of long-term care with the expected implementation of Medicaid managed care statewide will further strengthen and evolve the role of ALFs. In addition, Phase II of the AL Workgroup delved into the expanding role of ALFs providing residential services to the limited mental health population. The need for clear roles and responsibilities for provision of services to all categories of residents within ALFs is evident, and will help to provide more efficient and effective care to these residents

This report and the recommendations contained herein, if passed into law, would increase some regulations and continue Florida's tradition of providing the home-like characteristics that have allowed for such growth. These recommendations will also address the growing limited mental health community residing in ALFs with resident's safety and security ensured. Going forward, the Agency for Health Care Administration must continue diligent cooperation with other agencies, provider representatives, advocates, families and individuals to reduce regulation in areas that are overly burdensome while implementing further safeguards and regulations that will protect the residents of ALFs in the ever-evolving health care landscape.

ASSISTED LIVING WORKGROUP RECOMMENDATIONS

The Assisted Living Workgroup, Phase II, compiled a series of recommendations based on public meetings and member input. Although not all issues had the full support of each member, Phase II recommendations did receive approval by a majority of members.

Based on Phase II deliberations, the following recommendations were made:

Utilize Current Regulations

1. Utilize existing regulations to evict unethical or incompetent providers from the system. Recognize that most ALF residents are currently being well taken care of under the current regulatory environment. Do not undermine a social model of care that works.

2. Evaluate the ALF enforcement process beyond a punitive approach. Although the punitive approach is necessary for chronically poor performing facilities, it is not the best way to elevate quality across the ALF community. Examine the Wisconsin model for ALF regulation which is similar to the AHCA abbreviated survey with the addition of a consultative/collaborative regulatory model.

3. Maintain current law that fines will only be imposed for low-level citations if uncorrected, to focus penalties on poor performers without adverse impact on competent providers.

4. Work with long-term managed care plans, once selected by AHCA, to promote the number and use of ALF beds through reimbursement and other incentives, so that the plans increasingly serve as appropriate diversions to nursing home care as well as serving those on waiting lists for nursing home care.

Licensure Revisions

5. Enable a public record exemption for AHCA complaints. Complaints filed with AHCA are currently not protected from disclosure. Consider adding confidentiality to AHCA complaints equivalent to that of the Ombudsman.

6. Allow assisted living facilities to use bulk over-the-counter medications.

7. Amend Chapter 429, F.S., to authorize the use of a floating license for facilities that have a standard, LNS or ECC license.

8. Amend Chapter 429, F.S., to allow Assisted Living Facilities to use the acronym ALF on business cards and other forms of advertising rather than having to spell out Assisted Living Facility.

9. Make technical changes to Chapter 429.14 specific to administrative penalties by changing deficiencies to violations.

10. Include a volunteer representative from another licensed ALF in an AHCA ALF survey team, provided that the ALF being surveyed agrees to the presence of the volunteer representative. A volunteer representative must comply with confidentiality statutes or regulations applicable to the survey team.

Multiple Regulators

11. Form a workgroup of all agencies involved in ALF regulation and stakeholder groups to develop a new organizational structure streamlining the regulatory process. Designate AHCA as the lead agency for all regulatory activities in the interim.

12. Improve coordination between the various federal, state and local agencies with any role in long-term care facilities oversight, especially ALFs. This includes AHCA, the Long Term Care Ombudsman Program, local fire authorities, local health departments, DCF, DOEA, local law enforcement and the AG's Office.

13. Clearly define and formalize Agency responsibilities and lines of communication, coordination and cooperation between agencies with oversight/regulatory through inter-agency agreements.

14. Allow AHCA discretion to use DCF Adult Protective Services findings and pursue sanctions for verified abuse and neglect findings in a facility.

15. Evaluate the ability to determine Level of Care at the time a person is initially added to the wait list as well as allow a person who meets nursing home level of care to receive Medicaid at the ICP level while awaiting long-term care services. AHCA should work with DOEA on this evaluation.

16. Develop a strategy with the State Fire Marshal, DOEA and AHCA to deliver a proposal to address life safety plans and fire sprinkler systems for ALFs with communities with municipal water supply access issues.

17. Develop a strategy with the State Fire Marshal, DOEA and AHCA to deliver a proposal addressing locked unit requirement within facilities.

18. Authorize use of DCF Adult Protective Services finding and investigations in employment matters. As it currently stands, s. 415.107 (8), F.S., states that "information in the Central Abuse Hotline may not be used for employment screening." The current statutory construct allows for the verified perpetrators of abuse, neglect or financial exploitation to continue working with vulnerable populations as long as none of those cases subsequently result in prosecution and conviction. Allowing ALFs (and other providers) to use the information from the abuse registry to screen out such employees during the hiring process would necessitate a change in this law. This change would require DCF to offer due process hearings for perpetrators prior to the closure of all abuse investigations with verified indicators.

19. Modify existing administrative rules so that any licensee, direct service provider, volunteer or any other person working in a residential facility who is an alleged named perpetrator in an active protective investigation of abuse, neglect or exploitation of a vulnerable adult under

Chapter 415, F.S., or abuse, abandonment or neglect of a child under part II of Chapter 39, F.S., and upon reasonable suspicion by an DCF investigator, are prohibited from working directly with residents or being alone with residents until the investigation is closed. The only exception to this prohibition would be if the alleged perpetrator is under the constant visual supervision of other persons working in the facility who are not also alleged named perpetrators in the same investigation. This provision would only be applicable in situations where the licensee has been made aware of the investigation.

20. Work together within state agencies to minimize audit and documentation regulatory requirements on community mental health agencies and ALFs by at least 30 percent to provide for better patient coordination and outcomes.

21. Improve the accessibility of transportation services for ALF residents by working with the Florida Transportation Commission, DCF and AHCA.

Administrator Qualifications

22. Develop protocols for administrator mentorship programs by the provider community and ALF associations for ALFs with no Class I or II violations in the past two years.

23. Create a professional board with regulatory responsibility for assisted living facility administrators.

24. Require assisted living administrators to hold certification by a non-profit third-party credentialing organization. This certification is to be in lieu of licensing administrators.

Information and Reporting

25. Require AHCA to investigate the types of technology currently available for cost effective methods of collection, reporting and analyzing client information and allow facilities to select the type of technology most appropriate to each individual facility—including the availability of swipe or scan handheld devices. The fiscal impact of the equipment, software and staff time must be considerations.

26. Require AHCA to examine the "Dashboard" technology used by DCF in measuring the outcomes of Community Based Care agencies serving dependent children as some aspects of this oversight may be applicable to long-term care settings.

27. Amend Chapter 429, F.S., to consolidate the adverse incident report from two reports into one final report. This final report will be filed within 15 business days of the occurrence of the adverse incident, except in cases of death or elopement.

28. Establish through pilot projects the development of consultative health quality initiatives in Florida. The pilot projects should include criteria for quality improvement plans and a means of measuring progress towards implementation of quality improvement plans. These pilot projects should include data collection requirements regarding resident satisfaction, quality of care indicators and implementation of best practices into the hands of frontline caregivers.

29. AHCA should conduct a cost of care study that would establish cost of care to meet all the requirements associated with the care of a resident in a licensed LMH ALF, a standard licensed facility, a licensed LNS and ECC facility.

Resident Rights and Safety

30. Hold state and local hospitals accountable for discharge planning that matches individual needs and desires to an appropriate and available setting that best integrates individuals into the community. Modify Chapter 395, F.S., to require hospital document consideration of an individual's choices in discharge placements. Address hospitals that do not consider the individual's preferences and community integration in discharge planning.

31. Establish a hospital discharge protocol to an ALF that should include, at a minimum: 3 days of medication if the resident is being discharged during a non-business day, a completed 1823, insurance information, prescriptions, diagnosis, prognosis and discharge orders.

32. Enact legislation that provides ALF residents a formal appeal process for disputed discharge.

33. Afford ALF residents discharge protection that mandates specific reasons for relocation, provides ample notice to residents and provides residents with an administrative appeal hearing.

34. Increase the amount and quality of activities made available to ALF residents.

35. Evaluate expectations for quality of life and care in an ALF. Focus cannot be limited to physical health and safety—it must extend to other quality of life factors, including staff that are kind and focused of the individual wants/needs of each resident.

36. Amend Chapter 429, F.S., to include proposed language that will increase the provision an ALF may provide for the safekeeping of a resident's personal property and funds from $200 to $500. This is more in line with today's economy.

Consumer Information

37. Develop an independent Medicaid consumer choice counseling hotline for patients, their families or medical professionals to access information on making informed decisions about appropriate ALF placement. This single point of contact could provide options depending on managed care options. This will be operated by a third party to eliminate the possibility of referrals to facilities motivated for reasons other than resident needs.

Mental Health

38. Require the ALF's administrator, or designee, who acts to have a resident involuntary examined pursuant to Chapter 394, F.S., to document in the resident record the steps taken to prevent the

Baker Act within five business days after the initiation of the Baker Act. The presence of the documentation within the timeframe permitted shall be sufficient to satisfy the requirement.

39. Increase state funding to limited mental health facilities prior to imposing fee increases by state and local agencies.

40. Increase funding for personal needs allowance for ALF residents and provide cost of living increases for ALF residents receiving OSS funds.

41. Convene a summit to collaborate on issues to provide better care to residents of ALFs who have a mental illness with ALF operators and Community Mental Health Centers.

42. Allow DCF to provide more intense services for ALF residents with mental illness.

43. Improve case management services and advocacy for residents by offering residents choice of case managers and living arrangements.

44. Prohibit targeted case management from being provided by an assisted living facility.

45. Increase the monitoring of case managers.

46. Conduct a study to explore the methods of enhancing care for persons with severe and persistent mental illness in ALFs.

47. Develop methods for reducing the LMH ALF resident-to-staff case management ratios for community mental health agencies.

48. Work together to develop a crisis avoidance system for ALFs and ALF residents with the ALF providers, community mental health agencies and managed care organizations.

49. Increase the availability, use and responsiveness of emergency interventions, including but not limited to, mobile crisis services.

50. Clarify roles and responsibilities of LMH ALFs and make appropriate changes with AHCA, DOEA, DCF and any other appropriate agencies.

Additional Policy Issues

51. Support legislation to form an ALF Policy Council to continue to address issues identified by the workgroup. The ALF Policy Council should meet on a permanent, on-going basis.

52. Additional funds should be appropriated by the legislature for assistive care services and other budget categories that support the cost of care for residents of assisted living facilities.

53. Address the issue of tort reform in assisted living facilities through legislation.