DEVELOPING ASSISTED LIVING FACILITIES: THE IMPACT OF STATE LICENSING

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Abstract

The purpose of this study is to assess the positive and negative impacts of state licensing on the development and affordability of assisted living facilities for the elderly. Elderly advocates, government officials, and the assisted living industry are divided on whether licensing will serve to promote or hinder the industry. Although, strong feelings exists on all sides, no hard evidence exists to determine licensing's effect on attracting capital, developers, or consumers.

In order for state agencies to craft the best policy to encourage the development of assisted living as an alternative to nursing homes, an objective assessment of licensing's costs and benefits is an important area for research. The findings will allow policy makers to factor the financial and market consequences of licensing into their broader health and welfare debate, reviewing licensing options with a full understanding of their costs and benefits to the critical participants in the industry.

The primary information for this study came from interviews with participants in the field (developers, sponsors, lenders and government officials,) with background information from available literature and a review of existing (and proposed) licensing statutes.

The research indicated a strong support for licensing in the developer and sponsor communities, while capital market were unexpectedly neutral on the topic. The industry's support was a result of the marketing advantages licensing is perceived to provide in consumer and financial markets, while lenders' indifference results from the inability of licensing standards to protect their investments. Neither group believed that the model standards under discussion pose significant threats to the philosophy or operational expenses of assisted living.

With substantial evidence supporting licensing's advantages for the development of the assisted living industry and little fear of negative consequences, appropriate state licensing (as defined in the study) is recommended as a tool to promote the quality and quantity of assisted living development necessary to meet the needs of the fast growing frail elderly population.

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TABLE OF CONTENTS

CHAPTER I

INTRODUCTION

PURPOSE: Many in the public and private sectors view assisted living facilities as an integral element in improving the quality and affordability of long-term care in the US. The desire of elderly advocates, government officials, and project sponsors to promote assisted living as an alternative to nursing homes is strong.[1] However, the lack of financing and absence of broad market acceptance pose substantial impediments to producing the quantity and quality of assisted living development required to serve the growing elderly population.

In the context of promoting assisted living development, the issue of state licensing for such housing is receiving national attention. Currently, opinion is divided on licensing's potential impact on the financing, marketing, and operations of these facilities. Conflicting and unsubstantiated theories are espoused for both pro and anti-licensing arguments.

With all sides debating the best strategies to facilitate development, an objective assessment of licensing's costs and benefits for the assisted living industry is an important area for research. The findings will allow policy makers to factor the financial and market consequences of licensing into their broader health and welfare debate, crafting regulatory policy with full cognizance of its impact on the development and affordability of assisted living facilities. Without full and unbiased information regarding licensing, officials may inadvertently inhibit the very development process they hope to foster.

THE ARGUMENT: Many in the senior housing industry and government[2] suggest that the cost of state licensing for assisted living facilities is greater than the potential development benefits. They believe that licensing will cause higher development and

[1]Eleanor White - Deputy Director, Massachusetts Housing Finance Authority
[2]See Chapters V, VI, & VIII

operating costs without equivalent advantages, unnecessarily increasing the cost of delivering assisted living facilities. As a result, monthly fees for residents will be increased, reducing affordability and requiring greater government subsidies for low and moderate income residents. With higher subsidies required per unit, fewer units will be available, depriving low and moderate income elderly of adequate housing opportunities.

This view of licensure is rejected by industry participants who feel that licensing offers significant advantages in the development process, mitigating perceived risks in the industry, thus attracting investors and lenders. The lower risk reduces loan premiums and investors' expected returns, reducing the costs of financing product. It is further suggested that licensing provides a desirable stamp of official sanction, facilitating consumer marketing by clarifying the industry's definition and place in the continuum of long-term care. With market stability, it is argued, developers will be encouraged to enter the assisted living field, increasing the availability of the product.

RELEVANCE: Examination of licensing's implications for assisted living is particularly relevant in Massachusetts today in light of the Weld administration's policy initiatives to reduce government regulation of long-term care. Deregulation's stated purpose is to reduce public expenditures on regulation and reimbursement while stimulating private investment by eliminating onerous and counterproductive requirements (i.e. licensing.) However, as noted disagreement exists in the health care community regarding the wisdom of strict anti-regulation positions, with many convinced it will hurt the development it seeks to promote.

The research conducted for this thesis will serve to clarify the actual costs and benefits of licensing on the assisted living developments, allowing policy to be debated on solid evidence rather than supposition.

METHOD: My research examined the opinions of the key participants in the development process, including lenders, developers/sponsors, and policy analysts (see Primary Sources.) Interviews were conducted around the questions:

- What are the costs and financial advantages of state licensing for private or non-profit developers of assisted living facilities?
- Is state oversight viewed as beneficial by private lenders and developers?
- Can public sector oversight provide benefits (risk mitigation, liability protection, lower debt costs) to private investors?
- Do the costs of licensing outweigh the benefits?

The information and opinion gathered around these question was analyzed and became the basis for both conclusions on the current status of licensing in the industry, as well as the foundation from which policy recommendations were formulated.

To properly interpret the information from the interviews, substantial background information was required to understand the various licensing biases encountered. This information was collected from primary (see Primary Sources) and secondary sources (see Bibliography) and is outlined in Chapter III: History of Licensing. In addition, clarity regarding the innovative care philosophy driving assisted living is important in understanding the debate over appropriate licensing models (see Chapter IV.) While much disagreement over the exact parameters of assisted living currently exists, Chapter II contains the definition I adopted for the purpose of this research. Various licensing models are discussed in Chapter IV. Also important to understanding the nuances of the licensing debate is a familiarity with its impact on federal and state reimbursements, an issue outlined in Chapter V.

With the ground work laid, Chapters VI through VIII summarize the information collected from primary sources (see Primary Sources) in the areas of: developers/sponsors (Chapter VI,) government agencies (Chapter VII), and financial markets (Chapter VIII.) Conclusions and recommendations formulated from the data collected are presented in Chapter IX.

CONCLUSIONS: The research findings in both the lending and development sectors showed majority support for a flexible licensing process.[3] The official "sanction" licensing provides was considered beneficial by both groups in establishing the credibility of the industry, facilitating financing and marketing. Few if any costs or risks were attributed to a flexible model of regulation (see Chapter IV,) prompting the conclusion that appropriate licensing[4] serves to encourage development and affordability, with no identifiable negative consequences. While the industry's avid desire for licensure contradicts conventional anti-regulatory rhetoric, the reasoning is sound and should be heeded by policy makers in their attempts to reform the cost and quality of long-term care.

[3]See Chapters VI & VIII
[4]See Chapter IV

CHAPTER II

DEFINITION OF "ASSISTED LIVING"

I do not intend to enter into the current debate surrounding the issue of defining "assisted living." Rather, I have adopted the definition that best explains my understanding of assisted living's philosophy, as offered by Victor Regier in his recent book Best Practices in Assisted Living:

> Assisted living housing represents a model of residential long term care. It is a housing alternative based on the concept of outfitting a residential environment with professionally delivered personal care services, in a way that avoids institutionalization and keeps older frail individuals independent for as long as possible. Care can consist of supervision with minor medical problems, assistance with bladder or bowel control and/or management of behavioral problems as a result of early stages of dementia. In an assisted living environment all of these problems are managed within a residential context. As a housing type, assisted living fits between congregate housing and skilled nursing care.[5] (emphasis added)

It is important to make clear the conceptual distinction between assisted living and skilled nursing care. Again an excerpt from Best Practices in Assisted Living summarizes the issue:

> The nursing home is conceived physically and operationally around a model of care provision which has its precedent in the hospital building type. Nursing home staff are trained in conformance with the "medical model" of care and building codes used to construct these settings are based on institutional occupancies. The configuration, exiting/egress requirements and general safety considerations of nursing homes are derived from codes that are used to build hospitals. In essence, the nursing home is a transformation of the hospital environment. Assisted living, on the other hand, has its topological roots in the residential housing and is a transformation of the mansion house, country villa, or bed and breakfast hotel building type.[6]

[5]Victor Regnier, Jennifer Hamilton, Suzie Yatabe, Best Practices in Assisted Living, Andrus Gerontology Center, University of Southern California, Los Angeles, CA (May 1991), p.1
[6]Regnier, Hamilton, & Yatabe, op. cit., p.2

Within the variety of service-rich housing models currently available, Keren Brown Wilson's four concept model clearly distinguishes the philosophy of assisted living. The four tenets of assisted living as articulated by Dr. Wilson are:

> 1) **Create a place of One's Own:** Each resident has a single occupied, lockable housing unit, with a private bathroom and kitchen.
>
> 2) **Serve the Unique Individual:** A range of resident competencies requires a flexible and individualized service response. Basic services involve meals, housekeeping, laundry, and assistance with activities of daily living. A monthly resident assessment should adjust the level of service provided by the facility to a tenant in accordance with need. The ability to custom fit services levels to the specific requirements of an individual resident is an important aspect of a flexible assisted living model. (emphasis added)
>
> 3) **Shared Responsibility Among Caretaker, Family Members, and Resident:** Shared responsibility in decision making allows the resident and their families to participate in goal setting and negotiating a care plan. The direct participation of family members in the assisted living model is viewed as an important emotional and instrumental aspect of the care provision.
>
> 4) **Allow Resident Choice and Control:** Older residents should be able to exercise a full range of choices and control their destiny within the context of a supervised, service intensive, assisted living housing arrangement. Allowing residents choice and control reinforces their self-esteem, self-reliance, and self-respect.

As emphasized in Dr. Wilson's four tenets, flexibility of care is the foundation of assisted living's capacity to foster "aging-in-place." It is the central criteria in the model's ambition to improve the quality of life for institutionalized elderly and the characteristic which allows assisted living to provide the multi-level range of care necessary to span between independent living and skilled nursing facilities.

The loss of the ability to respond creatively to each resident's individual needs is the most feared consequences of licensing's potential requirements and standards. If assisted living regulation repeat the pattern of highly proscriptive "medical" licensure experienced by nursing homes, the industry's ability to match service and care plans to individual needs

would be lost. Should a high level of minimum services be mandated regardless of individual residents needs, unnecessary staffing and procedural requirements would result. The "medical" model of licensing would erode a facility's ability to maintain a residential character, raising costs without improving the quality of care. As a result, assisted living would be unable to offer the alternative to the institutional care it was established to provide.

CHAPTER III

HISTORY OF LICENSING

INTENT: The history of licensing long-term care for the elderly in the United States can be traced to the Social Security Act of 1935, the federal government's first significant expansion into social welfare policy.[7] The Act established Old Age Assistance, a grant program designed to relieve the high levels of poverty in elderly populations. In the guidelines established in *Title 1: Old Age Assistance* (OAA) of the Act, federal funds for health care services were made available to "skilled homes," the forerunner of today's modern nursing home.

To insure that an institutionalized recipient's welfare was protected in the absence of a guardian and to prevent Supplemental Security Income (SSI) from becoming "a source of funding for substandard institutions,"[8] the amendment also included a requirement that states develop a licensing system for nursing homes receiving federal funds. Because the initial federal guidelines were minimal and without an enforcement mechanism, regulatory standards varied dramatically among states.

As reports of abuse and unsafe facilities grew during the 50's, 60's and 70's, regulatory requirements increased, "developing in an incremental manner in response to changing social forces rather than in a deliberate and comprehensive fashion."[9] Without a cohesive federal framework through which to define and reimburse various levels of care, regulation grew increasingly restrictive to meet the worst case needs of the institutionalize population. The resulting "medical" model for nursing homes requires intense skilled staffing patterns and rigid procedural and physical requirements.

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[7]Baggett, Sharon & Adler Sy, "Regulating the Residential Care Industry: Historical Precedents and Current Dilemmas," *Journal of Aging & Social Policy*, vol. 2(1) (1990), p.19
[8]Baggett & Adler, op. cit., p.22
[9]Baggett & Adler, op. cit., p.20

Both nursing home administrators and resident advocates agree that the generally excessive procedures,[10] standards, and documentation requirements increase expenses without benefiting the residents' environments. Nursing home licensing requirements are universally sighted for causing sterile institutional environments, preventing the warmth and dignity of a residential environments through their physical specifications and operational guidelines. The inflexibility of the *process oriented*[11] procedures prevents a facility's ability to respond creatively to individual residents needs and lifestyle choices. The rigid facility standards stipulated by Medicaid prevent the residential scale and character sought by elderly advocates for the industry.

NEED FOR ALTERNATIVES: With the elderly population (65+) expected to increase over 60% in the next four decades to 22% of our population, the segment of the old-old (75+) with physical or cognitive impairments is increasing dramatically. Average life expectancy has increased nine years in the last half century, however, only two of those years are healthy and lived without some form of physical assistance. Currently, 210 out of every 1000 old-old elderly need assistance with activities of daily living. However, only 35% of these old-old require care that must be delivered in skilled nursing facilities.

Unfortunately, the Social Security Act of 1935 specifically excluded "group quarters" from receiving federal funding under the assumption that the service needs of those living

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[10]Regnier, Hamilton, & Yatabe, op. cit., p.7

[11]*"Process oriented"*: characterized by emphasis on regulating the method of delivering care rather than the results desired (characterized as "*results-oriented.*") An example is of the distinction between *process-oriented* and *results-oriented* regulation is illustrated in the comparison between meal requirement as stipulated by Oregon's Assisted Living licensing statute and Massachusetts' Long-term Care Facilities licensing standards. Oregon's *results-oriented* statue simply requires "Three meals daily, seven days a week, including special diets and snacks which are appropriate to residents' needs and choices" (Ore. 411-56-015, p. 6) while Massachusetts' statue specifies "The minimum daily food allowance for adults shall be based on the following: (1)Milk: Two or more cups as beverage or in food preparation. (2) Meat Group: Two or more servings of beef, veal, pork, lamb, poultry, fish, cheese or eggs; occasionally, cooked dry beans, dry peas or nuts may be served as alternatives..." (Mass. 105 CMR 150.009, p.621.)

in age-segregated housing were already being met.[12] Without public funding for lower levels of care in sheltered housing, low income elderly with moderate service needs have had no option but to be "over-housed" in nursing homes. As a result of this reimbursement policy, an artificial demand for skilled nursing facilities was created, with the percentage of institutionalized elderly residing in nursing home increased from 34% to 72% between 1940 and 1960, while those in boarding homes decreased from 41% to 12%.

The lack of appropriate alternatives, in combination with the dramatic costs of over-housing the elderly, prompted congress to create the Intermediate Care Facility (ICF) program in 1967, with Medicaid reimbursement approved in 1972. The ICF legislation represented the Congress' first attempt to address varying levels of care within federal funding mechanisms. The less intense care provided in ICF's was meant to lower costs and thus reduce the strains placed on the federal and state governments budgets by nursing home reimbursement. Unfortunately, the ICF's regulatory requirements still followed an expensive medical model, which like a skilled nursing facilities (SNF), was subject to rapidly increasing regulatory restrictions as abuses continued to be uncovered. The medical nature of ICF's and heightened restrictions imposed, negated any potential for the program to provide less institutional care or substantial savings.

Without adequate alternatives and available funding, the elderly population unable to live independently and without sufficient personal resources to pay privately has lacked an alternative to institutional care. The large gap existing in the current continuum of care between home health services and a licensed nursing home, forces elderly into medically

[12]Keren Wilson Brown, Ph.d. "Assisted Living: a Model of Supportive Housing," *Advances in Long-term Care,* Springer Publishing, New York (1991)

oriented nursing facilities when residential models would be more appropriate, diminishing the quality of life for the resident and unnecessarily diverting scarce public resources from other programs.

Medicaid's recent initiatives to serve the elderly in their own homes with community based services, allowing "aging-in-place," has benefited many elderly. The availability of skilled nursing homes, similarly, has benefited the severely impaired. Unfortunately, there is a large segment of the population cannot be cared for safely or efficiently in independent residential settings, yet whose needs are not sufficiently severe to require the intensity of care provided in nursing homes.

Assisted living facilities residential character and flexible service packages are designed to fill the gap in the housing continuum. They are conceived to provide housing options both congruent with older Americans' desire to live independently from their children (regardless of health, economic, or social status)[13] and their determination to avoid the loss of independence, privacy and self-determination experienced in nursing homes.

[13]Hurd, 1990 (as sited by Brown, op.cit.)

CHAPTER IV

PROPOSED LICENSING MODELS AND OBJECTIVES

The debate over licensing for assisted living is fueled by the negative regulatory experience of the nursing home industry. Advocates for assisted living (public and private) are torn between the need for oversight and the fear that licensing will lead to the same restrictive, *process-oriented* regulation that has frozen nursing homes into sterile institutions. Government agencies and developers alike are anxious to foster assisted living's development without destroying the unique and progressive character of the facilities.

For this reason the licensing models under discussion are very careful to avoid restrictive clauses specifying exact procedures or even language that may be construed to restrict staffing and program options.[14] The current and proposed licensing (and/or regulatory) statues are *results-oriented* regulations in which methodology is left undefined, but outcome is clearly stipulated. The regulatory language is often more interesting for what it leaves out, than for what it includes:

> The residential care facility/assisted living facility shall provide the following...
> (G) Household services essential for the health and comfort of resident (e.g. floor cleaning, dusting, bed making, etc.)[15]

Phrases such as "essential for the health and comfort" are typical of the proposed statutes currently circulating. Their flexibility derives from their "end-result" qualitative structures, allowing providers to determine the best delivery method in light of a patient's or facility's needs.

[14]See Oregon (Appendix A) & Massachusetts (Appendix C)
[15]State of Oregon - Administrative Rules for Residential Care Facilities/Assisted Living Facilities, 411-56-015 (2), p.6

There are 5 models currently circulating that exemplify appropriate licensing for the assisted living industry. Each contain varying levels of specificity. The highlights of the 5 comparative models (Oregon, Florida, the American Association of Homes for the Aging - *AAHA*, American Association of Assisted Living Facilities - *ALFAA* and Massachusetts' Draft Assisted Living Program Model) are summarized below.

Oregon Statute: Oregon's statute was the first flexible, "results-oriented" assisted living statute to be adopted by a state government (see Appendix A.) It is considered a model of what appropriate regulation should be, setting standards and philosophical goals, while allowing flexibility to individual providers in how they may best accomplish the mission of assisted living. The statue provides oversight mechanisms in the form of facility surveys and establishes clear procedures and penalties for non-compliance.

The areas covered in Oregon's statue are:

- Purpose
- Range of services
- Residency criteria
- Business organization (including management, finance, and contractual)
- Building standards
- Licensing requirements
- Monitoring & penalties
- Payment/reimbursement
- Exceptions/variances

These categories define the population that may be served in assisted living facilities (through the number of ADL's required and category of ADL's,) required care, educational requirements for the administration & staff, licensure standards (both physical and service,) and compliance monitoring methods.

The statue allows facilities to provide assistance with all 6 activities of daily living for a resident, providing the broadest continuum of care possible. The standards are

comprehensive in their scope, touching on all major issues, but avoiding procedural specificity except in areas where certain minimums (i.e. physical standards for units) must be achieved to maintain the underlying philosophy of assisted living. The statute accomplishes its purposes in 25 (large type) pages, a model of brevity compared to Massachusetts' Long-term Care regulations (130 pages of dense text.)

FLORIDA'S INITIATIVE: Florida currently regulates assisted living facilities separately from nursing homes as "Adult Congregate Living Facilities" (ACLF's). This distinction exempts assisted living facilities from the certificate of need (CON) process and entails lower regulatory standards. A critical provision of the ACLF legislation is the permissibility of limited service delivery and the ability to dispense medication to residents.

A new initiative,"[16] extended congregate care" (ECC), would allow greatly expanded services. The Florida model is interesting for the specificity it contain on the issue of residents' criteria, carefully defining the spectrum of individuals able to be served in assisted living settings. The salient points of Florida's initiative are summarized by Martin Leinwand in his paper *Licensure of Assisted Living Programs:*[17]

Permitted Services

- Assistance with up to 3 ADL's
- Nursing Services and intermittent nursing care for medically stable residents with no specific health problems and for whom a regimen of treatment has been established, e.g.:
  - change of colostomy bag
  - routine catheter care
  - administration of oxygen
  - routine care of stabilized amputation or fracture
  - prophylactic and palliative skin care
  - care of stage 2 pressure ulcer

[16]Florida Aging and Adult Services Division, Department of Health and Rehabilitative Services (July 1992)

[17]Martin Leinwand, *Licensure of Assisted Living Programs,* paper presented at the Association of Massachusetts Home for the Aging Conference - Emerging Issues in Supportive Residential Environments for Older People, Framingham, MA (23 June 1992), pp.11-12

Required Care:

- Nursing diagnosis
- Ongoing medical/social evaluation
- Control of infection
- Promotion of normal elimination
- Early diagnosis
- Early diagnosis
- Measurement/recording of vital functions
- Administration of medications
- Treatments prescribed or authorized by licensed practitioner
- Prevention of pressure ulcers
- Provision/arrangement of rehab services
- Transportation and escort services for health-related appointments

Residency Criteria:

- Cannot require 24 hour nursing supervision
- Cannot be bedridden for more than 14 consecutive days
- Cannot require assistance with 4 or more ADL's (except for quadriplegics, paraplegics, residents with muscular dystrophy, multiple sclerosis or other neuromuscular diseases who can communicate needs and do not require help with complex medical problems)
- Cannot have cognitive impairments which prevent resident from generally being able to make simple decisions like choosing a dessert or a garment
- Cannot require treatment for a stage 3 or 4 pressure ulcer
- Cannot require more than assistance with transfer
- Cannot be a danger to oneself or others and uncontrollable by medication
- Cannot be in a medically unstable condition, have special health problems or have no established treatment regimen

Licensure Standards

Standard ACLF license plus:

- Administrator and ECC supervisor must take 6 hour initial ECC training
- ECC facilities may be required to meet more stringent requirements regarding staffing, structural materials, means of escape, interior finishes, automatic extinguishing systems, corridor wall construction and the like depending upon ability of ECC residents to evacuate in an emergency
- Staff must include (on staff or by contract) a registered nurse, licensed practical nurse or advance registered nurse practitioner
- Staffing levels determined by amount and type of services provided to residents
- ECC homes must promote privacy and independence, providing residents with "opportunities and encouragement...to make personal choices and decisions."

It is interesting to note the distinctions between Oregon's statute and Florida's in the areas of residency requirements including permissible number of ADL's (Oregon all 6, Florida

3,) need for 24 hour supervision (not allowed in Florida, no limit in Oregon,) and number of allowable bedridden days (Florida 14, no limit in Oregon.) Oregon's model is more flexible in its criteria simply stating under the section titled Move Out Criteria that:

> Residents may be asked to leave for the following reasons...
> (c) The facility cannot meet the resident's needs with the available support services or services are not available and are required by the division.[18]

This distinction leaves Oregon's providers with greater flexibility in determining how broad a range of the continuum and what segment they choose to serve.

AAHA's STANDARDS: In 1990 the American Association of Homes for the Aging released recommended "Standards for Assisted Living" (see Appendix C) in order to give some definition to the industry and set minimums to meet the needs of "many older people." They are careful to preface their recommended standards with the comments:

> "The assisted living industry is extraordinarily diverse. This diversity is healthy, and should be encouraged...What might be seen as a protective requirement might indeed have a detrimental effect on costs and therefore on residents, and on the accessibility, marketability, and future stability of assisted living programs."[19]

The attitude that regulatory oversight (not explicitly named as licensing) is necessary, but dangerous and corruptible, is a common sentiment from regulators and providers alike. It explains the very open ended, 3 page draft standards, containing a paragraph or less on the following issues:

- Mission, Goals and Objectives
- Service and Care Philosophy
- Planning and Evaluation
- Governing Body and Ownership
- Administration
- Human Resources
- Marketing and Promotion
- Matching Consumer Needs to Programs and Services

[18]State of Oregon, op. cit., p.8
[19]AAHA - Assisted Living Standards (1990) p.4

- Consumer Services
- Community Involvement
- Contract
- Physical Plant
- Financial Management
- Disclosure
- Health Services

Staffing and administrative requirements are a textbook example of *results-oriented* standards, setting no specific guideline for educational qualifications or training (as in Oregon & Florida,) rather stipulating:

> The provider has a qualified staff that is adequate both in number and in productivity to perform effectively the duties assigned. The provider has a system for the provision of adequate orientation and continuing education.[20]

ALFAA GUIDELINES: While the Assisted Living Facilities Association of America's model guidelines parallel AAHA's in character and tone, they contain more specific requirements to ensure compliance with ALFAA's vision of assisted living.[21] An interesting departure from the AAHA model is ALFAA's specific requirement for state licensure, which includes a requirement for states to aggressively seek out and act against unlicensed facilities (a stance which would represent a dramatic shift any from the current non enforcement policy of many states,[22] e.g. Massachusetts.) As a national member organization representing <u>for profit</u> assisted living providers, ALFAA's position in support

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[20]AAHA, op. cit., p.6

[21]ALFAA's definition of assisted living: "A special combination of housing and personalized health care designed to respond to the individual needs of those who need help with activities of daily living. Care is provided in a way that provides maximum independence and dignity for each resident and involves the resident's family, neighbors and friends." (ALFAA - National Minimum Standards Act for Assisted Living Facilities.)

[22]With the current uncertainty surrounding assisted living, many states are caught in the difficult position of recognizing the need for assisted living, while not clear about how to regulate it. In many states, the current broad definition of board and care homes would require assisted living to license under regulations that would severely restrict their service capacity, crippling the concept. For this reason some states have an unofficial policy of no prosecuting unlicensed assisted living facilities, even when state statues clearly require licensure for "any institution whether conducted for charity or profit which is advertised, announced or maintained for the express or implied purpose of providing three or more individuals admitted thereto with...supervision and care incident to old age..." (Mass. 105 CMR 150.001, p.597)

for licensing is an important indication of the industry's desire for a specific regulatory mechanism to foster development potential and protect the industry's image.

ALFAA's model standards include requirements for:

- Residents' rights to privacy and personal possessions
- Preservation of choice (including meals, physicians, religion)
- Freedom from abuse, neglect and restraints
- Residents' fund management
- Grievance procedures
- Resident criteria (limited by services available at the facility, not levels of impairment)
- Staff and administration educational, training, and character requirements (including initial and continuing education programs)
- 24 hour staffing
- Physical requirements
- Sanitation
- Dietary
- Resident activities programs
- State licensing (including inspections, enforcement policies, sanctions, and consumer complaint investigation mechanisms)
- Operator rights (including initial admission guidelines, "move-out" criteria, and due-process protections)
- Waiver Procedures (specific language requiring minimum standards waivers for providers in special circumstances)
- Incentive program (to reward high quality providers)

MASSACHUSETTS' DRAFT INITIATIVE: Issued in June of 1992, Massachusetts' draft "Assisted Living Program Model" (see Appendix B) follows the example and tenure of AAHA's "Assisted Living Standards" (including their 3 page format,) adding only marginally to the specificity of the regulatory language. The most significant aspect of Massachusetts' Draft Initiative is that it is an unlicensed model, providing only voluntary registration for providers. Supervision is provided through "appropriate oversight agencies, such as local building inspectors, fire and safety authorities, etc."

Massachusetts draft includes guidelines for:

- Philosophy
- Potential Settings
- Registry
- Consumer Protection
- Base line Model (inc. 24 hour supervision, minimum of 3 ADL's but no maximum, medication, & supportive services)
- Resident Criteria
- Care Planning

- Resident Record
- Training and Other Personnel Qualifications
- Physical Plant

The interesting departures from other models are:

- A state registry (rather than licensing process) for self defined assisted living providers meeting the "base line requirements of the document.
- The stipulation of 24 hour supervision by a "responsible person" (not defined). (A position directly opposite Florida's prohibition of admitting residents requiring 24 hour supervision.)
- The consumer driven oversight method, relying on complaint based oversight by designated agencies and existing authorities to act against violations (i.e. fire marshall, health inspector, building inspector) should issues "require further action."
- Specific unit requirements focused on providing privacy and control within a facility.
- The specific language allowing the administration of medication by approved "unlicensed personnel."
- The sweeping resident criteria requiring that a potential tenant be elderly and/or disabled.
- The lack of educational requirements (background or continuing) as contained in both Florida and Oregon. Substituting the term "suitably trained" for any specific guidelines (including administration of medications.)

CONCLUSIONS: Although varying substantially in scope and specific requirements, all 5 regulatory models share a common theme of hands off, *results-oriented* requirements indicating that both governmental policy makers (Oregon, Florida and Massachusetts) and assisted living member organizations (AAHA & ALFAA) share a philosophy of regulation consistent with the goals and needs of the concept.[23] The various models are all notable for the care they take to delineate required and excluded services, staffing patterns, staff qualifications and physical amenities.

While many policy debates may be conducted on the appropriateness of individual models and presence or lack of specific criteria, all concerned have worked hard to design statutes that define assisted living and its role in the continuum, clarify its regulatory definition

[23]See Assisted Living Definition in Chapter II

(separating it from medically base nursing home requirements,) and establish oversight mechanisms appropriate to the model.

With government and industry in agreement on the direction assisted living regulation needs to take, fears of repeating the mistakes made with nursing home regulation are being assuaged. Even in a state notorious for its adversarial regulatory atmosphere, Massachusetts' assisted living providers found themselves faced with a draft proposal that was characterized at the July 1992 meeting of the state ALFAA chapter as "difficult to imagine being more desirable, even if we had written it ourselves."[24]

[24]Unidentified member, Massachusetts ALFAA Chapter Meeting (16 July 1992)

CHAPTER V

LICENSING'S IMPACT ON FEDERAL AND STATE REIMBURSEMENT

Until recently, licensing has been all but mandatory for health-care facilities to receive federal reimbursement for low income residents, with unlicensed (sub-acute) "group homes" specifically excluded under the Social Security Act. However, this restriction has been lifted as a result of the Medicaid Home and Community Care Options Act (OBRA 1990, Section 4711.) The Act formally recognized the need for non-institutional group-care for the elderly who can no longer remain in independent settings despite home health care options, but who do not require the intensity of care provided in skilled nursing facilities.

The legislation expands reimbursement for non-medical services (see below) to a population much broader than those currently qualified under Medicaid "Section 2176" waivers (a program which reimburses for home health services but restricted to elders "at risk of institutionalization.") The bill adds "community care" services to the optional services for which Medicaid reimbursement is available.[25] Community services are defined as:

- Homemaker/home health services
- Chore services
- Personal care services
- Nursing care services provided under the supervision of a registered nurse
- Respite care
- Training for family members in managing the individual
- Adult day care

[25]Sandy Harless, *Retirement Housing Report,* Volume V, Number VIII, Eldermark Publishing Company (1991) p.5

The eligibility requirements for Community Care Services are:

- 65 years of age of older.
- Medicaid eligible due to low income.
- Determined to be functionally disabled in at least 2 of the 3 activities of daily living (ADL's): toileting, transferring and eating, or have a primary or secondary diagnosis of Alzheimer's disease.

Community care services may be delivered in private homes (home health-care) or in small and large group residential settings. Small residential settings are defined as "a residential setting in which more than 2 and less than 8 unrelated adults reside and in which personal services (other than merely board) are provided."[26] Large residential settings are defined as more than 8 people.

The reimbursement stream the legislation provides has major implications for assisted living. With reimbursement from Medicaid for health and home-maker services combined with SSI (as well as other federal and state programs) to fund room and board, full reimbursement for low income residents is now available to assisted living facilities. Both the "2176" waiver program and the Community Care Options Act, as well as HUD's 202 and HOPE programs (funding service coordinators and up to 40% of service costs in their housing subsidies,)[27] provide access to government funding for unlicensed assisted living facilities, providing the industry access to an income stream comparable to nursing homes.

Although currently limited in scope (with 1992 federal funding at 580 million dollars, 19% of federal Medicaid spending on nursing homes) the legislation clears the way for large shifts in Medicaid funding away from nursing homes and toward assisted living, as the

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[26]Harless, op. cit., p.5

[27]Paul Lanzikos and Susan McDonough, *The Potential of Assisted Living Services to Meet the Needs of Todays Older Adults,* Paper presented at the Association of Massachusetts Home for the Aging Conference- Emerging Issues in Supportive Residential Environments for Older People (23 June 1992) p.8

country rethinks its elderly housing and health care policies, "correcting mistake it made 25 years ago when the federal government decided to fund care for the elderly only in nursing homes."[28] The Home and Community Care Options Act removes the issue of reimbursements from the debate over regulations potential benefits to the assisted living industry.

[28]Harless, op. cit., p.5

CHAPTER VI

INDUSTRY PERSPECTIVES ON LICENSING

"The best way to deregulate assisted living is to regulate lightly."
David Roush, ADS Consulting, Cambridge Massachusetts

In order to establish the assisted living industry's perspective on the impact of state licensing, a variety of developers, providers, consultants, and member associations were interviewed (see Primary Sources.) The opinions expressed were surprisingly consistent within and between groups. The major concerns and suggestions which emerged are detailed below.

AVAILIBLITY OF FINANCING: Without question the single greatest concern expressed by all industry participants interviewed was the availability of financing for assisted living projects. Almost invariably, discussions with developers and providers began with licensing's impact on their ability to obtain financing. The consensus was that the industry definition (see next page) and oversight provided by licensing would clarify the ambiguity[29] currently surrounding assisted living's place in the health care continuum, substantially increasing the industry's access to capital. In addition, many interviewed believed that lenders would not provide financing in the current period of regulatory transition and uncertainty. As one provider commented, "just because bankers lost their minds in the eighties does not mean that they have not regained their senses."[30]

Unfortunately for the industry, capital markets do not place the importance on licensing that providers believe they do. The major impediment identified by lenders interviewed was not the ambiguity of the field and regulation (see Chapter VIII,) but individual

[29]Robert Mollica, National Academy for State Health Policy, Portland, ME.
[30]Joan Hyde, Sterling Health Care, Wellesley, MA (10 July 1992)

sponsor's credit worthiness, project equity levels, depth of management experience, and the general risk[31] perceived in the elderly housing field.

The fact that licensing and regulatory issues did not prove to be an issue with the lenders interviewed does not diminish the impact regulatory uncertainty has on project starts. Providers and developers interviewed all felt that the uncertainty surrounding licensing and its perceived negative consequences for capital (and consumer) markets had kept developers from pursing projects they might otherwise have initiated.

Whether or not the lack of licensing actually hinders financing, the fact that it is perceived to by the industry has prevented developers from entering the field.

INDUSTRY DEFINITION: In general, apart from the current systemic problems in the financial markets, developers and sponsors sighted the lack of understanding of the assisted living product as a large impediment to accessing debt and equity markets. Without a clear legal definition clarifying the parameters and regulatory requirements applicable to the industry, the consensus was that significant segments of the investment and development sectors are avoiding the industry, waiting for the ambiguity surrounding the field to be resolved.

Although no one interviewed felt that state licensing would completely resolve the lack of public understanding of assisted living, most believed[32] that licensing was a critical step in

[31]Lenders perception of risk in the senior housing markets is attributed to their reluctance to analyze projects as businesses rather than real estate, the lack of time proven models, and the high failure rates in of CCRC's during the 70's and 80's.

[32]Notable exceptions to the majority's support for licensing as a tool to define assisted living were John Zeisel, Springhouse and Steve Kauffman, MGH. Both believed that licensing was an very inappropriate tool for this purpose, with far too many political pitfalls to be used to set parameters objectively.

the path to defining the product. The lack of licensing was sighted as "indirectly" contributing to the uncertainty felt by the investment markets and consumers.

Three people interviewed[33] expressed reservations about using licensing to define the industry. Each felt that an attempt to define such a young and evolving industry would stifle the natural market forces that are most suited to identifying the needs of consumers. To impose licensing at this stage, they argued, runs the risk of creating a regulation driven environment (such as nursing homes) "locked into a formula" that is unable to respond and adapt over time to the needs of the residents.

Furthermore, each felt that licensing runs the risk of adding additional costs to operational costs. With the low profit margin typical in the industry,[34] any additional costs will be passed directly to consumers and lower the affordability of the product.

COSTS OF LICENSING: The nearly universal opinion among providers was that appropriate licensing would not increase the cost of operating assisted living facilities.[35] The anticipated position that "regulation just naturally increases the cost of what you are doing,"[36] was only expressed during three interviews. Most industry members were comfortable that the staffing levels and qualifications, facility requirements, and administrative procedures contained in proposed licensing models would not impact costs (see Chapter IV.)

The flexible nature of the models is deliberately designed to allow providers the ability to determine the appropriate care for the resident population being served. The "wonderfully

[33]Robert Chellis - Consultant, Steve Kauffman - MGH & John Zeisel - Springhouse
[34]Steve Kauffman, MGH
[35]Not an opinion shared by Steve Kauffman, MGH
[36]Ken Stewart - AAHA, Steve Kauffman - MGH, and Robert Chellis - Consultant

unstructured,"[37] *results-oriented* statues are carefully framed to avoid the rigid procedural requirements that often result in over staffing or unnecessary procedures. Licensing standards conforming to Oregon's or ALFAA's models are considered to contain minimum standards that will easily be exceeded by levels necessary to market the assisted living concept.

Providers commented that the only organizations that might suffer increased costs were operators who were not currently staffing adequately to insure minimum standards. Consensus among those interviewed was that if licensing keeps substandard providers out of the field or forces them to upgrade their facilities, it provides a great service to both the industry and resident population.

With typical licensing requirements for facilities and staffing substantially below minimums demanded by the marketplace, no one I spoke to believed that licensing conforming to the flexible models discussed in Chapter IV would increase costs.[38] In fact, several people interviewed believed that licensing would reduce the cost of operation by protecting facilities from more stringent regulation in states where assisted living is legally interpreted to require licensing under nursing home statues (e.g. Massachusetts.)

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[37]Joan Hyde, Sterling Care, Wellesley Massachusetts

[38]In addition to the increased costs of licensing if high minimum services were required, Steve Kauffman at Massachusetts General Hospital raised concern over the cost and redundancy of licensing surveys in light of the quality control measures MGH would have in place internally. However, the survey process alluded to was the nursing home model, not an Oregon type, 2 page form. The half day required of an administrator to complete the model assisted living survey and interview does not appear to add measurable cost or redundancy to providers. Ken Stewart at AAHA also felt that regulation of any type would add cost and make the assisted living option less affordable, while acknowledging that without regulation, government subsidies (reimbursements) are unlikely.

In states where licensing may be avoided through administrative rulings or officially sanctioned neglect.[39] several operators stated that they would voluntarily seek licensing under the lowest level available for their facility.[40] The determination to seek licensing demonstrates the providers and developers strong faith in the advantages of licensing. However, the lack of appropriate licensing to choose from has caused several providers[41] to accept over-regulation and its additional costs. It is telling that even when over regulation results, licensing's benefits are believed to outweigh their costs. The unfortunate aspect of the unnecessarily increased costs is that the residents ultimately bear the economic consequence.

It may be concluded from the information collected in the majority of interviews that the majority of providers do not fear additional costs from regulation and in many cases feel that appropriate licensing may serve to reduce their costs.

Note: The research in this thesis is geared to determining the impact of state licensing on adding to the stock of existing assisted living units and therefore not specifically addressed to the views of existing facilities. However, at least one currently operating, non-profit assisted living provider[42] (licensed under Massachusetts' Level IV Nursing Home Statue) expressed complete support for licensing, stating that it provides security for residents and staff and important on going marketing benefits to the facility. Without licensing, she felt that the facility would be "nothing."

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[39]Joan Hyde of Sterling Care commented that many facilities in Massachusetts that easily fall under the broad definition established for Level IV nursing homes operate without licenses. With many of these facilities listed in directories which clearly outline the services they provide, it would be difficult for the state not to be aware of their existence.

[40]Keren Brown Wilson, Ph.d., Concepts in Community Living, Portland, Oregon

[41]Keren Brown Wilson, Ph.d., Concepts in Community Living, Portland, Oregon

[42]Carolyn Widen, Hale House, Boston, Massachusetts

The provider did acknowledge that the current regulations require certain unnecessary staffing and procedural patterns that diverted funds from better uses. However, she stated that the current benefits outweighed these expenses and that the proposed assisted living licensing standards would eliminate inappropriately rigid standards and introduce the flexibility required to address the individual needs of the facilities resident population.

The reason this provider's opinion is of particular interest is that as a non-profit facility, without plans for future expansion, her views are free from the suspicion of self-promotion and territorial considerations often attributed to an industry's seeking licensing.

SCOPE OF LICENSING: As expressed by a developer and policy consultant, the question is not "whether to have licensing, but the appropriateness of the licensing requirements."[43] Opinion was unanimous among all groups interviewed that *process-oriented*[44] licensing standards similar to current nursing home regulations would destroy the foundations of the industry, preventing individually tailored services to clients in affordable residential environments.

Oregon's statute (see Appendix A) was described by many as an excellent example of appropriate *results-oriented*[45] licensing, providing service parameters and goals without specifying the method of delivery. However, while Oregon's statue was often suggested as the proper model for other states, there was not a high degree of familiarity with its content among industry participants interviewed. Concern among developers and providers was not focused on the exact specifications proposed licensing, rather the

[43]Keren Brown Wilson, Ph.d., Concepts in Community Living, Portland, Oregon
[44]See Chapter III, footnote 11
[45]See Chapter III, footnote 11

common sentiment was that "as long as it is not nursing home type licensing or regulation, any licensing is good."[46]

The prevalent sense that any licensing would do is quite telling. The lack of rigid qualification standards in the proposed licensing deflates the hypothesis that licensing is being sought as a means to exclude small and inexperienced providers. It also indicates that licensing is being supported by the industry almost entirely for marketing advantages, rather than the quality and safety assurances licensing is established to promote.

The danger of the proposed licensing models exceeding reasonable requirements or straying into performance criteria is considered minimal. The counterproductive nature of nursing home regulation "is understood by even diehard regulators,"[47] with states as anxious to avoid the cost and quality ramifications of traditional regulation as is the industry.[48] Licensing regulations as proposed are not expected to require anything that a responsible and competitive provider would not provide as a matter of course in a market driven environment. As a result the industry is comfortable with the scope of the 5 licensing models under discussion.

INDUSTRY PROTECTION: Interestingly, licensing is seen by developers and providers as a critical piece of the industry's defense against the negative public relations and regulatory backlash of the "inevitable" scandal when a provider is found to be abusing residents. Licensing is believed to shield the industry from the scandal and negative

[46]Massachusetts provider, identity withheld. This casual attitude toward the specifications of licensing was not shared by all in the industry. Both of the assisted living member organizations, ALFAA and AAHA, are actively involved in monitoring and consulting on proposed legislation. Several developer's and provider's interviewed were also actively involved in monitoring government activity.
[47]Joan Hyde, Sterling Care, Wellesley Massachusetts
[48]Based on interviews with state officials, consultants, developers, and providers.

publicity of sub-standard care provided by organizations operating either within or outside of regulation.

It is argued that with licensing in place, if an unlicensed facility claiming to provide "assisted living" is discovered to be mistreating its residents, the industry (licensed facilities) are not tarnished by the actions of the substandard provider. Once the situation is discovered, the facility made be shut down rapidly for operating without proper documents. Not only will the abuse suffered by residents not be blamed on the industry, but the system may be seen to provide the protection and assurance of care that is necessary for public acceptance of assisted living.

In the case of abuse discovered in a licensed facility, state regulators may act to remove the license for non-compliance and close the facility. Licensing's clearly defined administrative procedure will facilitate the closure of substandard facilities, serving to contain negative publicity and reinforcing the public's confidence that procedures are in place to protect the residents. The majority of those interviewed believed that the ability to remove a facility's license, enabling the industry to isolate itself from a disreputable provider, was the second most important function of licensing after access to capital.

Furthermore, without licensing in place, all interviewed were certain that once a case of abuse surfaced, public outrage would force legislation to be imposed under the worst possible circumstances. It is be hypothesized from previous experience in nursing homes, that legislation resulting from scandal would be highly *process-oriented*, inflexible, and cumbersome, representing the worst case scenario for licensing. To avoid these consequences the industry is lobbing hard for "preemptive" legislation.

LICENSING VS SELF REGULATION: Although voluntary accreditation through member associations (as in the CCRC industry) is an option for assisted living facilities in states where licensing is not available, it does not provide three of the major benefits that state licensing offers:

1. Self-regulation does not achieve the degree of credibility offered by licensing.
2. Self-regulation would fail to provide the ability to delicense a substandard provider and therefore fail to protect the industry from the public relations and regulatory liability of a investigation.
3. The lack of state licensing currently prevents assisted living facilities from accessing both financing and reimbursement streams that could benefit the industry, substantially decreasing the populations currently served.

Official recognition and oversight for the assisted living industry in the form of licensing is seen as critical to achieving and maintaining broad public acceptance and is the preference of the majority of the industry.

EXCLUSIONARY PRACTICES: Many of the public and lending sector officials interviewed felt strongly that the developers' and providers' desire for licensure was motivated by an effort to restrict entry into the field. Although this accusation is often leveled at professional and industrial organizations, perhaps justified in some cases, it does not appear to have merit in this instance. No where in my research was I able to identify exclusionary benefits in the licensing recommendations as set forth by member groups or individuals.

To be labeled exclusionary, the industry's proposed standards would either have to contain criteria requiring experience, education, or financial credentials that may be argued to be unnecessary or counter productive for a residents' welfare, or contain an overt system to limit entry into the field. However, the charge that potential providers might be excluded by inappropriately stringent entry requirements is refuted by the minimal and flexible nature

of the proposed licensing statute and the *results-oriented* staffing and physical requirements neither of which may not be said to unnecessarily burden or exclude capable providers. The fear of licensing leading to an overt rationing system should be pacified by the absence a Certificate of Need process in any of the proposed licensing models and the industry's strong objection to such a process.

Educational and training requirements do exist in varying degrees in the licensing models, but are reasonable and may be satisfied without undue hardship. Staffing requirements are kept to a minimum, with most positions requiring little training. As well the modest financial requirements and disclosure rules as stipulated in the proposed models could not be construed to impose hardships on appropriate providers.

In no discussion with government officials, the legal community, or lenders was a credible argument set forth to substantiate the claim that the licensing, as envisioned, would create a inappropriate burden or barrier to entry for any group interested in participating in the industry.

CHAPTER VII

PUBLIC POLICY PERSPECTIVES

Two forces are conspiring within the public sector to push assisted living to the forefront of long-term care policy debates; quality of care and fiscal constraints. At the same time elderly advocates are lobbing state and federal governments to restructure institutional reimbursement and licensing criteria to foster supportive residential environments for the elderly, the spiraling costs of Medicaid are straining the budgets of the state and federal government.

Assisted living facilities address both these concerns. The promise of a higher quality environments for appropriate elderly, together with significant cost reductions (20-50%),[49] combine to create an extremely popular long-term care delivery model for public officials. The successful cooperation between public agencies and the private sector,[50] demonstrated in both Florida's and Oregon's model statutes (hailed by industry and elderly advocates,) is evidence of the public sector commitment to draft oversight standards that are appropriate and beneficial to the growth of the young industry.

Public policy objectives for assisted living facilities are three fold:

- To "ensure appropriateness of setting based upon residents needs."[51]
- To provide appropriate, lower cost alternatives for nursing homes in an effort to lower government (Medicaid) spending on long-term care.
- Create an lower cost environment for private pay residents to promote financial self sufficiency (self sustaining or slower pay down), eliminating or decreasing the duration of an individual's reliance on Medicaid.

However, to achieve these goals the state and federal government will need to clarify assisted living's role in the continuum of care and provide a statutory legal definition for

[49]Derived from various interviews and research material.
[50]Providers, consultants, and developers
[51]Leinwand, op. cit., p.2

the purpose of clarifying and defining regulatory requirements. Without this definition (see Chapter VI,) many believe that large scale developments of assisted living facilities will be stifled under the burden of inappropriate or uncertain regulation.

Unfortunately, the regulatory dilemma facing for state and federal government is growing. No one in government wants to repeat the medical, *process-oriented* licensing procedure that developed for the nursing home industry, however all agree that enlightened oversight for an industry serving such a frail population is essential. The dilemma, as described by Sharon Baggett and Sy Adler, is:

> On the one hand, the framers of the policy have tried to retain the "alternative" nature of residential care setting, hoping to preserve their non institutional character; on the other hand, the evidence of abuse (e.g., lack of necessary medical care, exploitation, physical mistreatment) in these facilities and the level of frailty of the residents require that regulation be implemented in order to assure the quality of care provided. Trying to accomplish the dual goals of freedom and protection while relying on mechanisms of intervention designed for nursing home settings has created a confusing situation within which the potential for inadequate care of residents in RCGs (residential care facilities) is great.
>
> If regulatory policy addressing residential care merely repeats that pattern established in the nursing home industry, much is at stake. The spiraling costs of nursing home care in the past two decades, in part the result of regulation, have forced the elimination of lower-cost alternatives. The imposition of similar regulations on these care alternatives, however, does not seem cost-effective. In addition, excessive regulation, which could lead to environments more institutional in nature, clearly defeats the purpose. Yet, the frailty of residents in these facilities requires that certain regulations be implemented to assure the quality of care provided.[52]

Different states have chosen to approach the question of regulation, and specifically licensing, with varying degrees of specificity. The variation may be more a reaction to individual states' experience with previous health care regulation (good, bad, nightmarish)

[52]Baggett & Adler, op. cit., p.6

and political special interest groups,[53] than strong ideological differences between their philosophies of assisted living.

The licensed and unlicensed regulatory processes discussed in Chapter IV exemplify the range of endorsed prototypes, from extremely "hands-off" regulation in Massachusetts to much more specific statutory language in Florida. Outlined below are the perceptions of public officials (Massachusetts) and policy analysts interviewed regarding the role of regulation and licensing in promoting the development of assisted living.

OBJECTIVES: Paul Dryer, policy analyst for the Massachusetts Department of Public Health (DPH), stated without qualification that Massachusetts' assisted living policy debate was driven by a desire to respond to providers' needs. As the administration restructures elderly health-care services, defining nursing home admissions criteria more narrowly in order to reduce the institutionalized population, every effort is being made to foster private, community based alternatives for the elderly requiring sub-acute services.

These efforts include the state's recently issued "Assisted Living Program Model" (see Appendix B) and DPH's recent attempts to clarify which facilities are regulated under the State's Long-term Care licensure regulations (see DPH's Long Hill Licensing Opinion, Appendix D.) A full legal opinion on assisted living's regulatory responsibilities under existing statues is anticipated from DPH by the end of the summer.

[53]Discussion at ALFAA's July 1992 Massachusetts' Chapter meeting encompassed the potential of nurses unions and nursing home operators organizing to lobby for more specific language in Massachusetts' draft initiative. AALFA members expressed concern that out of self-interest, the nursing home associations would attempt to restrict the population qualified to receive care in order to preserve their segment of the market. Fears were also expressed that the provision for unlicensed personnel administering medication might provoke political action from the registered nurses associations in an effort to opposed to any action that threatens to erode their "turf." Whether these factors played a role in Florida's more restrictive licensing standards was a matter of supposition.

POLITICAL ENVIRONMENT While acknowledging that the Weld Administration's anti-regulatory predisposition "played a part in the direction taken" by the policy committee in drafting the Program Model, Dryer believed that the private sector's desire to avoid the determination of need process (DON) had been the primary reason for the resulting unlicensed model. As explained by Dryer, assisted living facilities licensed under DPH would by statute require a DON process "flowing from the creation of a new health-care type." According to Dryer, the policy committee was very sensitive to assisted living developers desire to avoid a DON process, aware that the 12 to 18 month process presents a major hurdle and financial hardships that can not be sustained by many developers.

REIMBURSEMENT A further negative consequence of DPH licensing for assisted living was its impact on the reimbursement funds available to facilities. Because licensing implies an institutional model (resulting in a definition similar to that of rest homes), the facility would not qualify for Medicaid's Community Benefits Program, while at the same time failing to qualify for reimbursement under Medicaid's nursing home program. The end result of DPH licensing would be a denial of funding from all federal sources.

POLICY IMPACT What Dryer said the policy committee failed "to hear" amid the clamor against a DON requirement, was the developers and providers desire for official recognition for public relations, liability and financial reasons. Although "everybody (in the policy committee) agreed early on that oversight was necessary from a quality assurance standpoint,"[54] they failed to understand the distinction between the industry's objection to a DON requirement and licensing in general, mistakenly assuming that they were one in the same. Once it became clear that the industry wanted some form of official

[54]Paul Dryer, Massachusetts Department of Public Health, 14 July 1992

recognition of assisted living and its role in the continuum of elderly care, Dryer stated that the state took the concern "very seriously." At the same time there was "unanimous" belief in the committee that licensing would raise costs and frighten developers.[55]

Although the state may license assisted living under departments other than DPH and avoid the institutional characterization and requirement for a DON process, this option was not pursued. Rather, the resulting Program Model Draft provides a registration system, not licensing. Registration, as summarized by Dryer, requires that providers specify "what you want to do, how you're going to do it, and proof of your capacity to do it." Consumer protection is address through the Ombudsman program of the Executive Office of the Elder Affairs (EOEA) and "appropriate oversight agencies" (e.g. building inspectors, fire marshals, safety authorities, etc.,) as well as market and Medicaid oversight. Although providers failing to meet registration standards could still operate, the policy committee believed that market pressures associated with the lack of registration would cause providers to upgrade or be forced out of business. Building and safety codes would provide a safety net in the worst case scenarios.

The registration requirement was included specifically because it was believed to "encourage" the private sector, providing the recognition desired by the industry without the regulatory intensity and costs of licensing. However, Dryer commented that the state may move to statutory regulation (providing licensing) in response to pressure from the private sector.

[55]Eleanor Shea-Delany, Massachusetts Department of Public Welfare

CHAPTER VIII

LENDER'S PERSPECTIVES ON LICENSING

My research with lenders was conducted to address the issue of licensing's impact on financial markets. The goal of the research was to ascertain what the consequences , positive and negative, of licensing were for capital markets, their decision to lend and at what premium. With a clear understanding of the impacts of licensing on the costs and availability of capitol, state policy may be more prudently formulated to promote assisted living facilities.

Interviews with commercial banks, insurance companies, bond underwriters, and state financing agencies provided surprisingly consistent opinions. Without fail, all lenders contacted listed their primary lending criteria for assisted living projects as:

1. Market assessment/uncertainty
2. Sponsor's financial strength (depth)
3. Sponsor's management experience
4. Projects financials

When questioned regarding licensing, most replied that although the oversight offered by licensing's survey standards added an "extra comfort level" for lenders, it was not on the critical list for lenders' criteria.

The hypothesis that state oversight added value for a lender as a third party monitor and guarantor of minimum standards was discounted by the financial sources interviewed (see Chapter VII.) The common sentiment among lenders was that the quality standards required to maintain a competitive facility were substantially higher than the licensing minimums contained in typical statues. Furthermore, the lenders pointed out that the quality issues truly important to competitive advantage (atmosphere & aesthetics) were not parallel to the items regulated by licensure. As a result, the presence of licensing does not result in any loan premium discount.

The alternate hypothesis postulating that licensing's requirements result in a risk premium was also disproved. The assumption that lenders attach a risk premium to regulated heath care facilities due to the potential for loss of licensure or "regulatory creep"[56] was also not borne out by my research.

Lenders interviewed did not attach a premium to loans in order to compensate for the risk of a facility's losing its license. Lenders indicated that their contractual standards were well in excess of licensing minimums (due to the market forces with which their facilities had to contend,) placing a facility in the hands of a lender long before service or program deterioration could result in license suspension.

In the interviews conducted, "regulatory creep" and its potential impact on a projects long-term performance did not appear to be an identifiable element in a lenders' debt pricing either. As Jeannette Price at Smith Barney pointed out, the priority return position of lenders insulates them from the potential costs of new or increased licensing, protecting them from reduced returns due to regulation. No one interviewed felt that the "regulatory creep" could ever be severe enough to place a project qualified for commercial funding in jeopardy of default. As a result no premium is attached to health-care projects requiring licenses.

The only real advantage of licensing in the eyes of the financial community appeared to be the necessity for licensing statutes to define assisted living before they can regulate it. Official definition of assisted living, clarifying its place and parameters in the spectrum of elderly care, was considered valuable by capitol sources, but not sufficiently to result in a premium discount.

[56]"Regulatory creep": the belief that regulation, once established, naturally and irreversibly grows more comprehensive and restrictive over time.

The factors important to lenders from various segments of the financial field are outlined below.

COMMERCIAL BANKS: (excerpted from interview with Jan Adams, Virginia Stolzenhaler, and John Bigelow of Fleet Bank, Health-care/Not-for-Profit Lending Group, Boston, MA.)

Positive attributes:

- Assures quality control/third set of eyes.
- Gives comfort knowing state is in their checking facility (especially useful for small community lenders without sophisticated specialized lending departments.)
- Differentiates providers through minimum criteria, "hassle factor" of licensing process self-selects serious developers.
- Consumers perceive as positive attribute, helps with marketing.

Negative characteristics:

- Know smart providers are manipulating state system. Licensing does not guaranty providers are giving best quality care, merely that they are good at the system.
- With low profit margins in long term care generally, any additional costs associated with licensing will come out of quality of care, not profit, jeopardizing projects' competitiveness with other products (i.e. home health care, adult day care, etc.)

General comments:

- Issue of licensing "minimal" in lending process, does not impact interest rate.
- Important issues for commercial bank:
  - reputation of sponsor/developer
  - financial depth
  - management depth of development team (important that management is not overextended in other projects)
  - previous experience
  - strength of proposed facility management team
  - focus of development
  - level of detail in proforma's market and sensitivity analysis
- Bank discomfort with incidence of default in long-term care field (i.e. Continuing Care Residential Communities - *CCRC's,*) what is a lender to do with the elderly residents of foreclosed projects?
- Licensing without DON does not guaranty market.

INSURANCE INDUSTRY LENDING: (excerpted from interviews with Anthony Pierson - CIGNA, David Ingram - Aetna, Thilo Best - Prudential Mortgage Capital Company)

Positive attributes:*

- minimum standards mitigate risks to lender
- Third party oversight relieves lender from need to be "in the health care business"
- Licensing surveys good source for monitoring compliance with minimum standards

Negative Attributes:

- Cost of regulation may jeopardize project financials
- Licenses not that hard to get

General comments:

- Most important criteria for loan:
  - sponsor
  - management strength
  - proforma
  - loan size
  - percentage of private pay clients
- Medicaid surveys for nursing homes very stringent and very valuable, important part of lending decision.
- Third party oversight makes big difference in lending decision.

*David Ingram felt quite strongly that there were no positive attributes to licensing for a lender or investor, commenting that he had a personal "distaste for regulation." Ingram's view diverged sharply from both Best and Pierson.

BOND UNDERWRITTERS: (excerpted from conversations with Jeanette Price - Smith Barney, Anthony Luzzi - Sims Mortgage Funding, Jay Sterns - Ziegler Securities)

Positive aspects:

- Licensing perceived by investors to open reimbursement stream from government, provides security.

Negative Aspects:

- Licensing may increase costs, making projects less viable.
- Licensure opens facility to Medicaid admissions requirement, high % of public pay population may threaten proforma if government reimbursement schedule falls below costs.

General Comments:

- No premium discount or penalty attached to licensed facilities.[57]
- CON process makes financing easier and cheaper because of market protection[58]
- "Deal are done and interest set on the credit of borrower" sponsors history "far outweighs" anything licensure could add.
- License issued after rates set and bonds sold.
- Long-term care projects have had bad history (especially CCRC's), assisted living seen as "first cousin" and suffers from association.
- License does not insure necessary quality of care to maintain private pay clients, project at risk without private pay.
- Difficult to finance assisted living because not purely market driven and not purely needs driven, hard to analyze.

PUBLIC FINANCE AGENCY: (excerpted from an interview with Eleanor White, Deputy Director of Massachusetts Housing Finance Authority, *MHFA*)

Positive aspects:

- Appropriate state agency's oversight[59] of assisted living facilities valuable, MHFA not completely competent to access quality of care.
- Licensing allows removal of bad operators.[60]
- Good marketing and consumer protection tool for private projects.[61]

Negative Aspects:

- Licensing creates another state bureaucracy.

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[57]Anthony Luzzi (Sims Mortgage Funding) felt that to the extent that licensing "legitimized" the assisted living field it helped in financing the product. He believed benefit might be measurable in terms of interest premiums charged.

[58]Jay Sterns (Ziegler Securities) stated that when Arizona eliminated the CON process for nursing homes, cost of financing skilled nursing facilities in the state increased.

[59]According to White, licensing is not necessary. A memo of understanding would be sufficient to assure oversight and avoid complications of oversight.

[60]Licensing's ability to remove bad operators is not necessary for MFHA projects. MFHA's contracts allow management to remove operators "without cause." White did believe that the licensing structure could be useful to private sector lenders in their efforts to remove inadequate management. She suggested a licensing standard that would exempt state financed projects to avoid redundancy with MFHA's existing powers.

[61]Marketing advantages of licensing not important for MFHA projects because MFHA approved status more powerful endorsement of quality than license. However, license beneficial for privately financed project.

- Licensing's redundancy with MHFA's standards create additional work for MHFA without additional results, unnecessarily raising costs for MFHA.
- Licensing does not guaranty quality. May give substandard providers undeserved credibility.

General Comments:

- "Licensing is not of any particular value."
- MHFA's lending criteria and contractually based monitoring policies much more rigorous than state's, licensing merely redundant given "heavy" oversight of MHFA (additional & unnecessary hoop for MHFA,) however, licensing may be useful to conventional lenders without MHFA's contractual powers.

CHAPTER IX

CONCLUSIONS

The adoption or rejection of state licensing will have major implications for the assisted living industry, affecting the character, quantity and affordability of the product developed. Because the consequences of licensing are far reaching and often contrary to expectations, it is important that policy makers understand fully the implications for assisted living developers, providers and lenders. If state and federal policy is to be crafted to foster the private sector's delivery of adequate and affordable assisted living alternatives, all potential regulatory measures must be examined to assure that policy decisions do not unnecessarily or inadvertently hinder development.

The research conducted shows clear patterns of preferences for licensing within private sector groups (capital markets, developers and providers,) while public officials hold less unified opinions (likely due to ideological differences.) The impact of licensing for each group are concluded below:

CAPITAL MARKETS

The strong consensus among lending sources interviewed (see Chapter VIII) is that the presence or absence of state licensing does not effect the cost of capital for individual assisted living projects. Lenders and underwriters indicated that given comparable proposals, they would not attach a premium or discount to a project requiring licensing.

The primary consideration for the lenders interviewed was the track record and reputation of the sponsor. Financial depth and management expertise were sighted as the factors most critical to assessing the long-term viability and risk of a project. Neither the oversight provided by licensing, nor "regulatory creep" factored in the decisions of the lenders interviewed.

Oversight: The consensus among those interviewed was that licensing in no way assured quality of care. Although all lenders interviewed expressed an added "comfort level" with licensing, none felt that current (or future) standards could offer adequate oversight to assure the quality of care necessary to mitigate lending risks. Financial sources interviewed stated that licensing was inherently flawed,[62] allowing "smart" care providers (good at "manipulating the system") to achieve high survey scores without providing the type of care required to compete effectively in an unrestricted marketplace. As such, licensing had no positive value as an oversight tool.

Regulatory Creep: The costs of licensing were not a concern for the lenders in their analysis of a project. No where in my research was I able to substantiate the thesis that licensing increases the perception of regulatory risk within the financial community, raising the cost of capital. Lenders stated that a projects initial proforma would reflect the cost of current regulation, while the impacts of increased regulation would be absorbed in the returns to equity investors, not the preferred returns of lenders. Loans would not be furnished to a project whose financial projections lacked a sufficient cushion to absorb increased operating expenses. "Regulatory creep," therefore, would not jeopardize debt coverage ratio and would not increase the cost of debt.

While licensing's potential "regulatory creep" does not play a part in increasing debt's cost, lenders stated that the absence of licensing did create anxiety regarding regulation in the future. Without licensing in place for assisted living, it is widely held by lenders (and developers) that as instances of abuse are uncovered in assisted living facilities, the lack of licensing will increase public outrage and eventually result in excessively harsh regulation being imposed. The financial risks associated with reactive regulation, combined with the negative market impact of a highly publicized scandal, are considered a far greater threat to a project's long term financial viability than "regulatory creep."

[62]Jan Adams, Fleet Bank

Without a mechanism in place to remove substandard institutions (and thereby distance the industry from their negative publicity,) lenders perceived the industry as highly vulnerable to the same type of rigid regulation that has stifled the nursing home industry's ability to provide the flexibility, residential based care that assisted living was conceived to provide. The perceived regulatory instability resulting from the lack of licensing procedures was sited as a contributing cause to the current lack of capital for assisted living projects.

DEVELOPERS/PROVIDERS

While the financial community appears to be neutral on the issue of state licensing for assisted living, the development community is not. The industry feels adamantly that appropriate state licensing (see Chapter IV) would provide substantial assistance in promoting the development and marketing of assisted living facilities. This contradicts the assumption the state has made that avoiding licensing is the most effective way to foster the private sector's efforts.

As long as licensing is in line with the *results-oriented* licensing models described in Chapter IV, the fear of regulation increasing assisted living's costs while diminishing its residential character, is avoided. The industry representatives interviewed felt that providers and government officials would never allow licensing or regulation to follow the restrictive and cumbersome medical model experienced by the nursing home industry, noting that "even the most die-hard regulator types"[63] recognized that *process-oriented* regulation had failed dramatically in the nursing home industry.

[63]Joan Hyde, Sterling Care, Wellesley Massachusetts

The unexpected desire of the assisted living industry for licensing stems from business development concerns. These issues may be generalized into three categories:

Industry Definition: To accomplish broad acceptance of assisted living,[64] it is necessary to familiarize the public with the product. An important step in the effort is to define the services provided and the population served by the model. The current confusion surrounding assisted living's definition and role in the continuum of elderly care (see Chapter II) complicates this effort. Licensing is seen as a valuable tool with which to define the product offered by assisted living facilities and clarify its position in the continuum. The industry believes that a clear definition and officially acknowledge role for assisted living facilities will stimulate both the financial and consumer markets.

Industry Liability: Licensing is also desirable in many states where ambiguity exists over the regulatory guidelines currently applicable to assisted living facilities. Without clear statutory language recognizing assisted living as a distinct entity and delineating parameters for both the physical plant and services, there is no way to establish that assisted living facilities are not legally regulated under nursing home statues. In states where ambiguity exists, a facility must choose to either voluntarily submit to nursing home regulations that may jeopardize the philosophy of assisted living care (and almost certainly raise the cost of care,) or risk criminal and financial penalties if they are determined to be in violation of statutory requirements.

Marketing: Developers and providers believe that the current lack of product clarity and regulatory uncertainty hurts the industry's image, making investors scarce and lenders nervous[65] (see Chapter VIII.) The official sanction licensing implies provides assisted

[64]Although the concept of a residential model with supportive services existed informally in the form of old age homes, the Social Security Act of 1935 (see Chapter III) shifted resources away from residential care for the elderly, to a medical model delivered in institutional nursing home settings. The assisted living industry is attempting to reintroduce the residential model of care as a widely available alternative for the segment of the elderly population that does not require skilled nursing care.

[65]Although neither of these assumptions is borne out in my research, it is significant that developers may be discouraged from attempting projects because of the perceived road block.

living credibility believed to be quite important in marketing assisted living to residents and their families.[66]

The consensus among providers and developers interviewed was that the current lack of state statues legally defining the product and clarifying its status, serve as a large deterrent to sponsors entering the field.[67] The clarity and endorsement offered by licensing is perceived by providers to enhance their ability to obtain financing, investors and customers.

All providers interviewed asserted that licensing standards and practices, roughly equivalent to the Oregon model, were minimums and easily exceeded by the standards necessary to remain competitive in the market. For this reason, licensing was not viewed as a threat to affordability. The minimal additional administrative costs for documentation and survey fees (if required) were considered minor in comparison to the benefits.

The additional predevelopment time required to develop care plans and submit them for approval was not an issue. There was no discussion of additional development costs associated with the applications process as the process runs simultaneously with other preconstruction development activities and does not add to the predevelopment time line. Unless the application process fails to run simultaneously with construction document preparation and permitting, licensing will not add perceptibly to development costs.

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[66]It is quite interesting to note that although nearly all of the lenders interviewed stated that licensing would make no difference in their lending decision, acknowledging that licensing's minimum standards could not provide the quality of care required to protect their investment, all volunteered that they would want a facility for their mother to be licensed. This interesting discontinuity between the rational analysis of licensing in a financial context and the emotional reaction when a decision involves a family member, is indicative of the power of licensing holds as a marketing tool, despite the underlying realities of what it might or might not provide.

[67]Joan Hyde, Sterling Care, Wellesley Massachusetts

Without fear of cumbersome and expensive requirements, licensing is viewed by the industry as very beneficial to their attempts to inform, assure, and attract both investors and residents.

PUBLIC SECTOR

One of the most interesting findings of my research on the public sector's debate over licensing assisted living (limited to Massachusetts government,) was the complete lack of discussion by policy committees around the issue of licensing's impact (positive or negative) on the industry delivery of product. With assisted living seen by state government as a real solution to the cost crisis in elderly health care, enthusiastically backed by Medicaid and the Massachusetts Executive Office of Elder Affairs,[68] it is curious that serious research was not pursued regarding the implications licensing has for the development and affordability of assisted living facilities.

The failure to analyze investors' and capitol markets' valuation of licensing while crafting public policy for assisted living, could result in the loss of significant opportunities to encourage private sector delivery and financing. Without proper research it is impossible to establish whether regulation actually benefits or hinders an industry. The thesis that deregulation (or in this case the decision not to regulate) benefits an industry is naive. To dismiss regulation as counterproductive without sufficient research to substantiate the hypothesis, risks overlooking an opportunity to foster broader policy goals due to preconceptions.

[68]Eleanor Shea-Delany, Massachusetts Department of Welfare, Long-term Care Division

RECOMMENDATIONS

Because both excessive and insufficient regulation[69] pose a threat to the optimal production and affordability of assisted living facilities, it is my recommendation that appropriate and proven licensing for the industry (as outlined in Chapter IV) be adopted.

While the presence or lack of licensing may not be identified as a factor in the current dearth of financing for assisted living, my research indicates that explicit, *results-oriented* licensing will assist in the industry's development and affordability.[70] The marketing and liability advantages of licensing, combined with its (worst case) neutral impact on the costs of capital and operations, make a strong case for licensing as a tool to promote development of assisted living as an alternative to skilled nursing facilities.

The more governments policy may be tailored to clarifying and reinforcing the place of assisted living in the continuum of care, while providing mechanisms to protect the industry from the impacts of disreputable providers, the faster private markets will become comfortable with the industry. As familiarity and comfort are established, markets will learn to properly value the product. Stabilized demand will result in a lowered risk associated with assisted living, encouraging production and affordability of assisted living facilities.

[69]Current regulatory ambiguity results in assisted living facilities licensing themselves at higher levels than appropriate, resulting in additional costs. Appropriately defined assisted living licensing would prevent over-regulation, promoting affordability.

[70]Although not a subject of my research, my literature review indicates that appropriate licensing is also favored by patient advocates to insure a safety and quality of life for assisted living residents.

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APPENDIX A

Assisted Living Facilities Statute: Oregon

Amended 7/1/91

RESIDENTIAL CARE FACILITIES
ASSISTED LIVING

Index

Administrative Rules
for Residential Care Facilities/Assisted Living Facilities

411-56-000 Purpose

(1) The purpose of these rules is to establish standards for assisted living. The standards promote the availability of appropriate services for elderly and disabled persons in a home-like environment to enhance the dignity, independence, individuality, privacy, choice and decision making ability of the resident. The purpose of these rules is to also promote the concept of "aging in place."

(2) Assisted living requires the facility to address the standards in the delivery of services to the residents and the design of the physical environment to support dignity, independence, individuality, privacy, choice, and decision making abilities of individual residents.

(3) Assisted living requires the Residential Care Facility\Assisted Living Facility to provide each resident a separate living unit with a lockable door to guarantee their privacy, dignity, and independence.

411-56-005 Definitions

For the purpose of these rules, authorized under ORS 443.400 - 443.640 and 443.991, the following definitions apply:

(1) "AAA" means a Type B Area Agency on Aging (AAA) which is an established public agency within a planning and service area designated under Section 305 of the Older Americans Act which has responsibility for local administration of Division programs. For the purpose of these rules, AAAs contract with the Division to perform specific activities in relation to licensing Assisted Living Facilities including receiving applications; conducting inspections and investigations regarding protective service, abuse and neglect; monitoring; and making recommendations to the Division regarding Assisted Living license approval, denial, revocation, suspension, non-renewal and civil penalties.

(2) "Abuse" means any act or absence of action inconsistent with prescribed resident care. This includes but is not limited to:

(a) Physical assault such as hitting, kicking, scratching, pinching, choking or pushing;

(b) Neglect of care, including improper administration of medication(s), failure to seek appropriate medical care, inadequate changing of beds or clothes, and failure to help with personal grooming;

(c) Denying meals, clothes, or aids to physical functioning;

(d) Use of derogatory or inappropriate names, phrases, or profanity; ridicule; harassment; coercion; threats; cursing; intimidation; or sexual exploitation;

(e) Placing unreasonable restrictions on residents which violates the resident Bill of Rights;

(f) Using restraints, except when a resident's actions present an imminent danger to self or others, and only until appropriate action is taken by medical, emergency, or police personnel;

(g) Financial exploitation which includes, but is not limited to, unreasonable rate increases, borrowing from or loaning money to residents, witnessing wills in which provider is beneficiary, adding provider's name to resident bank accounts or other personal property without approval of family or case manager, inappropriately expending residents' personal funds, co-mingling residents' funds with provider or other residents' funds, or becoming guardian or conservator.

(3) "Activities of Daily Living (ADL)" means those personal functional activities required by an individual for continued well-being including eating/nutrition, dressing, personal hygiene, mobility, toileting and behavior management.

(a) "Independent" means the resident can perform the ADL without help;

(b) "Assistance" means the resident can perform some part of an activity, but cannot do it entirely alone;

(c) "Dependent" means the resident cannot perform any part of an activity; it must be done entirely by someone else.

(4) "Aging in Place" means the process by which a person chooses to remain in his/her living environment ("home") despite the physical and/or mental decline that may occur with the aging process. For aging in place to occur, needed services are added, increased or adjusted to compensate for the physical and/or mental decline of the individual.

(5) "Applicant" means the person who completes an application for a license who is also the owner of the business.

(6) "Assisted Living" means a program approach, within a physical structure, which provides or coordinates a range of services, available on a 24-hour basis, for support of resident independence in a residential setting. Assisted living promotes resident self direction and participation in decisions that emphasize choice, dignity, privacy, individuality, independence, and home-like surroundings.

(7) "Choice" means viable options created for residents to enable the individuals to exercise greater control over their lives. Choice is supported by providing sufficient private and common space to provide opportunities for selecting where and how to spend time and receive personal assistance.

(8) "Department" means the Department of Human Resources.

(9) "Dignity" means providing support in such a way as to validate the self-worth of the individual. Dignity is supported by designing a structure which allows personal assistance to be provided in privacy and delivering services in a manner which shows courtesy and respect for a resident's right to make decisions.

(10) "Division" means the Senior Services Division of the Department of Human Resources.

(11) "Exception" means a written variance from a regulation or provision of these rules.

(12) "Home" means a living environment which creates an atmosphere supportive of the resident's preferred lifestyle. Home is also supported by the use of residential building materials and furnishings.

(13) "Independence" means supporting resident capabilities and facilitating use of those abilities. Independence is supported by creating barrier free structures and careful design of assistive devices.

(14) "Individuality" means recognizing variability in residents' needs and preferences and having flexibility to organize services in response to the needs and preferences.

(15) "Neglect" means failure (whether intentional, careless, or due to inadequate experience, training, or skill) to provide agreed upon services to a resident; or failure to make a reasonable effort to assess what care is necessary for the well-being of a resident; or failure to provide a safe and sanitary environment.

(16) "Nursing Care" means the practice of nursing by a licensed nurse, including tasks and functions that are delegated by a registered nurse to persons other than licensed nursing personnel, which is governed by ORS Chapter 678 and rules adopted by the Oregon State Board of Nursing in OAR Chapter 851.

(17) "Personal Incidental Funds" (PIF) means the monthly amount allowed each Medicaid and General Assistance resident for personal incidental needs. For purposes of this definition, personal incidental funds include monthly payments, as allowed, and previously accumulated resident savings.

(18) "Privacy" means a specific area and/or time over which the resident maintains a large degree of control. Privacy is supported by designing living space which is not shared, except by personal choice, with others. Privacy is supported with services that are delivered with respect for the resident's civil rights.

(19) "Resident" means any individual who is residing in a unit within a residential care facility/assisted living facility.

(20) "Service Plan" means a written plan for services developed with the resident and/or significant others and includes recognition for the resident's capabilities and choices. The plan defines the division of responsibility in the implementation of the services and specifies measurable goals.

(21) "Services" means activities which help the residents develop appropriate skills to increase or maintain their level of most independent psycho-social and physical functioning, or which assist them in activities of daily living.

(22) "SSD" means the Senior Services Division of the Department of Human Resources.

(23) "Unit" means an individual living space constructed as a complete private apartment, including living and sleeping space, kitchen area, bathroom and adequate storage areas.

411-56-010 Administration of Services

The facility shall have written policies and procedures approved by the Division, which incorporate the assisted living principles of individuality, independence, dignity, privacy, choice, and home-like environment. These include:

(1) Recognition of the resident's rights, responsibilities, needs and preferences;

(2) The form of addressing the resident;

(3) Assurance that the resident and/or significant other is free to select or refuse service and to accept responsibility for the consequences;

(4) Development and maintenance of social ties with opportunities for meaningful interaction and involvement with the community;

(5) Provisions for furnishing and decorating personal space;

(6) Recognition of personal space as private;

(7) Precautions to insure well-being without violating civil rights;

(8) Freedom of the resident to set his/her own schedule, have visitors and leave the facility;

(9) Development of a resident "bill of rights", methods of resolving resident complaints, freedom from abuse, freedom from neglect, freedom from use of chemical and physical restraints;

(10) Identifying methods of preventing and responding to incidents involving injury, loss of property, abuse and neglect.

411-56-015 Range of Services

(1) Service Plan

(a) The residential care facility/assisted living facility shall conduct an interdisciplinary team assessment of needs, plan responsive services, implement services, record changes or results, and periodically evaluate results of the plan. The plan shall reflect assessed needs and resident decisions (including resident's level of involvement); support principles of dignity, privacy, choice, individuality, independence, and home-like environment; and shall include significant others who may participate in the delivery of services.

(b) A service plan shall be developed and followed for each individual consistent with that person's unique physical and psycho-social needs with recognition of his/her capabilities and preferences. The plan shall include a written description of what services will be provided, who will provide the services, when the services will be provided, how the services will be provided, how often services will be provided and the expected outcome. Each resident shall actively participate in the development of the service plan to the extent of his/her ability to do so.

(c) The initial service plan shall be developed prior to the time the resident moves into his/her unit and shall be revised if needed within 30 days. The service plan shall be reviewed and updated by the facility, the resident, others as designated by the resident, and for SDSD/AAA residents, the case manager, initially and at least quarterly or more often as needed.

(d) The facility shall designate a staff member to review, monitor, implement, and make appropriate modification of the service plan for each resident.

(2) Services

(a) The residential care facility/assisted living facility shall provide the following:

(A) Three meals daily, seven days a week, including special diets and snacks which are appropriate to residents' needs and choices;

(B) Personal and other laundry services;

(C) Opportunities for individual and group socialization and to utilize community resources to create a normal and realistic environment for community interaction within and outside the facility;

(D) Services to assist the resident in performing all activities of daily living, including bathing, eating, dressing, personal hygiene, grooming, toileting, and ambulation;

(E) Nursing assessment, health monitoring, and routine nursing tasks, including those which may be delegated to unlicensed persons by a currently licensed registered nurse under the provision of the Nurse Delegation Standards as adopted by the Board of Nursing;

(F) Services for residents who have behavior problems requiring on-going staff support, intervention, and supervision;

(G) Household services essential for the health and comfort of resident (e.g., floor cleaning, dusting, bed making, etc.);

(H) Medication assistance.

(b) The residential care facility/assisted living facility shall also have the capability to provide or arrange access for the following:

(A) Medical and social transportation;

(B) Ancillary services for medically related care (e.g. physician, pharmacist, therapy, podiatry), barber/beauty services, social/recreational opportunities, hospice, home health, and other services necessary to support the resident;

(C) Maintenance of a personal fund account for residents showing deposits and withdrawals.

(3) Medications

(a) Self Medication

(A) Residents must have physician, physician assistant or prescribing nurse practitioner's written order of approval for self-medication of prescription medications;

(B) Residents able to handle their own medication regimen may keep prescription medications in their unit;

(C) Residents may keep and use over-the-counter medications in their unit without a written order unless otherwise contra-indicated by a physician, physician assistant, or prescribing nurse practitioner written orders;

(D) If more than one resident resides in the unit, an assessment will be made of each person and his/her ability to safely have medications in the unit. If safety is a factor, the medication shall be kept in a locked container in the unit;

(E) The facility will work with the resident to develop a means to mutually resolve any problems relating to self- medication.

(b) Medication Administration

(A) Prescription and non-prescription medications which the facility has responsibility for administering to a resident must be identified in the resident's record and must be prescribed in writing for the resident by a physician, physician assistant or prescribing nurse practitioner.

(B) The facility shall provide and implement policies and procedures which assure all medications administered by the facility to a resident are reviewed at least every ninety days by either a licensed nurse, physician assistant, or physician.

(C) Residents who self-medicate with prescription drugs or maintain over-the-counter drugs in their units shall be encouraged to have all their medications reviewed by either a registered pharmacist, licensed nurse, physician assistant, or physician at least every ninety days.

(D) An individual record shall be kept for each resident, recording any prescription drugs administered by the facility. This written record shall include:

(i) Name of resident;

(ii) Name and telephone number of prescribing physician;

(iii) Description of the medication, including prescribed dosage;

(iv) Times and dates administered;

(v) Method of administration;

(vi) Any adverse reactions to the medication;

(vii) Signature of staff administering medication; and

(viii) Review date.

(E) The facility will develop and follow a written policy for unused, outdated or recalled medications being kept in the facility.

(F) The facility may not require residents to purchase prescriptions from the pharmacy who contracts with the facility.

411-56-020 Move-Out Criteria

In support of the philosophy of "Aging in Place," which advocates allowing the resident to choose to remain in his/her living environment despite the physical and/or mental decline that may occur with the aging process, the following requirements apply:

(1) Residents may not be asked to leave without 14 days' written notice stating reasons for the request. Resident's shall have the right to object to the request, except where undue delay might jeopardize the health, safety or well-being of the resident or others. Residents may be asked to leave only for the following reasons:

(a) Behavior which imposes an imminent danger to self or others;

(b) The facility has had its license revoked, not renewed, or voluntarily surrendered;

(c) The facility cannot meet the resident's needs with available support services or services are not available and are required by the Division;

(d) Resident or responsible person has a documented established pattern, in the facility, of not abiding by agreements necessary for assisted living; or

(e) Non-payment of charges.

(2) Residents who object to the move shall be given the opportunity of an informal conference if requested within ten days of receipt of notice to move. The purpose of the conference is to determine if a satisfactory resolution can be reached. Participants in the conference may include the facility representative, the resident, and at the resident's request, a family member, case manager, and/or legal representative of the resident. The informal conference is not to be considered an administrative hearing.

411-56-030 Organization of Business

(1) Management Capability

(a) Each facility, through its policies and procedures, shall have a statement approved by the Division that demonstrates knowledge of the assisted living philosophy and a commitment to that philosophy.

(b) The facility administrator shall have 20 hours of continuing education credits each year.

(c) Each facility shall document that staff have received assisted living training as prescribed by the Division.

(d) The facility administrator shall be accountable for training all facility staff in provision of services and principles of assisted living.

(e) The facility staff shall demonstrate competency in provision of services and principles of assisted living.

(f) A change in administrator requires that the new administrator demonstrates knowledge of the assisted living philosophy and has received the required training.

(g) Each administrator shall serve an internship in an established assisted living facility.

(A) Intern training programs must be approved by the Division;

(B) The administrator shall be responsible for payment of the internship to the Division-approved training facility;

(C) The internship would meet the requirements for the twenty-hour continuing education requirement for the first year.

(2) Financial Management

The residential care facility/assisted living facility shall have written policies, procedures, and accounting records for handling residents' personal incidental funds, which are managed in the resident's own best interest.

(a) The resident may manage his/her personal financial resources, or may authorize another person or the assisted living facility to manage personal incidental funds only.

(b) Records shall include a statement as to whether or not the facility will handle the resident's personal incidental funds.

(c) Records will include the Resident Account Record (SDS 713) or other comparable expenditure form if the facility manages or handles a resident's money. The resident account record shall show in detail with supporting documentation all monies received on behalf of the resident and the disposition of all funds received. Persons shopping for residents shall provide a list showing description and price of items purchased, along with payment receipts for these items.

(3) Contractual Responsibilities

(a) The facility shall have a resident rental/service agreement with each resident which includes terms of occupancy, charges, fees, deposits, and billing information; services to be provided, with itemized charges for ancillary services; conditions under which the rates can be changed; the policy on refunds; furnishings; obligations of the facility and resident; and rights of the facility and resident.

(b) Thirty (30) days prior to any increases, additions, or other modifications of the rates, the facility shall give written notice of the proposed changes to residents and/or their representatives.

(c) Ancillary services shall be identified with written agreements as to which are the responsibility of the resident and which are the responsibility of the facility.

411-56-040 Building Standards

(1) General Conditions

(a) All facility buildings shall meet applicable zoning, building, housing, water, sewer and fire safety codes, rules and regulations. If an exception or waiver is granted by a regulatory agency, the Division may accept the waiver or exception.

(b) The building shall be constructed in such a way as to be adaptable to meet the physical needs of the resident.

(c) The building owners shall maintain in good repair and operable condition all structures, installed equipment, grounds, and individual living units.

(d) The building shall have and utilize adequate, locked storage where the following are kept:

(A) All poisons, chemicals, rodenticide, and other toxic materials which shall be properly labeled;

(B) All flammable and combustible materials which shall be properly labeled and stored in their original containers, and

(C) All maintenance equipment (lawn mowers, tools, etc) used or stored at the building.

(e) Hot water temperature in resident units shall be maintained within a range of 110 - 120 degrees Fahrenheit.

(2) General Building Exterior

(a) All exterior pathways and/or accesses to the facility's common use areas and entrance/exit ways shall be of hard smooth material, handicap accessible, barrier free, and be maintained in good repair.

(b) There shall be a means of monitoring all entry/exits for security purposes.

(c) Outdoor recreation areas are required and shall be available to all residents and shall have handicap accessibility and five footcandle lighting.

(d) The facility shall have covered refuse containers of adequate capacity.

(3) General Building Interior

(a) Carpeting and other floor materials shall be constructed and installed to minimize resistance for passage of wheelchairs and other ambulation aids. Thresholds and floor junctures shall also be designed and installed for passage of wheelchairs and to prevent a tripping hazard.

(b) Each resident/unit shall be provided a handicapped accessible mailbox which meets postal requirements.

(c) Door handles for all exit and interior doors used by residents shall be handicapped accessible.

(d) All rooms with toilets or shower/bathing facilities shall be exhausted to the outside by a mechanical ventilation system.

(e) All common areas and resident units shall be accessible through temperature-controlled common corridors.

(4) Resident Units

(a) Unit Dimensions

(A) New construction units shall have a minimum of 220 square feet not including the bathroom. Each unit shall have a bathroom, as required in Subsection (4)(g) of this rule.

(B) Units in pre-existing structures being remodeled shall have a minimum of 160 square feet not including the bathroom. Each unit shall have a bathroom, as required in rule Subsection (4)(g) of this rule.

(b) Windows

(A) All units shall have an escape window that opens directly into a public street, public alley, yard or exit court. This window section shall be operable from the inside to provide a full clear opening without the use of separate tools and shall have a minimum net clear open area of 5.7 square feet, shall have a minimum net clear opening height of 24 inches, shall have a minimum net clear open width dimension of 20 inches, and have a finished sill height not more than 44 inches above the floor. Windows shall not be below grade.

(B) Each resident's living room and bedroom shall have an exterior window which has an area at least one-tenth of the floor area of the room. One window shall be at least 3'-6" x 5'-0" in size and have a maximum sill height of 36". Operable units shall be designed to prevent accidental fall when sill heights are lower than 36".

(c) Heating - Each unit shall have individual heat controls.

(d) Ventilation - Ventilation in each unit shall occur via an open window to the outside, or with a mechanical venting system capable of providing two air changes per hour with one-fifth of the air supply taken from the outside.

(e) Doors

(A) Each unit shall have an entry door which is at least 36" wide, open inward into the unit, have handles (lever hardware) and have locks which are operable from the inside via lever action with no key needed. The lock for the entry door shall be individually keyed and a key supplied to the resident.

(B) The unit exit door shall open to an indoor, temperature controlled, common area or common corridor.

(f) Lighting

(A) Each unit shall have general illumination in the bath, kitchen, living space and sleeping area. The general lighting intensity in the unit shall be at least 20 footcandles.

(B) The lighting in the unit bathroom shall be at least 50 footcandles.

(C) The lighting in the unit food preparation/cooking area shall be at least 50 footcandles.

(g) Bathroom

(A) The unit bathroom shall be a separate room with a toilet, sink, roll-in shower, be wheelchair accessible, have at least one towel bar (36" in height), one toilet paper holder, and one handicapped accessible mirror. The door to the bathroom shall open outward.

(B) Wheelchair accessibility shall allow 5' turning radius, ANSI T-shape or Y-shape, for wheelchair maneuverability.

(C) Wall construction shall have proper and appropriately placed blocking near toilets and in shower to allow installation of grab bars.

(D) Roll-in, no curb, shower enclosures shall have minimal nominal dimension of 3' by 4', nonporous surfaces, hand-held shower head, non-slip floors, cleanable shower curtains, and at least one grab bar.

(h) Kitchens - Each unit shall have a kitchen area equipped with a sink, refrigerator, a cooking appliance that can be removed or disconnected, adequate space for food preparation, and storage space for utensils and supplies.

(i) Telephone - Each unit shall have at least one telephone jack to allow for individual phone service.

(j) Resident Storage Space - Each unit shall provide space totaling at least 100 cubic feet for resident clothing and belongings and include one clothes closet with a minimum of 4 linear feet of hanging space. The rod shall be mounted no higher than 54 inches and no lower than 36 inches for handicapped accessibility.

(5) Common Areas

(a) Bathing Room

(A) There shall be a special bathing room with a tub and sufficient floor space to allow handicapped accessibility, mechanical aids for transfer, and access for direct "hands on" bathing assistance (hand held shower head when needed).

(B) The room shall have an individual heat control and be provided with an exhaust to the outside.

(C) There shall be direct access to a toilet and sink in the same room or in an adjacent room.

(b) Public Restrooms

(A) There shall be handicapped accessible public restrooms convenient to common areas based on the number of residents and the number of floors in the building.

(B) The room shall contain a toilet, sink, appropriate waste containers, and a hand drying means that cannot be reused.

(c) Dining Room

(A) The building shall have a dining area with the capacity to seat 100% of the residents.

(B) The dining room(s) shall allow 22 sq. ft. per resident for seating, exclusive of service carts and other equipment or items that take up space in the dining room.

(d) Social/Recreation Areas - The building shall have common areas for social-recreational use totaling at least 15 sq. ft. per resident.

(e) Resident Laundry Facilities - There shall be handicapped accessible laundry facilities provided for resident use and shall be operable at no additional cost.

(f) Public Telephone - There shall be a handicapped accessible local access public telephone in a private area that allows a resident or another individual to conduct a private conversation.

(g) Smoking Area - If there is a designated smoking area, it shall be separate from other common areas, be indoors, and exhausted so the rest of the building remains smoke free.

(6) Support Service Space

(a) Medication Storage - The facility shall provide a secured space for medication storage with access to a sink and cold storage in the same area. Space for necessary medical supplies and equipment shall be provided.

(b) Housekeeping/Sanitation

(A) The building shall have a secured janitor closet, for storing supplies and equipment, with a floor or service sink.

(B) There shall be an outside area to sanitize laundry and food carts and to clean garbage cans.

(C) Incontinency supplies and laundry shall be separated from other laundry and transported in a sealed container from the resident's unit or other areas for refuse or laundry.

(c) Laundry Facility

(A) On-site laundry facilities, used by staff for facility and resident laundry, shall have capacity for locked storage of chemicals and equipment.

(B) The area shall have adequate space and equipment for locked storage of clean and soiled laundry. The processing area shall be arranged to provide a "one-way flow" of linens from a soiled area to a clean area; incontinent laundry shall be stored/processed separately from other soiled linens with a "one-way flow" to the clean linen area.

(C) There shall be sinks for laundry rinsing and hand washing in the laundry area.

(d) Communication Center - There shall be an interactive communication system which is linked from the communication center in the facility to each unit, staff area and common area.

(7) Food Sanitation - Assisted living facilities shall comply with Health Division Food Sanitation Rules for primary meal preparation areas, with the following exceptions:

(a) Rules relating to manual cleaning and sanitizing are not applicable for equipment requirements when there is a dishwasher for all cooking equipment; or the wash, rinse, and sanitizing functions can be accommodated by alternate methods.

(b) Facilities with 60 or fewer residents need only meet dishwashing method rules relating to the mechanical equipment requirements for temperature and cycling (not pressure).

(c) Rules relating to drains are not applicable within the individual residential units or when using portable food preparation, cooking and washing equipment; when using vending machines with evaporator for dispensing food/beverage; or when vending machines dispense all products in sealed containers.

(d) Public toilet facilities required under Subsection (5)(b) of this rule may also serve kitchen staff when conveniently available.

411-56-050 License\Contract

To operate and be designated as an assisted living facility, the facility must be licensed as a residential care facility/assisted living facility and comply with OAR 411-56-000 through 411-56-095.

(1) Licensing Requirement

(a) No person or governmental unit acting individually or jointly with any other person or governmental unit shall establish, maintain, conduct, manage or operate an assisted living facility without its being duly licensed.

(b) The Administrator of the Senior Services Division or his/her designee shall determine whether an assisted living facility license is required in cases where the definition of a facility's services is in dispute.

(2) Application Process

Application for a license accompanied by the required fee shall be made to the AAA/SDSD office upon forms provided by the Division and shall include full and complete information as to the:

(a) Identity of:

(A) Each officer and director of the corporation if a facility is organized as a corporation; and

(B) Each general partner if the facility is organized as a partnership; and

(C) The governing body if the facility is a government owned facility.

(b) Name of the administrator of the facility;

(c) Location (address), mailing address, and telephone number of the facility;

(d) Maximum number of residents at any one time;

(e) Maximum number of units; and

(f) Policies and procedures consistent with the Assisted Living philosophy and a written statement of the administrator's understanding of the philosophy.

(3) Identification - Every facility shall have distinct identification or name and shall notify the Division prior to changing such identification.

(4) Descriptive Titles - A residential care facility/assisted living facility licensed by the Division shall neither assume a descriptive title nor be held under any descriptive title other than that which is permitted within the scope of its license.

(5) Reporting of Changes

Each residential care facility/assisted living facility shall promptly report to the AAA/SDSD office changes which would affect the current accuracy of Section (2) of this rule.

(6) Submission of Plans

(a) One set of building plans and specifications shall be submitted to the State Office of Health Policy for approval:

(A) Prior to construction of any new building;

(B) Prior to construction of any addition to an existing building;

(C) Prior to any remodeling, modification, or conversion of an existing building; or

(D) In support of any application for an initial license of a facility not previously licensed under this rule.

(b) Plans shall be in accordance with the current edition of the State Fire and Life Safety Code.

(c) Plans shall be drawn to a scale of one-fourth inch or one-eighth inch to the foot and shall specify the date upon which construction, modification, or conversion is expected to be completed.

(d) Construction containing 4,000 square feet or more shall be prepared and bear the stamp of an Oregon licensed architect or engineer.

(7) Required Fees

(a) Each application for a residential care facility/assisted living facility license shall be accompanied by a non-refundable fee of $60.

(b) No fee shall be required of any governmental operated facility.

(8) License Issued

(a) Upon receipt of an application and fee, the AAA/SDSD office shall refer the application and fee to the Division which shall cause an investigation to be made. Initial action by the Division on the application shall begin within 30 days of receipt of application.

(b) The Division shall issue a license for two years to an applicant found to be in compliance with these rules.

(c) No assisted living facility license is transferable or applicable to any location, facility, management agent or ownership other than that indicated on the application and license.

(d) A residential care facility/assisted living facility license shall be effective for two years from the date issued unless sooner revoked or suspended.

(e) The license issued shall state:

(A) Name and address of the facility to which license applies;

(B) Name of the owner of the facility;

(C) Name of the administrator of the facility;

(D) Maximum number of residents to be served at any time;

(E) Number of units; and

(F) Such other information as the Division requires.

(f) No assisted living facility shall be operated or maintained in combination with a nursing facility, hospital, residential care, congregate care or other type of retirement facility unless licensed, maintained and operated as a separate and distinct part.

(g) The license shall be posted in the facility and available for inspection at all times.

(h) Each license shall be considered void immediately on suspension or revocation of the license, or if the operation is discontinued by voluntary action of the license holder, or if there is a change of ownership.

(9) Renewal of License

(a) A license is renewable upon submission of an application to the Division and the payment of a non-refundable $60 fee, except that no fee shall be required of a governmental operated facility.

(b) Filing of an application for renewal before the date of expiration extends the effective date of expiration until the Division takes action upon such application.

(c) The Division shall refuse to renew a license if the facility is not in compliance with these rules.

(10) Denial, Suspension or Revocation of License

(a) The Division shall deny, suspend or revoke a license where it finds there has been substantial failure to comply with these rules.

(b) In cases where an imminent danger to the health or safety of residents exists or if the facility is not in substantial compliance with these rules, a license may be suspended immediately.

(c) Such revocation, suspension or denial shall be done in accordance with rules of the Division and ORS Chapter 183.

411-56-060 Monitoring

Monitoring of assisted living facilities shall be an ongoing process by the Division or its designee. The facility shall make available for monitoring the following:

(1) Service plans of Division clients and private residents to be audited for compliance with these rules. All assessment and service plan activities shall be consistent with the assisted living principles.

(2) Written outcome measures for both Division clients and private residents which reflect planned and actual results. Application of outcome measures shall include:

(a) Functional abilities;

(b) Psycho-social well being;

(c) Stability of medical condition; and

(d) Client/family satisfaction.

411-56-065 Payment

(1) There shall be five levels of monthly service payment for Division clients based on:

(a) The degree of client impairment in each of the six Activities of Daily Living (ADL) as determined by the Division's assessment document and service priority rule (OAR 411-15-000). The assessment shall be completed upon admission and every 90 days thereafter per OAR 411-56-015(1)(c). The levels are as follows:

(A) Level 5 shall be for a person who is assessed as service priority (A), or who is assessed as service priority (B) and is Dependent in the Behavior ADL.

(B) Level 4 shall be for a person who is assessed as service priority (B), or who is assessed as service priority (C) with Assistance required in the Behavior ADL.

(C) Level 3 shall be for a person who is assessed as service priority (C), or who is assessed as service priority (D) with Assistance required in the Behavior ADL.

(D) Level 2 shall be for a person who is assessed as service priority (D), or who is assessed as service priority (E) with Assistance required in the Behavior ADL.

(E) Level 1 shall be for a person who is assessed as service priority (E) or (F), or who is assessed as service priority (G) with Assistance required in the Behavior ADL.

(b) The Division will determine Consumer Price Index adjustments as authorized by the Oregon Legislature.

(2) An incentive payment shall be made for quarterly accomplishment of one or more specific, maintenance or improvement outcomes for predetermined portions of the eligible resident population. The amount and duration of incentive payment and the percentage of clients for which criteria must be met shall be established by the Division. For an incentive payment to be granted, there shall be objective documented evidence that the service plan, or an appropriate modification of it, resulted in measurable accomplishment of the targeted outcome by the end of the 90 days.

(3) Payment for and placement of Division clients in assisted living facilities shall be according to the following priority:

(a) Residents already living in Assisted Living who have spent down to Medicaid standards or persons discharged from a nursing facility directly to Assisted Living;

(b) Persons discharged from a hospital and awaiting placement to an ICF;

(c) Persons currently residing in an Adult Foster Home or Residential Care Facility and awaiting placement to an ICF;

(d) Persons currently in other living situations and awaiting placement to an ICF.

(4) In all instances, placement in assisted living facilities is contingent upon the client meeting the levels described under OAR 411-56-065(1).

(5) To receive payment from the Division, the facility must enter into a contract with the Division.

(6) The reimbursement rate for Division clients shall not be more than rates charged private paying clients receiving the same type and quantity of service.

411-56-070 Restriction or Limitation of Moves into the Facility

(1) The Division reserves the right to restrict or limit moves into the facility under the following conditions:

(a) One or more complaints of elder abuse in the residential care facility/assisted living facility have been reported and investigated according to ORS 410.610 - 700, and have been substantiated by the Division. The restriction will be in effect until such time that the conditions leading to the abuse have been corrected or the facility demonstrates to the Division's satisfaction that the corrections have been made.

(b) The facility has been inspected and found that rules related to health or safety are not being met, or are in the process of being corrected and allowing additional persons to move into the facility would place current residents in jeopardy. The restriction will be in effect until such time that the facility demonstrates to the Division's satisfaction that the corrections have been made.

(2) The Division shall notify the facility by certified mail when a decision is made to restrict or limit moves into the facility. The restriction or limitation shall take effect immediately upon receipt of notice or on a date specified in the notice.

(a) The notice shall include the basis of the Division's decision and shall advise the facility of the right to request review if such request is made in writing within 30 days of the receipt of the notice.

(b) If a request for review is made, the Division will review all material relating to the allegation of resident abuse or health or safety violations and to the limitation or restriction on moves into the facility. The Division shall determine, based on review of the material, whether or not to sustain the decision to limit or restrict moves into the facility and shall notify the facility of the decision within 20 days of receiving the request for review.

(c) If the Division determines not to sustain the decision, the limitation or restriction shall be lifted immediately. Otherwise, the restriction or limitation will remain in effect until the Division determines that the conditions leading to the abuse or health or safety violations have been corrected.

411-56-080 Exception and Variance

(1) The Division may grant exceptions to Rules 411-56-000 through 411-56-095. Exceptions shall not be granted which are judged to be detrimental to the residents. The facility seeking an exception shall submit to the Division, in writing, reasons for the exception request.

(2) No exception shall be granted from a regulation or provision of these rules pertaining to the monitoring of the facility, resident rights, and inspection of the public files. Exceptions shall not be granted by the Division without prior consultation with agencies involved.

(3) Exceptions granted by the Division shall be in writing and be reviewed periodically.

(4) No exception shall be given for any of the six values of assisted living - choice, dignity, individuality, privacy, independence, and home-like environment.

(5) An individual exception shall be required for each resident sharing a room to assure personal choice.

(6) No exceptions to the building standards will be granted to assisted living facilities built after September 1, 1989.

411-56-090 Civil Penalties

(1) For purposes of imposing civil penalties, residential care/assisted living facilities licensed under ORS 443.400 to 443.455 and subsection (2) of ORS 443.991 are considered to be long-term care facilities subject to ORS 441.705 to 441.745.

(2) "Person" means a licensee under ORS 443.420 or a person who the Administrator of the Senior and Disabled Services Division finds should be so licensed but is not, but does not include any employe of such licensee or person.

(3) "Direct patient care or feeding" means any care provided to or for any resident related to that resident's physical, medical, and dietary well-being as defined by rules of the Health Division.

(4) "Resident rights" means that each resident shall be assured the same civil and human rights accorded to other citizens as described in OAR 411-55-100.

(5) The Division shall exercise the powers under ORS 441.705 to 441.745, and thereby issues the following schedule of penalties applicable to residential care facilities/assisted living facilities:

(a) A Class I violation exists when there is noncompliance involving direct resident care or feeding, adequate staff, sanitation involving direct resident care or resident rights. A Class I violation may result in imposition of a fine for first and subsequent violations of no less than $5 and no more than $500 per occurrence per day not to exceed $6,000 in any calendar quarter.

(b) A Class II violation exists when there is noncompliance with the license requirements relating to a license required, the license requirements relating to administrative management, personal services (care) and activities. Class II violations may result in imposition of a fine for violations found on two consecutive monitorings of the residential care facility/assisted living facility. The fine may be no less than $5 and no more than $300 per occurrence per day, not to exceed $6,000 in any calendar quarter.

(c) A Class III violation exists when there is noncompliance with the license requirements relating to building requirements, resident furnishings, and move-out criteria. Class III violations may result in imposition of a fine for violations found on two consecutive monitorings of the residential care facility/assisted living facility. The fine may be no less than $5 and no more than $150 per occurrence per day not to exceed $6,000 in any calendar quarter.

(6) For purposes of this rule, a monitoring occurs when residential care facility/assisted living facility is surveyed, inspected or investigated by an employe or designee of the Division or an employe or designee of the State Fire Marshal.

(7) In imposing a penalty pursuant to the schedule published in Rule 411-56-090, the Administrator for the Senior and Disabled Services Division or a designee shall consider the following factors:

(a) The past history of the person incurring a penalty in taking all feasible steps or procedures necessary or appropriate to correct any violation;

(b) Any prior violations of statutes or rules pertaining to residential care facilities/assisted living facilities;

(c) The economic and financial conditions of the person incurring the penalty;

(d) The immediacy and extent to which the violation threatens the health, safety, and well-being of residents.

(8) Any civil penalty imposed under ORS 443.455 and 441.710 shall become due and payable when the person incurring the penalty receives a notice in writing from the Administrator of the Senior and Disabled Services Division or a designee. The notice referred to in this section shall be sent by registered or certified mail and shall include:

(a) A reference to the particular sections of the statute, rule, standard, or order involved;

(b) A short and plain statement of the matters asserted or charged;

(c) A statement of the amount of the penalty or penalties imposed; and

(d) A statement of the party's right to request a hearing.

(9) The person to whom the notice is addressed shall have 10 days from the date of mailing the notice in which to make written application for a hearing before the Division.

(10) All hearings shall be conducted pursuant to the applicable provisions of ORS Chapter 183.

(11) If the person notified fails to request a hearing within the time specified in ORS 441.712, an order may be entered by the Division assessing a civil penalty.

(12) If, after a hearing, the person is found to be in violation of a license, rule, or order listed in ORS 441.710(1), an order may be entered by the Division assessing a civil penalty.

(13) A civil penalty imposed under ORS 443.455 or 441.710 may be remitted or reduced upon such terms and conditions as the Administrator of Senior and Disabled Services Division considers proper and consistent with the public health and safety.

(14) If the order is not appealed, the amount of the penalty is payable within 10 days after the order is entered. If the order is appealed and is sustained, the amount of the penalty is payable within 10 days after the court decision. The order, if not appealed or sustained on appeal, shall constitute a judgment and may be filed in accordance with the provisions of ORS 18.320 to 18.370. Execution may be issued upon the order in the same manner as execution upon a judgment of a court of record.

(15) A violation of any general order or final order pertaining to a residential care facility/assisted living facility issued by the Administrator of the Senior and Disabled Services Division is subject to a civil penalty in the amount of not less than $5 and not more than $500 for each and every violation.

(16) Judicial review of civil penalties imposed under ORS 441.710 shall be as provided under ORS 183.480, except that the court may, in its discretion, reduce the amount of the penalty.

(17) All penalties recovered under ORS 443.455 and 441.710 to 441.740 shall be paid into the State Treasury and credited to the General Fund.

411-56-095 Criminal Penalties

(1) Violation of any provision of ORS 443.400 to 443.455 is a Class B misdemeanor.

(2) In addition, the Division may commence a suit in equity to enjoin operation of a residential care facility/assisted living facility:

(a) When a residential care facility/assisted living facility is operated without a valid license; or

(b) After notice of revocation has been given and a reasonable time has been allowed for placement of individuals in other facilities.

APPENDIX B

Draft Assisted Living Program Model - Massachusetts

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ASSISTED LIVING PROGRAM MODEL

This document represents the consensus of the Departments of Public Health and Welfare, the Rate Setting Commission, and the Executive Office of Elder Affairs on a program model for assisted living. The document presents the philosophy of assisted living, potential settings, the oversight model, and the baseline program model.

Philosophy

The services available through assisted living are intended to help residents remain as independent as possible in order to avoid premature institutional placement. Assisted living entities should adopt policies that enable residents to "age in place" (remain in a familiar living environment despite the physical or mental decline that may occur with the aging process) when resources are available to meet their needs and accommodate their preferences.

For aging in place to occur, needed services are added, increased, or adjusted to compensate for the physical or mental status of the individual, while maximizing the person's dignity and independence. Assisted living entities can vary in the service packages they choose to provide, but all must meet the baseline presented later in this document.

Potential Settings

Assisting living models may include, but are not limited to, such sites as elderly housing units with supportive services, other group living arrangements that private developers are interested in pursuing, or individual homes. This option may also be available to any nursing facility or rest home wishing to convert to assisted living.

Registry

To be considered an assisted living entity by the Commonwealth, the entity must define the services the entity intends to offer, outline plans for meeting residents' needs as they arise, and demonstrate the capacity to meet the baseline requirements described below.

All entities which call themselves "assisted living" providers will be required to file applications with and be registered by the Executive Office of Communities and Development.

Consumer Protection

The Ombudsman program of the Executive Office of Elder Affairs will provide an advocacy and consumer protection role to residents of assisted living entities through an expansion of its current activities. The ombudsman role will be one of conflict resolution and mediation at the local level. For consumer protection issues that require further action, the program will refer these matters to appropriate oversight agencies, such as local building inspectors, fire and safety authorities, etc.

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Baseline Model

All services described in this model may be provided directly or by contract.

1. Responsible Person

An individual shall be on the premises on a 24 hour basis. The entity shall provide an emergency response system to assure that residents have immediate access to the responsible person.

2. Assistance with Activities of Daily Living (ADLs - Bathing, Dressing, Ambulation, Feeding, Transferring, Toileting)

The entity shall provide direct assistance with or reminders to perform any activities of daily living that it holds itself out as providing in its registration. Such assistance includes 24 hour response availability to an unscheduled need, including emergencies. All assisted living entities need not provide assistance with all activities of daily living, but must provide assistance with at least bathing, dressing and ambulation. Assisted living entities are strongly encouraged to provide assistance with feeding, transferring, and toileting, as well.

3. Medication Administration

The entity allows self-administration, provides prompting and reminding. Unlicensed personnel may supervise the administration of medication. This supervision includes: reminding residents to take medication, opening bottle caps for residents, opening prepackaged medication for residents, reading the medication labels to residents, observing residents while they take medication, checking the self-administered dosage against the label of the container, reassuring residents that they have obtained and are taking the dosage as prescribed, and immediately reporting noticeable changes in the condition of a resident to the resident's physician. These activities may be performed by any individual who has been suitably trained as specified in section 9.

Actual administration may be performed by licensed personnal, or by unlicensed personnel approved according to procedures specified in the Department of Public Health's food and drug regulations at 105 CMR 700.00.

Medications shall be properly stored based on the needs of the residents. In a multi-bedroom unit, a locked storage cabinet should be available for each roommate. In a single bedroom unit, the bedroom door should lock.

4. Supportive Services

The entity shall ensure that adequate daily nutrition is available and appropriate to residents' needs and choices.

The entity shall provide access to household services essential for the health and comfort of the residents. Such services may include laundry, floor cleaning, dusting, bed-making, dishwashing, vacuuming, cleaning kitchens and bathrooms, and shopping.

5. Resident Criteria

The target populations are the elderly and disabled.

6. Terms of Participation: Maximum Service Levels

The terms of participation shall be specified in a written agreement between the entity and the resident that shall extend for a least one year. The contract (lease or other agreement) shall address the following areas: responsibilities of the resident, responsibilities of the entity, services included in the assisted living package (must address ADLs, medication administration, supportive services provided, services not provided, supervision, etc.) frequency of service delivery, costs of standard and optional services. Specifics regarding the cost of and provision of food must be addressed.

Although the baseline model does not define resident characteristics requiring care in another setting, such characteristics may be specified in the written agreement. The agreement shall define responsibilities for finding alternative living arrangements in the event it becomes necessary.

7. Service/Care Planning

In addition to the written agreement in #6 above, a service plan, with which the resident/family agrees in writing, must be developed. The plan shall address the unique physical and psychosocial needs, abilities, and personal preferences of each resident. The plan shall include a brief written description of the services to be provided, the modality of service delivery, the timing and frequency of service delivery, and the purposes and benefits of the services. The plan shall include an assessment of personal care needs conducted by a licensed nurse.

The service plan shall be updated periodically by mutual consent of the parties to reflect current care needs. If skilled services are an identified need, an appropriate care plan must be developed.

8. Resident Record

Documentation of service delivery as specified by the service plan must be maintained by the entity.

9. Training and Other Personnel Qualifications

The assisted living entity shall ensure that personnel providing personal care are suitably trained for the duties they are expected to perform. Suitable training shall include training in the ADLs the entity contracts to provide, and other such services as identified in the contract, such as training in medication supervision. Candidates for hire should provide reasonable assurance that they would take or omit no action that would place the health or safety of any resident at risk. The state agencies purchasing assisted living services may define the areas of training that are appropriate for their programs.

10. Physical Plant

The locations where service is delivered must meet local fire, safety, and building codes and applicable American Disabilities Act (ADA) requirements.

APPENDIX C

Draft Assisted Living Standards - AAHA

DRAFT

DRAFT

ASSISTED LIVING

I. BACKGROUND

Within the continuum of services for older people, a vast array of living circumstances exist between what is called "independent living" and "nursing care". This broad spectrum encompasses, in the public mind, everything from home care, to foster care, to board and care, to institutional care, to integral parts of a multilevel continuing care facility, to the newer concept of free standing assisted living facilities.

No generally accepted standard of terminology and definitions exists. Some examples of terms frequently used include: adult congregate living, alternate living, assisted living board and care, boarding home, catered living, community care, custodial care, domiciliary care, enriched housing, foster care, group homes, personal care, residential health care, rest homes, and sheltered care.

Consumers are often unaware of the availability of this level of care, confused by terminology and definition used in marketing facilities and programs. In some geographic areas, such programs are not available. Often those in need of such care are not able to afford it.

Some programs are licensed and some are not, and estimates of the number of licensed and unlicensed programs vary. States typically have some type of regulation in place for "board and care facilities", but these regulations are quite different from state to state.

Little or no funding for Assisted Living programs has been available. Some states have funded board and care minimally through the use of medicaid waivers or state funds. Supplemental Security Income (SSI) is considered inadequate to cover the cost of services in most cases. As part of the 1990 budget reconciliation, states have the option of reimbursing such services for medicaid-eligible, nursing home eligible individuals, but this is not expected to have a major impact on the need for funding. As a result, most Assisted Living is paid for by the resident or family, some by long term care insurance, and some under long term contracts in Continuing Care Retirement Communities (CCRCs).

Many studies have been done, but the delineation of types of providers generally is not very clear. Terms are often not well defined or used to mean different things. Among those studying the broad area of "Board and Care" are the American Bar Association, American Association of Retired Persons, General Accounting Office, Inspector General of Health and Human Services, Select Committee on Aging of the U.S. House of Representatives,

and the Special Committee on Aging of the U.S. Senate. Studies have found inadequate regulation and enforcement, inadequate reimbursement, and instances of fraud and abuse. Findings also include the fact that this is a growing segment of the health care continuum, and that the general shortage of long term care will increase the need in the future. AARP cites this level of care as a critical but largely untapped resource for the long term care needs in this country.

II. DESCRIPTION OF THE INDUSTRY

Assisted living providers, who may go by any one of a number of names, typically fill the gap for older people between independent living and admission to a nursing facility. For facility-based providers, residential accommodations and a variety of services support and enhance independent functioning. Community-based providers augment other family and neighborhood supports to maintain aging people in their own homes.

A. Provider types

1. Community-based or Non-residential

Home health services - typically provide nursing, homemaker service, chore service, therapies.

Adult day care - provide respite services giving an older adult a place to stay, supervision, meals, and a variety of other services. Day care may be delivered in a medical model, catering to clients with medical needs, or a social model.

2. Facility-based or Residential - facility based programs may be designed on a medical model, to meet needs of medically needed older people, but much more commonly are a social model for less impaired individuals. Many providers care for a very wide range of resident needs, accommodating aging in place.

o Free-standing - provides the assisted living level of care only

o Continuing Care Retirement Community (CCRC) - provides a continuum of care, from independent living through nursing care, under a long term contract. CCRCs often provide assisted living in a dedicated unit, or to residents in their apartments, under a variety of payment plans.

o Multilevel facility - assisted living may be located on a site with other levels of care, such as independent housing, home health agency, adult day care, senior center, nursing facility, or a combination of these.

B. Accommodations – some facilities provide individual apartment units (usually studio or one-bedroom), some with kitchens or kitchenettes. Others provide single or double rooms. All have access to common areas for socialization and recreation, and meals are usually available.

C. Resident services – a facility may provide any number of services. Convenience services may include meals, housekeeping, maintenance, transportation, activities (social, recreational, educational, spiritual, etc.), assistance with personal business management, emergency alert systems, shopping, etc. Assistance is provided with basic essential personal services called activities of daily living, which include bathing, dressing, grooming, nutrition and assistance with eating, making and keeping appointments, walking, transferring, and medication management. Some degree of oversight is provided, which may mean a staff presence or more active supervision and case management. Some may provide programming for special needs, such as Alzheimer's disease.

An assisted living resident is one who cannot live completely alone, but does not need the intensive services given in a nursing facility. Sometimes residents only need reminders, guidance, observation, or just the security of being near other people. Sometimes they need services just to conserve energy for more enjoyable activities. Sometimes they need many of the services listed above. It is usual for the number of services required to increase as a resident gets older, called "aging in place". In any case, needs may change from day to day or week to week, and flexible programs work well to give residents just the amount of help they need.

D. Funding sources – In most instances, assisted living is not reimbursed. Payment is usually made by the resident, but in some states a Medicaid waiver or state reimbursement is available to qualified individuals. Supplemental Security Income (SSI), although generally considered inadequate, is accepted by some providers, as is long term care insurance. CCRC contracts often cover assisted living services, sometimes under a discounted rate or designated number of free days of service.

E. The decision to move – the decision is sometimes based upon a real need which has made it impossible to live alone. Sometimes, the decision is a result of increasing frailness, and the awareness that increasing help will soon be necessary. Frequently, residents make the decision themselves, with advise and consultation from family, friends, or legal advisors. Sometimes the family or friend actually makes the decision for a resident who cannot. Case managers, physicians and discharge planners often assist in obtaining assisted living services.

III. STANDARDS AND REGULATION

The purposes of regulation are the provision of reasonable safeguards to prospective residents and current residents, and establishing standards for successful development and operation.

The definition of assisted living will prescribe which providers are required to adhere to the provisions of a statute.

The assisted living industry is extraordinarily diverse. This diversity is healthy, and should be encouraged. Although we have described some common types, many variations exist. While a variety of different programs provides a wide choice of arrangements for older individuals, it also makes comparison and decision-making a challenge. Consumers should be given accurate, detailed information on which to base their decisions. Requirements for full disclosure set the framework for open and honest communication between residents or prospective residents, and the providers. Specific contract requirements provide minimum standards for the rights and obligations of both parties.

Assisted living is both a need-driven and a demand-driven option. Assisted living providers compete not only with other assisted living providers, but with the older individual's desire to stay at home, with other types of elderly housing and with home care. In addition to their commitment to residents, providers are motivated to maintain quality services and competitive pricing in order to maximize occupancy. What might be seen as a protective requirement might indeed have a detrimental effect on costs and therefore on residents, and on the accessibility, marketability and future stability of assisted living programs.

Regulations cannot provide an entirely risk-free environment for any industry. They can, however, provide safeguards and set minimum standards which encourage the responsible development of options which meet the needs of many older people.

AAHA has drafted Assisted Living Standards to guide providers in assessing their programs.

ASSISTED LIVING

STANDARDS

OCTOBER 1990

PHILOSOPHY: AAHA believes that the consumers served by Assisted Living providers are entitled to certain minimum "standards", reflected in the accommodations and services they utilize.

SCOPE: Recognizing the desirability of provider flexibility based upon local needs and conditions, AAHA believes that the scope of appropriate standards should be broad enough to ensure local autonomy and specific enough to safeguard against fraud, abuse, neglect, and unsafe conditions.

As such, AAHA believes the following general areas provide a logical scope for voluntary industry standards.

STANDARD I. MISSION, GOALS AND OBJECTIVES

The provider has a clearly defined statement of mission, goals and objectives. Development of the mission includes a philosophy of service and priorities in allocating resources. The mission statement serves as a guide and frame of reference for operations.

STANDARD II. SERVICE AND CARE PHILOSOPHY

The provider has a written statement of philosophy of care and services which is consistent with its mission. The philosophy is clearly communicated to consumers and staff and integrated into the program delivery.

STANDARD III. PLANNING AND EVALUATION

The provider has a structure for continuing evaluation of programs, services and planning to achieve future goals. The planning and evaluation process includes the Board, administration, staff, and consumers. The provider has a mechanism in place for promoting consumer satisfaction.

STANDARD IV. GOVERNING BODY AND OWNERSHIP

The governing body or owner has ultimate responsibility and authority for the provider, defining its mission and promoting and protecting the interest of the consumers, sponsors, and the public. It establishes policies that determine the kind of services offered and monitors the quality of those services. It provides competent, informed leadership. The Administrator is responsible for implementation of policies and management of resources to achieve goals.

STANDARD V. ADMINISTRATION

The provider has a qualified administrator/manager who is able perform effectively the duties assigned. The provider has general operating policies and procedures. The Administrator/Manager is qualified by education and experience, as well as by training in pertinent areas of management and consumer rights. On-going continuing education is made available to the administrator/manager.

STANDARD VI. HUMAN RESOURCES

The provider has a qualified staff that is adequate both in number and in productivity to perform effectively the duties assigned. The provider has a system for the provision of adequate orientation and continuing education.

STANDARD VII. MARKETING AND PROMOTION

The provider's promotional materials represent its mission and services clearly and accurately, and comply with applicable local, state, and federal law. The provider monitors occupancy levels, employing appropriate marketing techniques when warranted.

STANDARD VIII. MATCHING CONSUMER NEEDS TO PROGRAMS AND SERVICES

The provider has a written procedure for evaluation of residents or clients and prospective clients to assure that the client's needs can be met by the services and programs of the provider. The provider has a written procedure for transfer to appropriate alternative levels of care when indicated.

STANDARD IX. CONSUMER SERVICES

The provider serves the physical, social, emotional, and spiritual needs of consumers. The consumer has the right to practice or to abstain from the practice of religion. The provider makes available an environment that enhances personal dignity and protects individual independence and self-determination. The provider provides for humane treatment of consumer, and provides privacy and confidentiality. Consumers are free from abuse, neglect, and restraint. For facility-based providers, residents are involved in self-governance and activities planning. Consumers are provided with a written process for handling grievances. The provider encourages consumer and family group meetings, and provides space for groups to meet if possible.

STANDARD X. COMMUNITY INVOLVEMENT

Provider services and programs include interaction with the community in relationship to the mission of the provider. In facility-based programs, provision is made for appropriate activities which involve the community, and residents are encouraged to participate.

STANDARD XI. CONTRACT

The contract conforms to state and local requirements, and clearly describes the rights and responsibilities of consumers and the provider including fees and services provided for the stated rates, and fees and services for which there are additional charges.

STANDARD XII. PHYSICAL PLANT

If facility-based, the facility's physical plant functions to serve the needs of residents in relation to the mission. Buildings, grounds, and equipment are well-maintained, clean, safe and sanitary, and conform to applicable legal requirements. The provider seeks to provide comfortable, pleasant accommodations which are accessible to residents.

STANDARD XIII. FINANCIAL MANAGEMENT

The provider is managed in such a way as to insure financial responsibility, and reasonable continuation of services to consumers. Financial statements are prepared in accordance with generally accepted accounting principles. Consumer funds are managed in accordance with state requirements.

STANDARD XIV. DISCLOSURE

Audited financial statements are available to consumers, their legal representatives, and other interested parties on request.

STANDARD XV. HEALTH SERVICES

The provider, at a minimum, provides access to health care providers, assists residents or clients to obtain needed services, and if facility-based, makes provision for emergency services.

IV. AAHA POSITION

Every older American deserves appropriate supportive and long term care services as they age and needs change. Public Policy directions should result in provider flexibility to meet needs in a way which results in quality of life and quality of services, in an affordable, least restrictive service delivery program of the consumer's choice.

The challenges of Assisted Living - those programs which meet needs between independent housing and nursing facilities - are reflective of the dilemma in the long term care system in this country today. As the numbers of older people increase, the greatest growth is in the population over 85 years old - those most likely to need supportive services. Many cannot afford to pay for services they need. Individuals living in their own homes or residential settings without services are "aging in place", requiring additional supportive services to maintain independence. Most older people desire to stay in their own homes as long as possible, accessing home care services. When residential placement is necessary, the most homelike, least restrictive, and least expensive setting is naturally preferred. Families want their older relatives to be cared for in an environment which enhances quality of life, and is as near to the family as possible. AAHA supports the development and continuation of a wide variety of options which support the needs and preferences of aging people.

Standardizing terminology and definitions, fostering appropriate regulatory oversight, setting standards for development and operation of programs, improving public and consumer education and information, and increasing funding sources can help to begin to improve the availability and quality of Assisted Living services for older Americans.

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APPENDIX D

Massachusetts Department of Public Health:
Regulatory Clarification for Assisted Living Facility

William F. Weld
Governor
David P. Forsberg
Secretary
David H. Mulligan
Commissioner

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
150 Tremont Street
Boston 02111

April 23, 1992

Martin Leinwand, Esq.
McDermott, Will & Emery
75 State Street
Boston, MA 02109

Dear Mr. Leinwand:

Thank you for your letter dated March 30, 1992 and the draft program descriptions that you submitted on April 7, 1992 and April 10, 1992 regarding your client's proposed Long Hill "Assisted Living Facility" (the Proposed Facility) in Edgartown.

The Department of Public Health (the Department) has reviewed your client's letter dated March 19, 1992, your letter dated March 30, 1992 and the draft descriptions that you submitted on April 7, 1992 and April 10, 1992 in the context of the applicable statute and regulations regarding Level IV facilities. The Department has determined that, based upon the representations in the draft program description dated April 10, 1992 (Attachment A), under the current statutory and regulatory system, the Proposed Facility would not be subject to licensure by the Department as a Level IV facility. If the representations contained in Attachment A should change in any material respect, the Proposed Facility should promptly notify the Department. Under such a circumstance, the Department's determination that the Proposed Facility would not be subject to Level IV licensure may no longer be valid.

As I stated in my letter to you dated March 26, 1992, the Weld Administration is in the process of devising an initiative to provide expanded housing options for the elderly. This initiative would include supportive living arrangements, such as assisted living. The Department will gladly keep you informed regarding the initiative, and I would suggest that you advise your client accordingly.

I am sending a copy of this letter to Ronald Rappaport, the Town Counsel for the Town of Edgartown. As you know, Mr. Rappaport contacted the Department in February to find out

Leinwand, Martin
page two
April 23, 1992

whether the Proposed Facility would be subject to licensure by the Department. Based upon the revised information set forth in Attachment A, this letter supersedes the Department's prior letter to Mr. Rappaport dated February 3, 1992.

If you have any questions, please call my lawyer, Deborah Konopko, at 727-2655.

Sincerely yours,

Andrew S. Levine
Assistant Commissioner

Enclosure

cc: Charles Baker
David Mulligan
Virginia Sullivan
Dianne Barry
Deborah Konopko
Ronald Rappaport

ATTACHMENT A

LONG HILL

ASSISTED LIVING PROGRAM

Long Hill will provide seniors with the option of occupying private or semi-private accommodations within the Edgartown residence. There will be a written residency agreement between each resident and Long Hill. The residency agreement will set forth the basic monthly charges for the accommodations and for the "core" services (e.g., meals, housekeeping and laundry). Each individual will control access to his or her private residential space. Each room will have an adjacent private or semi-private bathroom. Residents will be able to furnish their rooms with personal belongings if they so desire.

Under the residency agreement, each resident will have access to common space, services and amenities such as the following:

- a solarium greenhouse
- laundry facilities
- kitchen facilities
- private studies
- a library
- a recreational deck and Jacuzzi
- storage space for personal belongings
- craft programs and
- access to transportation

Long Hill will employ a full-time project manager to oversee operations. Long Hill will also employ staff to provide housekeeping and laundry services, and a cook to prepare meals. Long Hill staff will also be available to provide residents with assistance in connection with dressing, bathing and similar personal grooming activities, but only to the extent that the provision of such assistance does not require the special skills of trained healthcare personnel such as nurses or nurses' aides and would not typically be provided by trained healthcare personnel if the resident was living elsewhere.

No resident will require 24-hour personal care or supervision. Long Hill will not accept or retain residents unless they are continent, ambulatory (or, if in a wheelchair, able to move from room to room without assistance) and able to feed themselves without assistance (although Long Hill will be responsive to special dietary requests from the residents). When a resident is no longer able to meet the above requirements for continued residency, Long Hill will encourage the resident to consult with his/her personal physician and will assist the resident (and the resident's family, if appropriate) in identifying and making provision for the resident's transfer to an appropriate alternative setting. Long Hill will also assist

such residents in making an orderly transition to such other setting, including making adequate provision for the transfer of the resident's personal belongings.

Long Hill will not provide medical or nursing services to residents, nor will it develop patient care plans or assume responsibility for providing clinical services to residents. Residents (or their families) will be asked to identify a personal physician who will be responsible for coordinating any medical services required by the resident from time to time. In the event a resident requires healthcare services of any nature, such services must be arranged for directly by the resident or the resident's family. If requested, the program manager may furnish the resident or the resident's family with a list of healthcare professionals and agencies in the community that are available to provide services to the residents; however, Long Hill will not maintain any contractual arrangements with such professionals or agencies to provide healthcare services to residents at Long Hill.

Long Hill will not administer medications to residents or provide medication "management" services to residents. All medication will be self-administered by residents. If appropriate, Long Hill staff members may from time to time remind residents to take medications that have been prescribed by the resident's physician, but Long Hill will not supervise the resident's self-administration of such medication.

At the time Long Hill executes the initial residency agreement with an individual, it will obtain confirmation that Long Hill is an appropriate residential setting for the individual. Such determination will be made by Long Hill after consultation with the prospective resident, the resident's family, and the resident's personal physician. If Long Hill subsequently has reason to believe that an individual requires hospital or skilled nursing care, it will seek authorization from the resident and the resident's physician to facilitate a transfer. Through its residency agreements and its internal policies, Long Hill will emphasize that it is not licensed to provide medical or nursing services and will not do so.

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