ADVISORY COMMITTEE ON AGING
MEETING SUMMARY
March 16, 2018

Members Present

Ada Anderson	Douglas County
Anne Gross	Arapahoe County
Barbara Boyer	Arapahoe County
Bob Brocker	At Large
Bob Davis	Broomfield County
Bob Lanky	Jefferson County
Cary Johnson	Jefferson County
Cathy Noon	At Large
Dawn Perez	Adams County
Donna Mullins	Jefferson County
Houston "Tex" Elam	At Large
Joyce Gallagher	Adams County
Karie Erickson	Douglas County
Larry Strock	DRCOG Board
Mary Ellen Makosky	Gilpin County
Maureen Spiegleman	City and County of Denver
Sally Daigle	DRCOG Board
Sean Wood	Clear Creek County
Sharon Perea	Gilpin County

Guests Present

Valerie Robson – Douglas County, Paulette St. James – Colorado, and Julia Woodward – The Center on Aging Anschutz

Others Present

Amy Pulley, AJ Diamontopoulos, Doug Rex, Jayla Sanchez-Warren, Kelly Roberts, Sharon Day, Mindy Patton, Shannon Gimbel, Ashley Summers

Call to Order and Introductions

Cary Johnson – Chair called the meeting to order at 12:00 p.m.

Public Comment Period (Non ACA Members)

No Public Comment

Approval of the March 16, 2018 Meeting Summary

Dawn Perez made the motion to accept the summaries, Bob Davis 2nd the motion, summaries were approved

Assisted Living Regulation Update – Shannon Gimbel

- Shannon has chaired and spent three years working on the revision to the assisted living regulations, process is now completed.

- Town hall meetings have been held.
- Stakeholder comments were recorded
- Regulations are set to go before the medical board. April 18th.

- Colorado Assisted Living Association an organization for smaller assisted living communities is rallying members creating a lot of misunderstanding about the proposed regulations
  - A lot of discussion around the administrator requirements, administrators will be required to have a degree or equivalent experience
  - Have gone forward and contacted legislators in opposition to this process.
    - The two legislators they have contacted are Senator Kefalas and Representative Ginal.
  - Introducing a bill to block the regulations from going forward.
  - Teamed up with Colorado Gerontological Society and started reaching out to legislators talking about how this these changes would put them out of business.

- Shannon will attend a meeting with the Department of Health, Leading Age Colorado, Colorado Health Care Association, Colorado Assisted Living Association and legislators who have been contacted.
  - These groups were present throughout the entire rewriting process.
    - The committee consists of assisted living providers, membership organizations, family representation, and consumer representation.

- Approval process goes through the Department of Health then proposed rules go before the Medical Board for vote, testimony is heard during that time.
  - Legislation does not need to be involved, this is a function of the executive branch.
  - Process is well thought out, highly intensive many hours spent going through regulations.
  - . There was stakeholder process, town hall meetings.
  - Committee spent a day going through each stakeholder comment
  - Adjusting regulations as much as we possible while making sure that protections were still in place for residents.

- These organizations had full opportunity to comment during the process
- The people who are in an uproar are developers and real estate people getting into the business
  - They are very disheartened to hear they have to pay a qualified person to be an administrator
  - And have to have staff awake to periodically check on residents.

- A packet was handed out to the group with several stories of incidents that have already happened, people have died because the lack of enforcement or lack of regulation.
- Assisted Living regulations have always been minor compared to nursing home regulations which are over 400 pages

  Jayla stated you're going to hear about this, people are going to say that it's unreasonable and too demanding. It is not other industries such as nail technicians have to have 600

hours of education and pass written and practical test for certification. Assisted living administrators will need 40 hours of training.

- Jayla and Shannon talked about the shortage of staff at the state because they do not have enough funding.
  - The state surveyors are paid by the fees that the Assisted Livings pay
  - They don't get federal dollars because there's no federal oversight.
  - Surveyors are strictly reliant on the fees that come in from the assisted living .
  - Fees haven't been adjusted in a long time.
  - Proposing a new fee structure in order to adequately survey the facilities.

- Some facilities have not been surveyed in five or six years in our area.

Senior Reach Presentation – Amy Miller

Amy's presentation is attached.

- experiencing depression in the general older adult population the estimate is about 15 percent
- 20 per cent of older adults have some sort of substance use problem misusing or abusing different substances
- Primarily funded by the AAA
- Applying for grant funding to assist with substance abuse.
- Want to extend hoarding services

A Look at DRCOG Data Sites – Ashley Summers

Ashley is the Information Systems Manager she oversees DRCOGs data analysis, mapping and application development.

They deal with data that has to do with DRCOG community's specifically aging data.

Ashley demonstrated several scenarios that can be looked at from the DRCOG website.

Attached is a card Ashley provided with how to access the sites she showed the group.

Directors Report – Jayla Sanchez-Warren

- Jayla met with Bonnie Silva the new Deputy Director of Community Living and Policy Innovation and Engagement of Health Care Policy and Finance
  - Bonnie wanted to know what DRCOG was doing and was interested in our transitions programs, the AHC grant as well as UCHealth project
  - Jayla spent time explaining the programs to help Bonnie understand them better
  - Bonnie wants to partner with DRCOG
  - Previously HCPF did not want a partnership.

- Jayla spoke about insurance costs going up dramatically for the AAA

- They are not doing anything different but there are new regulations and new requirements including HIPAA.
- Which consists of health protected information, client information and data
- The agency insurance costs amount to sixty thousand dollars a year
- Hackers are trending towards going after smaller organizations that don't have the level of protection needed.
- Taking on the SHIP program raised insurance costs $40,000 dollars

- DRCOG is investing in cloud and web based services to be more secure along with other technology such as secure apps on phones
  - The hope is to be in a position to be more competitive in the health care arena in the field of aging to bring in more outside funding

- Wade Buchanan the Governor's Senior Policy Adviser, the State Unit on Aging, the Commission on Aging, SAPGA and DRCOG are working together to do a statewide aging summit
- Jayla mentioned that Wade would like Colorado to become a senior friendly state
  - Jayla got Brad Calvert and Wade together to discuss Colorado becoming a senior friendly state
  - Brad designed the Boomer Bond tool to help communities become age friendly and is being used by several communities in the DRCOG region
  - He is also working with AARP to expand Boomer Bond
  - Wade and Brad had a good meeting Wade is very excited and is talking about how to take Boomer Bond statewide
  - They would like to adapt different versions of Boomer Bond to apply to any community in the state possibly involving the Colorado Planning Association.

    There was discussion about how Boomer Bond worked in the communities and some members would like to see it called something different.

- Jayla and Shannon have been on TV talking about facilities that are closing
  - There have been 6 facilities that have closed since the first of the year.
  - They are closing due to redevelopment
  - Golden Manner assisted living hasn't officially closed but have announced their closure, Shannon spoke about this closing last month
    - It is a longtime facility in Lakewood, with 76 residents who are hard to place because all except one are on Medicaid
    - Some residents have history of mental illness, behavioral issues and substance abuse.
    - 26 people have been placed some absolutely have to go to a nursing home because there is no other appropriate Medicaid assisted living facility in the region
    - We're worried that some will be homeless at their choice.
  - Ombudsman received calls from 4 Nurturing Care homes one in Federal Heights one in Lakewood 2 in Aurora
  - Federal Heights and Lakewood facilities were closed
  - Complaints consisted of no staff, residents without pain medications limited food

- Shannon called the health department to let them know they needed to go out to these facilities
- The person that leads the Assisted Living Survey team didn't think they would go
- Shannon let them know bad things were going on it was their responsibility to do something about it.
- It wasn't working with the with the health department so took another tactic since many of them were clients of Innovage and they called them
- Since Innovage is a for profit organization they were very interested in making sure those people don't have a lot of huge health care costs.
- A team of Innovage nurses came out and between their nurses and our case managers they were able to start the moving process before the health department came out.
- The health department came out told ombudsman they didn't need them for the relocation, Shannon told them her team would be there for relocation.
- Ombudsman had to intervene and do a lot of things like to keep them safe.
- The health department did recognize they couldn't have done it without the Ombudsman.

- Jayla read a letter from a satisfied resident who Nancy helped get him away from his roommate and felt much safer.
- Congress appropriated the budget but have not allocated funds. this will happen on March 23.
  - Will find out if there will be increased money and if the SHIP program will be eliminated.

- Due to the DRCOG move there will be no meeting in June.

Program Updates

AHC – Kirsti Klaverkamp

- The AHC team will be expanding,
  - Hiring 2 full time Navigators and a part time Quality Improvement Facilitator
  - Navigators will work with people who have more complex needs identified in clinic partner sites
    - Will complete home visits and make sure that they are connected to the resources they need
  - The Quality Improvement Facilitator will take the lead figuring out what's going well and what's not.
    - How can we improve the connection between our clinical partners and the community based partners to make sure the program is successful

- Jerry still working with the AHC committee on a strategic plan.
  - Have formalize the vision and now getting into specific goals and metrics for a unified vision of where they are headed and to track goals
  - AHC has been awarded a grant
    - Pivotal for the program and will help bulk up funding for three areas of need
  - Working on piloting the screening process at two sites.

    - First will be a mental health center and the second one will be with Denver Health.
    - Will begin training with mental health centers next week with Denver Health the following week

- The program will officially start in May.
- This program is getting interest nationally

Funding – Sharon Day

- Tuesday we found out from the State Unit on Aging that we are getting the rest of our federal funds
- Drastic cuts were going to have to be made if we did not get funding
- In January we cut funds to contractors because federal funding came in spurts
- The cut was 10 percent which was huge for some contractors
- Funds received will include carryover of federal dollars from last year.
- We are now able to restore contracts to their original amounts
- Are now moving forward with budgeting for our next 12 month funding cycle
- The Funding Subcommittee met and we're basically assuming level funding

  Sharon Perea brought up the hard work Rich Mauro and Colorado Senior Lobby have done to get money for us from Colorado. She suggested that each county have members whether commissioners, managers or residents who received services from the money that DRCOG provides write thank you notes for all the hard work.

  Rich is really an unsung hero he organized the AAAs to show how the four million dollars added to the government, in the governor's budget, was needed to clear the states waitlist of a number of clients.

- The City of Aurora senior commission on aging members approached Jayla and Doug about the need to improve transportation in Aurora
- The Commission approached their city council who approved$ 80,000 to fund senior transportation in Aurora this may be an ongoing amount for future years
- We now have excess of Part B dollars for services like transportation.
- Funding subcommittee will look at options for allocation of these funds.
- Sharon is working closely with providers to make sure that funds can be expended under state use it or lose it.
- The state may let us go above our limit on what we can carry over into next year
- Federal dollars are able to carry it over up to a certain percentage
- Revisiting some of those earlier options that we were looking at for transportation.

UCHealth Program – Amy Pulley

- Amy talked about UCHealth program starting to wrap up they are in the sixth month of the eight month pilot

- Started with 20 patients over a five month period got to the fourth month and realized there was still plenty of money to extend the program another month.
- They took the last referral this month and will finish up the case management in May
- Will start the analysis in June.

- Two main goals, one to improve the health outcomes for UCHealth patients and create an efficient system of communication between DRCOG and the social work staff at the hospital.
- The project was designed to take patients with multiple health conditions who are really sick with high health costs and complete a comprehensive assessment
  - Assessment includes their social supports, financial situation, to-day-to day activities and home environment.
  - Identify where there are problems that are contributing to their health issues and create an action plan

- They will check through the information and address issues.
  - They are seeing missed appointments because of a lack of transportation or prefer not to go out in the winter due to the cold
  - Talking to them about transportation make sure they have a good transportation option
  - Encourage them that just because it's cold outside and it is January they need to get to the doctor
  - And make sure they manage their medications.
  - Teach them that they have options rather than going to the emergency room, to call the doctor, the nurse line, use Dispatch Health or go to an urgent care.

Chair Report – Cary Johnson

No Chair Report

Information Sharing – (ACA members)

- Kelly will have the list of municipal senior commissions ready before the May meeting with the contact information and the websites.
- Barbara is having a visually impaired event April 25th at the Central Aurora library on Alameda. Dr. Carl Hanson will be the featured speaker with workshops and exhibitors.
- Senior Day at the capitol will be March 21st.
- Douglas County Senior Council is hosting an event on Wednesday May 2nd replacing their May meeting called Vintage and Vibrant it is an all-day event that includes a couple of keynote presentations.
- Donna mentioned that several went to Marion Smith's memorial service which was well attended. It was held at the church she founded and helped build.

Adjournment

Adjourned at 3:05 p.m.

ALR Rulemaking Information Packet

March 16, 2018

Onsite Survey (Inspection), Complaint and Enforcement Trends (CDPHE--HFEMSD)

Examples of Verified Deficiencies Related to Night Staff (CDPHE--HFEMSD)

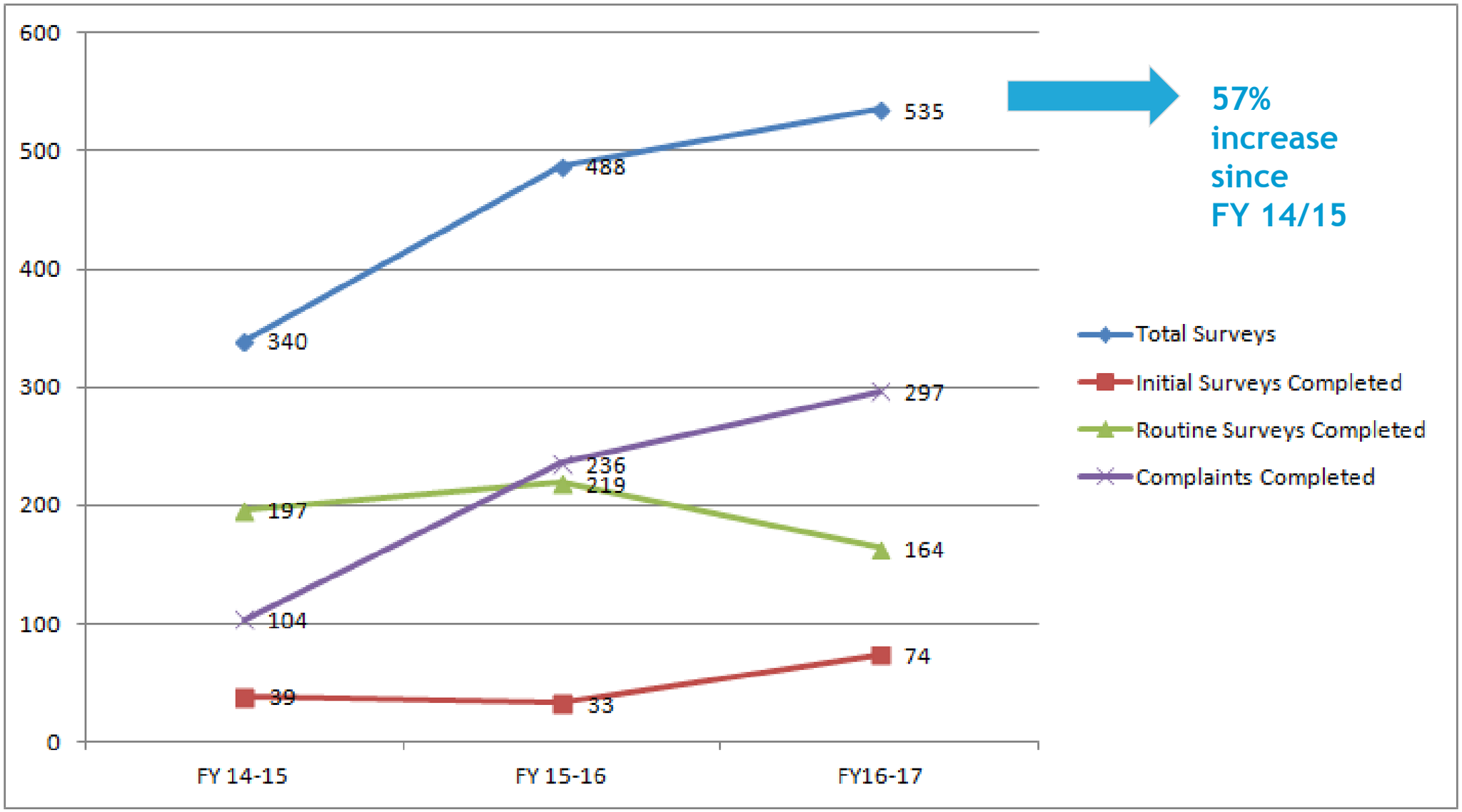
Food Safety Infographic (CDPHE--DEHS)

2017 Cost of Care (Genworth)

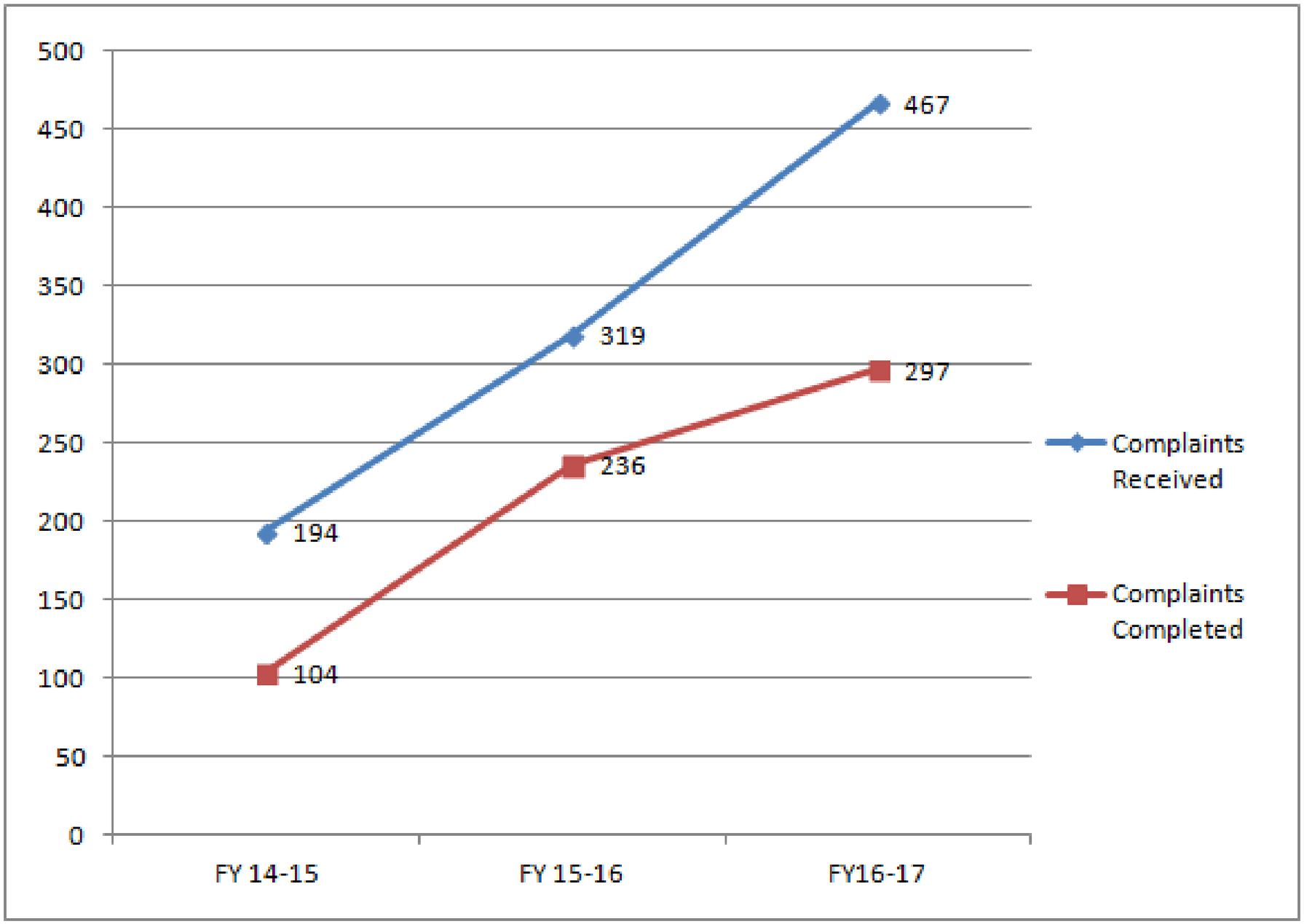
2017 and 2016 Assisted Living State Regulatory Review (National Center for Assisted Living)

Elderly, At Risk, and Haphazardly Protected (ProPublica)

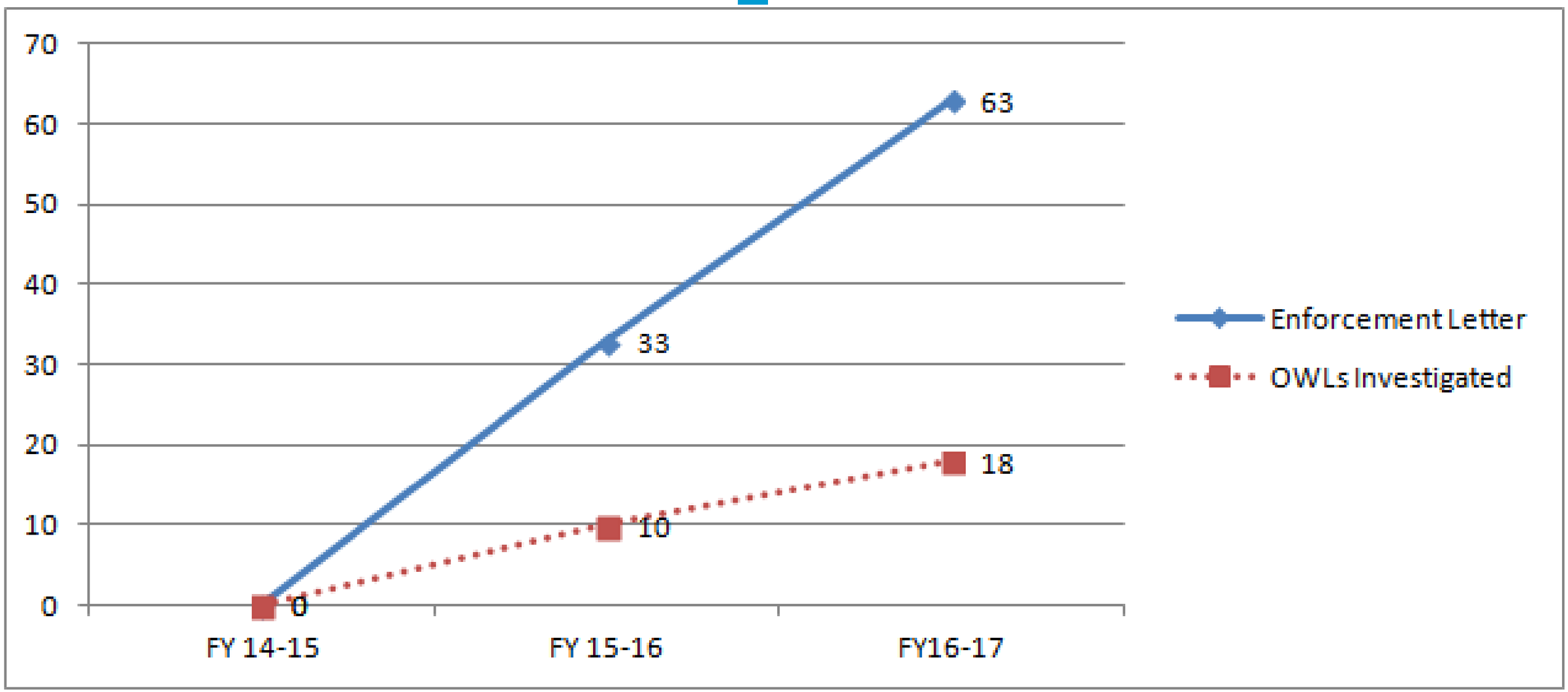
ALR Increased Workload Onsite Surveys



ALR Unmet Workload- Complaints



ALR Increased Workload- Enforcement



COLORADO EXAMPLES OF VERIFIED DEFICIENCIES RELATED TO STAFFING AND NIGHT STAFF

1. A resident wandered from a 16 bed private pay during the evening into the early morning hours of the following day without staff knowledge. The resident was found down outside of the facility during the early morning hours and was transferred to the hospital and subsequently pronounced deceased from heart failure, due to severe arteriosclerotic cardiovascular disease with hypothermia as a condition contributing to the death.

Investigative findings by the Department revealed the resident had a known history of being awake, up and about at night. On the evening of the event, facility staff were asleep and typically slept during the shift unless they happened to wake up. The facility's secure alarm system was not working, and had not alerted staff the resident had left the building and the exit door was not locked. Moreover, the facility had no process in place to routinely check the facility doors to ensure they were alarmed.

The family of this resident had previously hired a private sitter to monitor the resident throughout the night (paid for by the family in addition to the fees they paid for assisted living care and services), however eventually had to discontinue this due to the cost.

Review of the care for other residents in the home showed the residents were in need of incontinence care at night, which was not provided because the staff were sleeping. The facility had created documents that family members were asked to sign attesting to the knowledge and understanding that residents would not receive assistance at night. Routinely, morning shift found residents soaked in urine.

2. Facility staff for a 106 Medicaid facility failed to check on a resident's status when s/he did not attend the breakfast meal the morning of 11/3/07. At 12:30 p.m. staff realized the resident had not attended the noon meal and searched the facility premises. The resident was found unresponsive, face down, in pool of coffee ground emesis, on a bathroom floor in the facility, wedged between the toilet and wall.

Investigative findings by the Department revealed the resident had fallen in the space between the wall and the toilet during the evening on a Friday. Resident had fallen in a space between the wall and the toilet and was not discovered by staff until 2:00 p.m. the following day (Saturday) (a period of at least 18 hours). While a pull cord to summon staff was available in the bathroom, the cord had been wrapped around a handrail and was not accessible to the resident.

According to an emergency room report, the resident had hemorrhaging of the brain with left sided nerve damage due to being trapped in the same position for a prolonged period of time. The resident died the same date of hospitalization.

3. Three bedridden residents living in a small 6 bed private pay assisted living needed staff assistance for transfer from the bed, incontinence care and repositioning. The residents were typically put into bed by 8:00 p.m., but were not offered any assistance following this until the next morning after 8:00 a.m. Each morning the residents were found to be in urine soaked incontinence products with their bed clothes and sheets also frequently wet with urine. Throughout the day, staff had failed to provide incontinence care or provided protective cream as one measure to protect their skin from the urine. Staff routinely placed two layers of incontinent brief on residents to catch the urine that collected both during the night and day. The prolonged exposure to the urine and dependent status resulted in reddened, irritated skin with one resident requiring treatment by an external service provider for wounds on the lower back.

4. A complaint investigation in 2016 revealed a resident had wandered from a 114 bed private pay facility's third floor secured unit during the evening hours. The alarm on the third floor exit door alarm had not alerted staff that the resident had left the secure unit. The resident was subsequently found at approximately 12:30 a.m. lying on a cement floor in an unheated first floor stairwell, three flights down from the facility's third floor secured unit. The resident died two days later in the hospital from complications related to severe hypothermia and multiple blunt force injuries.

5. A resident who had a history of wandering behavior exited a 74 bed Medicaid facility onto the fourth floor outdoor fire escape and the door locked behind him/her. The former resident was then unable to re-enter the facility. The door alarms were not working; therefore, staff were unaware the former resident had exited the facility. Video revealed resident left the facility between 1-2:00 p.m. The resident was seen waving to people from the fire escape between 4 and 5 p.m. The following morning staff went to the former resident's room to check on him/her and, when the resident was not found, it was determined this was not uncommon. A search was later commenced at 9:15 a.m. The resident was found deceased on the facility's fourth floor outdoor fire escape after remaining outside in freezing temperatures for approximately nineteen hours, resulting in death from hypothermia.

6. An 8 bed private pay facility restrained a resident in bed at night, by placing a recliner next to the bed, which prevented the resident from getting out of bed when desired. The investigation revealed that this was done because the resident was up too much at night. The pre-admission assessment identified the resident's need for the assistance to get out of bed to use the bathroom, the resident wanted to get up from bed at night to urinate, but despite calling out for help, the former resident did not receive timely assistance from staff to get up to urinate at night.

7. Subsequent to a decline in health which resulted in increased agitation, pain, and wandering behaviors, a resident wandered out of an unsecured 8 bed Medicaid facility at 10:00 p.m. unbeknownst to the staff. The door alarm had been turned off. A neighbor saw the resident sitting outside clothed only in an incontinence product and t-shirt, and called emergency personnel. Upon returning the resident back to the facility the emergency personnel rang the doorbell and knocked on the door for several minutes before another resident answered the door; the emergency personnel woke up the sole staff member, who was not aware the resident had been missing.

8. A resident with diagnoses of amnestic disorder and dementia and a known history of elopements wandered from a 16 bed Medicaid facility during the evening and early morning hours unbeknownst to staff. The resident was last seen at approximately 9:30 p.m. The facility staff were unaware the resident had been missing at the time the resident was found deceased at 2:00 a.m., outside of the facility laying in a snow-packed driveway of an adjacent property. The death was a result of hypothermia.

9. A resident who had a history of elopements was found to be missing in the morning and was later found, unresponsive, outside in the cold. The resident was subsequently hospitalized for treatment of hypothermia. A staff member mistakenly thought the jumble of blankets on the bed was the resident, when it was not. The 70 bed private pay facility had not discharged the resident, whose needs they could no longer meet, because the census was low.

10. A resident was found in bed in the morning, deceased and in an advanced state of decomposition. The investigation revealed the 128 bed Medicaid facility had a procedure that staff were to visually observe residents on a daily basis and document the observation. Staff did not document observing the resident the day before being found deceased. Staff reported that the resident had not been seen since 3 p.m., two days prior to being found deceased. The investigation established that the resident had not been checked on for approximately a day and a half.

11. A resident returned to the 74 bed Medicaid facility from a hospital stay and subsequently fell during the early evening; however, was not found until approximately 2:15 p.m. the following day. The investigation revealed that the resident was on the floor for approximately 19 hours and did not receive medications, liquids, food, toileting, or change-in-position. When found on the floor, emergency responders were contacted for transportation to the hospital because the resident complained of neck and back pain, as a result of falling backward onto his/her back and laying in the same position for approximately 19 hours. The facility night checks consisted of staff walking halls and listening for calls for help.

FOOD SAFETY FOCUSED INSPECTIONS in Long Term Care*

150 Risk-focused inspections conducted by DEHS to assess the need for enhanced regulatory oversight of food service found serious risks to residents in long term care

Improper Holding and Cooking Temperatures and Poor Personal Hygiene are frequently linked to foodborne illness

In Schools and Prisons

- **7%** Are Cited for Cold Holding Violations
- **4%** Are Cited for Hand Washing Violations
- **3%** Are Cited for Hygiene Violations

In Long Term Care Facilities

- **57%** Were Cited for Cold Holding Violations
- **57%** Were Cited for Hand Washing Violations
- **58%** Were Cited for Hygiene Violations

3 of the top risk factors known to cause foodborne illness

55% of LTC had both hygiene and temperature violations, meaning over half of LTC had employees contaminating and temperature abusing foods

41°F temperature at which Listeria monocytogenes can grow to dangerous levels

90% of Listeria cases are in highly susceptible populations

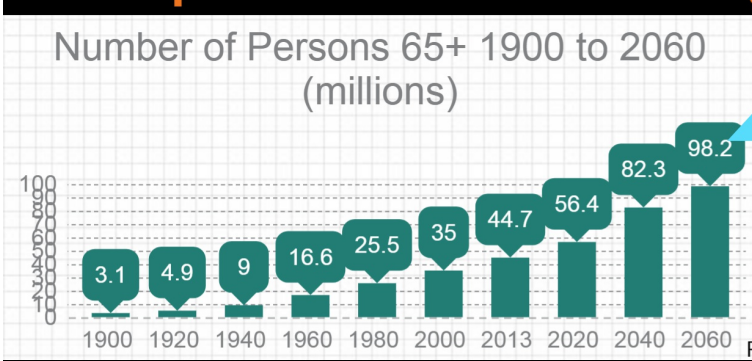
The average number of violations linked directly to foodborne illness is 9 times higher in LTC than in prisons and schools

33% of outbreaks are due to poor personal hygiene

15x the risk adults over 74 will die from foodborne illness compared to younger adults

Hospitalizations increase with age for every major food pathogen

Number of Persons 65+ 1900 to 2060 (millions)



100% Expected increase in Colorado's 65+ population between 1995 and 2025

Source: US Census Bureau, Populations Estimates and Projections

*Long Term Care includes Nursing Facilities, Assisted Living Residences or other group residencces with more than 20 beds

The need for long term care will double by 2060

CO CDPHE

2017 Cost of Care

Genworth®

Home Health Care

LOCATION	HOMEMAKER SERVICES[1] MINIMUM	HOMEMAKER SERVICES[1] MEDIAN	HOMEMAKER SERVICES[1] MAXIMUM	5-YEAR ANNUAL GROWTH[2]	HOME HEALTH AIDE[1] MINIMUM	HOME HEALTH AIDE[1] MEDIAN	HOME HEALTH AIDE[1] MAXIMUM	5-YEAR ANNUAL GROWTH[2]
USA – National	$18,304	**$47,934**	$114,400	3%	$18,304	**$49,192**	$125,748	3%
Alaska	$33,176	**$59,488**	$73,216	1%	$36,608	**$63,492**	$73,216	2%
Alabama	$29,744	**$38,553**	$52,624	1%	$29,744	**$38,553**	$54,912	1%
Arkansas	$30,888	**$41,184**	$51,480	1%	$30,888	**$41,184**	$51,480	1%
Arizona	$38,438	**$48,048**	$64,064	2%	$38,896	**$51,480**	$64,064	2%
California	$28,600	**$57,200**	$88,088	3%	$28,600	**$57,200**	$88,088	2%
Colorado	$38,896	**$54,866**	$84,313	4%	$38,896	**$54,912**	$84,313	3%
Connecticut	$27,456	**$45,760**	$68,640	1%	$27,456	**$52,624**	$68,640	2%
District of Columbia	$45,760	**$45,760**	$45,760	N/A	$45,760	**$45,760**	$45,760	N/A
Delaware	$45,760	**$50,336**	$59,488	1%	$45,760	**$50,908**	$82,368	-1%
Florida	$22,880	**$44,044**	$70,356	3%	$27,502	**$45,760**	$70,356	2%
Georgia	$27,456	**$43,472**	$91,520	2%	$27,456	**$43,472**	$91,520	2%
Hawaii	$50,336	**$57,772**	$68,640	3%	$56,056	**$59,488**	$68,640	1%
Iowa	$34,320	**$53,768**	$103,235	4%	$36,608	**$54,912**	$125,748	3%
Idaho	$38,896	**$48,620**	$65,208	3%	$38,896	**$49,192**	$65,208	3%
Illinois	$30,888	**$50,336**	$66,352	2%	$30,888	**$51,480**	$66,352	2%
Indiana	$22,880	**$45,760**	$68,640	2%	$24,024	**$47,956**	$80,080	2%
Kansas	$23,452	**$45,760**	$64,064	2%	$23,452	**$48,048**	$64,064	3%
Kentucky	$30,316	**$44,341**	$114,400	3%	$30,316	**$44,616**	$114,400	3%
Louisiana	$18,304	**$34,320**	$50,336	0%	$18,304	**$34,892**	$60,632	0%
Massachusetts	$41,184	**$57,772**	$72,072	2%	$51,480	**$59,488**	$74,360	1%
Maryland	$32,032	**$49,718**	$60,632	3%	$33,176	**$52,281**	$62,920	3%
Maine	$38,896	**$52,624**	$62,348	3%	$40,040	**$53,768**	$65,208	1%
Michigan	$24,024	**$48,048**	$67,496	2%	$24,024	**$49,192**	$67,496	1%
Minnesota	$45,760	**$59,488**	$91,520	3%	$43,472	**$61,776**	$102,960	1%
Missouri	$36,608	**$46,767**	$61,776	3%	$41,184	**$48,048**	$61,776	3%

Annual Costs

	Home Health Care							
LOCATION	HOMEMAKER SERVICES[1] MINIMUM	**HOMEMAKER SERVICES[1] MEDIAN**	HOMEMAKER SERVICES[1] MAXIMUM	5-YEAR ANNUAL GROWTH[2]	HOME HEALTH AIDE[1] MINIMUM	**HOME HEALTH AIDE[1] MEDIAN**	HOME HEALTH AIDE[1] MAXIMUM	5-YEAR ANNUAL GROWTH[2]
Mississippi	$35,967	**$40,475**	$57,200	1%	$35,967	**$41,184**	$57,200	2%
Montana	$45,760	**$52,578**	$66,352	4%	$45,760	**$55,781**	$73,674	3%
North Carolina	$18,304	**$41,184**	$57,200	2%	$20,592	**$42,328**	$57,200	1%
North Dakota	$30,888	**$63,972**	$63,972	3%	$35,464	**$63,972**	$63,972	3%
Nebraska	$43,472	**$52,624**	$77,792	3%	$48,048	**$54,912**	$77,792	3%
New Hampshire	$45,760	**$57,200**	$67,496	2%	$50,336	**$60,357**	$91,520	2%
New Jersey	$36,608	**$50,336**	$68,640	2%	$37,752	**$52,624**	$68,640	2%
New Mexico	$32,604	**$45,760**	$67,382	2%	$32,604	**$47,476**	$67,382	1%
Nevada	$38,896	**$50,336**	$62,920	2%	$38,896	**$50,336**	$62,920	1%
New York	$25,168	**$51,480**	$74,360	2%	$29,744	**$54,340**	$74,360	2%
Ohio	$28,600	**$48,048**	$64,064	3%	$33,153	**$48,483**	$64,064	2%
Oklahoma	$38,896	**$45,760**	$76,648	3%	$38,896	**$48,048**	$76,648	2%
Oregon	$43,472	**$54,912**	$66,352	4%	$43,472	**$56,056**	$69,670	3%
Pennsylvania	$32,032	**$50,336**	$66,352	2%	$32,032	**$50,336**	$68,640	2%
Rhode Island	$48,048	**$52,624**	$56,056	3%	$52,624	**$57,772**	$64,064	1%
South Carolina	$34,320	**$43,472**	$54,912	2%	$34,320	**$45,646**	$54,912	2%
South Dakota	$43,472	**$57,200**	$65,208	5%	$48,048	**$57,200**	$65,208	5%
Tennessee	$34,045	**$42,557**	$57,200	2%	$34,045	**$42,900**	$60,632	2%
Texas	$18,304	**$44,616**	$81,224	3%	$20,867	**$45,760**	$81,224	2%
Utah	$34,320	**$51,480**	$66,352	3%	$41,184	**$51,480**	$72,072	1%
Virginia	$28,600	**$45,440**	$70,928	2%	$32,032	**$47,430**	$70,928	3%
Vermont	$44,044	**$55,484**	$66,352	3%	$44,044	**$57,200**	$66,352	4%
Washington	$26,884	**$60,632**	$96,096	4%	$26,884	**$60,632**	$96,096	4%
Wisconsin	$29,744	**$53,768**	$68,640	4%	$29,744	**$53,768**	$68,640	2%
West Virginia	$20,592	**$38,896**	$59,488	3%	$20,592	**$40,040**	$59,488	2%
Wyoming	$45,760	**$59,488**	$64,613	5%	$45,760	**$61,776**	$74,360	6%

Genworth 2017 Cost of Care Survey, conducted by CareScout®, June 2017

[1] Based on 44 hours per week by 52 weeks

[2] Represents the compound annual growth rate based on Genworth Cost of Care Survey

N/A=data not available

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2017 Cost of Care

Genworth®

LOCATION	Adult Day Health Care[3]				Assisted Living Facility[4]			
	ADULT DAY HEALTH CARE MINIMUM	ADULT DAY HEALTH CARE MEDIAN	ADULT DAY HEALTH CARE MAXIMUM	5-YEAR ANNUAL GROWTH[2]	PRIVATE, ONE BEDROOM MINIMUM	PRIVATE, ONE BEDROOM MEDIAN	PRIVATE, ONE BEDROOM MAXIMUM	5-YEAR ANNUAL GROWTH[2]
USA – National	$1,300	$18,200	$126,880	3%	$6,870	$45,000	$254,880	3%
Alaska	$24,570	$43,709	$48,984	10%	$50,280	$72,000	$99,000	2%
Alabama	$5,200	$6,760	$18,200	1%	$8,640	$36,684	$64,200	1%
Arkansas	$16,640	$20,800	$33,280	5%	$7,200	$36,150	$69,600	1%
Arizona	$14,300	$21,190	$47,840	0%	$12,000	$42,000	$84,780	2%
California	$6,370	$20,020	$47,666	0%	$12,168	$51,300	$149,220	4%
Colorado	$14,300	$17,940	$42,120	2%	$15,000	$46,200	$85,800	1%
Connecticut	$7,800	$20,800	$26,520	1%	$22,200	$55,200	$121,680	1%
District of Columbia	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Delaware	$14,300	$18,850	$23,400	-1%	$43,080	$72,180	$82,800	3%
Florida	$11,050	$16,900	$42,900	2%	$11,700	$37,200	$96,000	2%
Georgia	$1,300	$15,600	$126,880	0%	$8,640	$33,600	$80,400	2%
Hawaii	$15,470	$18,200	$27,170	1%	$16,800	$51,000	$114,000	3%
Iowa	$9,165	$16,367	$39,913	4%	$15,000	$44,835	$254,880	5%
Idaho	$2,600	$26,218	$72,800	1%	$18,600	$37,800	$68,340	0%
Illinois	$10,140	$18,762	$29,900	2%	$20,700	$44,640	$111,600	-2%
Indiana	$9,100	$22,100	$25,740	6%	$13,020	$48,300	$72,600	2%
Kansas	$7,800	$19,500	$43,680	1%	$20,010	$51,000	$92,400	4%
Kentucky	$4,160	$17,659	$21,450	3%	$16,260	$41,340	$92,160	5%
Louisiana	$13,000	$16,250	$34,666	1%	$22,224	$39,510	$70,800	1%
Massachusetts	$9,100	$16,900	$22,880	1%	$34,200	$67,188	$108,000	4%
Maryland	$11,960	$20,150	$22,165	0%	$18,000	$49,800	$127,200	5%
Maine	$3,380	$28,080	$41,600	2%	$28,800	$58,680	$96,480	2%
Michigan	$4,160	$20,150	$52,000	2%	$10,020	$42,000	$95,400	5%
Minnesota	$10,660	$21,450	$39,000	2%	$10,692	$43,020	$142,200	3%
Missouri	$11,700	$20,800	$49,920	2%	$10,800	$32,400	$76,644	2%

Annual Costs

	Adult Day Health Care[3]				Assisted Living Facility[4]			
LOCATION	ADULT DAY HEALTH CARE MINIMUM	ADULT DAY HEALTH CARE MEDIAN	ADULT DAY HEALTH CARE MAXIMUM	5-YEAR ANNUAL GROWTH[2]	PRIVATE, ONE BEDROOM MINIMUM	PRIVATE, ONE BEDROOM MEDIAN	PRIVATE, ONE BEDROOM MAXIMUM	5-YEAR ANNUAL GROWTH[2]
Mississippi	$5,200	**$11,700**	$48,100	-2%	$7,800	**$39,978**	$92,880	3%
Montana	$18,304	**$30,984**	$59,280	8%	$34,200	**$43,800**	$65,340	3%
North Carolina	$7,800	**$13,780**	$37,700	0%	$14,184	**$39,000**	$93,600	2%
North Dakota	$11,180	**$25,480**	$48,100	13%	$8,220	**$36,219**	$74,100	2%
Nebraska	$6,427	**$19,110**	$52,000	7%	$13,200	**$45,414**	$80,700	3%
New Hampshire	$15,600	**$18,720**	$26,000	3%	$25,200	**$58,260**	$107,340	4%
New Jersery	$16,900	**$23,400**	$29,900	2%	$43,140	**$69,732**	$117,000	0%
New Mexico	$14,560	**$26,260**	$41,600	-2%	$18,000	**$48,000**	$90,000	3%
Nevada	$15,600	**$19,500**	$39,000	3%	$11,640	**$40,800**	$90,000	3%
New York	$3,900	**$20,800**	$52,650	8%	$14,280	**$47,850**	$164,250	2%
Ohio	$9,100	**$14,690**	$35,100	2%	$23,766	**$50,130**	$78,000	2%
Oklahoma	$11,700	**$15,600**	$39,000	3%	$8,946	**$36,390**	$81,600	2%
Oregon	$13,000	**$23,010**	$89,440	-2%	$28,320	**$48,840**	$79,800	1%
Pennsylvania	$9,750	**$16,120**	$43,680	2%	$11,340	**$41,400**	$95,400	1%
Rhode Island	$13,000	**$19,500**	$23,140	1%	$17,400	**$61,860**	$71,640	6%
South Carolina	$5,720	**$14,300**	$32,240	2%	$13,824	**$34,380**	$69,840	0%
South Dakota	$5,782	**$17,680**	$31,200	19%	$20,400	**$42,841**	$84,444	5%
Tennessee	$3,900	**$16,900**	$36,975	3%	$15,600	**$43,140**	$73,800	2%
Texas	$2,600	**$9,100**	$46,280	1%	$12,450	**$42,000**	$94,500	2%
Utah	$10,189	**$15,990**	$32,500	6%	$10,200	**$37,800**	$59,100	4%
Virginia	$2,600	**$17,649**	$118,643	4%	$13,200	**$54,090**	$100,080	5%
Vermont	$18,200	**$34,320**	$42,328	0%	$6,870	**$49,527**	$81,000	1%
Washington	$9,100	**$16,900**	$41,600	2%	$7,500	**$55,920**	$126,000	2%
Wisconsin	$8,580	**$16,952**	$49,920	3%	$15,816	**$48,000**	$113,400	2%
West Virginia	$10,920	**$16,120**	$26,000	4%	$27,000	**$45,000**	$84,600	5%
Wyoming	$18,200	**$22,100**	$26,000	9%	$18,762	**$40,974**	$60,870	1%

Genworth 2017 Cost of Care Survey, conducted by CareScout®, June 2017

[2] Represents the compound annual growth rate based on Genworth Cost of Care Survey

[3] Based on 5 days per week by 52 weeks

[4] Based on 12 months of care, private, one bedroom (Referred to as Residential Care Facilities in California)

N/A=data not available

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2017 Cost of Care

Genworth®

LOCATION	Nursing Home Care							
	SEMI-PRIVATE ROOM[5] MINIMUM	SEMI-PRIVATE ROOM[5] MEDIAN	SEMI-PRIVATE ROOM[5] MAXIMUM	5-YEAR ANNUAL GROWTH[2]	PRIVATE ROOM[5] MINIMUM	PRIVATE ROOM[5] MEDIAN	PRIVATE ROOM[5] MAXIMUM	5-YEAR ANNUAL GROWTH[2]
USA – National	$19,345	**$85,775**	$515,380	3%	$23,334	**$97,455**	$515,380	4%
Alaska	$178,850	**$292,000**	$515,380	1%	$178,850	**$292,000**	$515,380	2%
Alabama	$54,750	**$73,000**	$107,675	3%	$54,750	**$77,563**	$145,818	3%
Arkansas	$47,450	**$62,050**	$79,570	3%	$47,450	**$69,350**	$98,550	3%
Arizona	$57,305	**$76,650**	$116,800	3%	$65,700	**$91,250**	$153,300	2%
California	$41,245	**$97,367**	$228,125	4%	$41,245	**$116,435**	$292,000	4%
Colorado	$65,700	**$91,958**	$130,305	4%	$71,175	**$102,565**	$165,345	4%
Connecticut	$105,850	**$150,198**	$197,830	2%	$111,325	**$162,060**	$217,175	2%
District of Columbia	$109,500	**$118,443**	$129,575	7%	$109,500	**$126,838**	$139,430	6%
Delaware	$107,675	**$127,750**	$141,255	7%	$114,063	**$131,948**	$144,905	6%
Florida	$73,000	**$94,900**	$172,463	4%	$76,650	**$106,580**	$173,193	5%
Georgia	$48,728	**$74,668**	$110,778	5%	$49,275	**$80,483**	$133,225	5%
Hawaii	$23,334	**$137,240**	$229,585	3%	$23,334	**$158,593**	$247,105	5%
Iowa	$58,400	**$68,894**	$155,490	4%	$62,050	**$74,825**	$155,490	4%
Idaho	$65,335	**$88,695**	$124,100	4%	$72,635	**$94,918**	$150,865	3%
Illinois	$47,450	**$68,255**	$381,425	3%	$49,275	**$78,293**	$381,425	2%
Indiana	$47,450	**$80,300**	$116,070	3%	$73,208	**$93,805**	$165,710	3%
Kansas	$54,750	**$66,613**	$118,625	4%	$57,305	**$74,004**	$157,315	4%
Kentucky	$55,663	**$80,731**	$104,025	3%	$58,400	**$88,148**	$164,250	3%
Louisiana	$43,070	**$62,050**	$82,490	4%	$45,990	**$65,700**	$131,400	3%
Massachusetts	$102,200	**$140,525**	$177,755	4%	$109,500	**$149,650**	$209,145	3%
Maryland	$77,015	**$109,500**	$152,205	4%	$80,300	**$118,990**	$172,645	4%
Maine	$71,175	**$109,683**	$134,685	3%	$76,650	**$117,165**	$156,950	2%
Michigan	$47,450	**$95,630**	$164,250	4%	$56,768	**$103,295**	$245,218	3%
Minnesota	$48,665	**$98,094**	$144,358	5%	$73,000	**$107,854**	$153,483	5%
Missouri	$42,705	**$58,948**	$102,200	3%	$50,005	**$65,700**	$143,263	3%

Annual Costs

	Nursing Home Care							
LOCATION	SEMI-PRIVATE ROOM[5] MINIMUM	**SEMI-PRIVATE ROOM[5] MEDIAN**	SEMI-PRIVATE ROOM[5] MAXIMUM	5-YEAR ANNUAL GROWTH[2]	PRIVATE ROOM[5] MINIMUM	**PRIVATE ROOM[5] MEDIAN**	PRIVATE ROOM[5] MAXIMUM	5-YEAR ANNUAL GROWTH[2]
Mississippi	$63,145	**$77,928**	$102,200	2%	$64,970	**$79,753**	$106,580	1%
Montana	$70,536	**$86,505**	$108,770	4%	$72,635	**$95,667**	$136,693	5%
North Carolina	$43,800	**$82,125**	$127,020	3%	$60,225	**$91,250**	$253,310	4%
North Dakota	$89,009	**$127,630**	$155,673	11%	$91,929	**$130,367**	$156,257	10%
Nebraska	$40,150	**$76,011**	$127,933	3%	$47,450	**$81,213**	$176,478	3%
New Hampshire	$41,063	**$115,888**	$143,080	3%	$54,020	**$126,838**	$160,731	4%
New Jersery	$78,475	**$120,450**	$164,250	2%	$90,520	**$129,575**	$176,660	2%
New Mexico	$19,648	**$76,194**	$178,485	2%	$30,069	**$88,878**	$193,614	3%
Nevada	$47,147	**$87,600**	$144,299	2%	$56,575	**$99,463**	$157,800	3%
New York	$86,140	**$132,907**	$394,565	2%	$87,965	**$140,416**	$394,565	3%
Ohio	$59,495	**$81,578**	$117,530	2%	$65,700	**$91,250**	$163,520	2%
Oklahoma	$45,625	**$53,655**	$109,500	2%	$51,830	**$63,510**	$129,210	3%
Oregon	$47,450	**$105,408**	$182,500	5%	$51,053	**$111,143**	$182,500	4%
Pennsylvania	$41,063	**$111,325**	$165,126	4%	$56,210	**$120,085**	$174,974	4%
Rhode Island	$76,650	**$101,835**	$124,100	2%	$83,950	**$104,025**	$169,725	-2%
South Carolina	$56,575	**$77,015**	$130,670	3%	$60,225	**$82,125**	$137,970	3%
South Dakota	$62,415	**$75,599**	$105,485	3%	$65,335	**$81,760**	$114,610	4%
Tennessee	$63,510	**$73,318**	$111,325	2%	$65,335	**$79,205**	$156,585	3%
Texas	$19,345	**$54,750**	$109,500	3%	$37,230	**$72,635**	$169,725	3%
Utah	$24,273	**$67,525**	$91,250	3%	$30,149	**$83,585**	$152,388	4%
Virginia	$67,525	**$85,775**	$149,650	4%	$70,810	**$94,900**	$175,200	3%
Vermont	$95,995	**$105,120**	$132,130	3%	$100,010	**$111,508**	$140,525	2%
Washington	$60,225	**$102,930**	$175,200	3%	$60,225	**$113,362**	$186,150	3%
Wisconsin	$41,990	**$94,900**	$135,404	3%	$52,753	**$107,430**	$164,250	3%
West Virginia	$75,190	**$116,435**	$143,810	7%	$77,380	**$122,823**	$148,920	7%
Wyoming	$67,525	**$84,939**	$108,770	3%	$71,175	**$96,725**	$118,625	4%

Genworth 2017 Cost of Care Survey, conducted by CareScout®, June 2017

[2] Represents the compound annual growth rate based on Genworth Cost of Care Survey

[5] Based on 365 days of care

For more information visit
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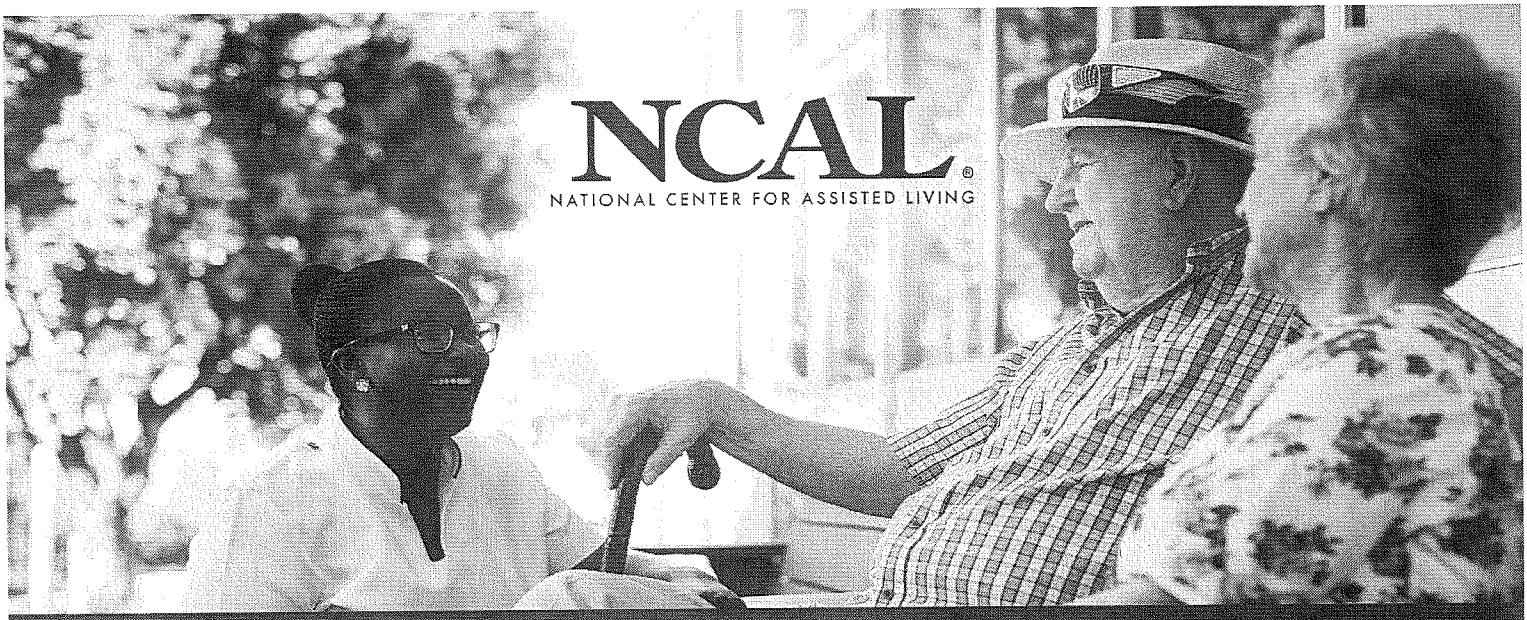
NCAL®
NATIONAL CENTER FOR ASSISTED LIVING



2017
ASSISTED LIVING
State Regulatory Review

About the National Center for Assisted Living

The National Center for Assisted Living (NCAL) is the assisted living voice of the American Health Care Association (AHCA). AHCA/NCAL represent more than 13,500 non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers and homes for individuals with intellectual and developmental disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly, and individuals with disabilities who receive long term or post-acute care in our member facilities each day.

NCAL is dedicated to serving the needs of the assisted living community through national advocacy, education, networking, professional development, and quality initiatives. In addition, NCAL supports state-specific advocacy efforts through its national federation of state affiliates. NCAL state affiliates work to create local education, advocate on behalf of assisted living providers, and provide the direct, ongoing support their assisted living members need to improve quality and grow their businesses.

Executive Summary

This report summarizes key selected state requirements for assisted living licensure or certification. For every state and the District of Columbia, this report includes information on topics such as which state agency licenses assisted living, recent legislative and regulatory updates affecting assisted living, and requirements for resident agreements, admission and discharge, units serving people with Alzheimer's or other dementias, staffing, and training.

States use various terms to refer to assisted living, such as residential care and personal care homes. This report includes requirements for those types of communities that offer seniors housing, supportive services, personalized assistance with ADLs, and some level of health care.

Seventeen states reported change to requirements between June 2016 and June 2017 that will affect assisted living communities. These states reported a variety of types of requirements that were changed, either to the licensing requirements or to other regulations that also apply to assisted living providers (e.g., nursing scope of practice or life safety). This variety indicates that assisted living providers and states are focused on a range of issues. The most common changes were raising civil monetary penalty maximums or strengthening oversight requirements. Other changes affected, for example, training, administrator licensing, background check requirements, and medication administration. Over time, states are generally increasing the regulatory requirements for assisted living communities.

Four states—California, Oregon, Rhode Island, and Virginia—each passed new laws to enhance penalties and oversight.

- California legislature increased civil penalties for licensing violations and required the Department of Social Services to make a good faith effort to work with licensees to determine the cause of the deficiency and ways to prevent repeat violations, among other changes.
- Oregon enacted a bill with several updates affecting assisted living, including enhanced oversight and supervision, as well as enhanced fee and fine structures. Specifically, the Department of Human Services will be required to develop an evidence-informed framework for assessing compliance with regulatory requirements and requiring corrective action that accurately and equitably measures compliance and the extent of noncompliance. In addition, the department must administer an advanced standing program that rewards assisted living communities for positive performance and penalizes poor performance.
- Rhode Island passed legislation requiring the licensing agency to conduct unannounced on-site inspections of all licensed assisted living residences, on a biennial basis, with not less than 10 percent of those inspections to be conducted on nights and weekends. The licensing agency must also conduct additional on-site inspections and investigations that it deems necessary.
- Virginia legislature increased the aggregate amount of civil penalties that the Department of Social Services may assess against an assisted living community.

Thirty-three states and the District of Columbia reported no finalized legislative or regulatory changes between June 2016 and June 2017 that affect assisted living communities.

Over the next year, more than half of the states will be proposing, formally reviewing, or considering changes that would affect assisted living communities. The reported scope of potential changes varies considerably, as does the likelihood of changes being finalized. For example, some states noted plans to review the entire set of licensing regulations and make significant changes. In contrast, others plan to make small targeted regulatory updates to implement new legislation. A few states reported that proposed regulations will be finalized before the end of 2017, while others are just beginning a process that will likely take several years to go through the notice and comment rulemaking process.

Several states reported finalizing state regulatory changes necessary for the 2014 HCBS final rule, which will affect assisted living communities that are Medicaid certified. However, most are still in the process of reviewing and possibly revising requirements for assisted living Medicaid providers. To comply with the rule's home and community-based settings requirements, all states must conduct a systemic review of their statutes and regulations to assess whether its standards for such settings comply with the new regulations.[7] Licensing requirements covered in this report are generally separate from the rules overseeing Medicaid providers; states that must make changes are determining whether to revise requirements only for Medicaid providers or instead to change licensing requirements so that all assisted living providers, not just those that are Medicaid certified, comply with the HCBS final rule.

[7] Centers for Medicare and Medicaid Services, Department of Health and Human Services. *Home and Community-Based Settings Requirements: Systemic and Site-Specific Assessments and Remediation.* December 9, 2015, at 17.

Methodology

From April 2017 through June 2017 the National Center for Assisted Living (NCAL) reviewed each state and the District of Columbia's assisted living licensing regulations and statutes relying on the resources published on state licensure agency webpages. NCAL did not review sub-regulatory guidance. NCAL did not review regulations and statutes outside of the licensure requirements from the state agency overseeing assisted living. States with Medicaid programs that cover services in assisted living may have additional requirements for participating providers; this report does not summarize these requirements for Medicaid certified assisted living providers.

To verify its research, NCAL sent each state's updated summary to both the state official responsible for assisted living licensure or certification and to NCAL's state affiliate staff.

NCAL also distributed a survey asking about legislative or regulatory changes between June 2016 and June 2017 to state licensure requirements.

NCAL did not harmonize assisted living terminology across states, and therefore each state's summary conveys the terminology adopted by that state. NCAL did attempt to present a consistent level of information across states. The absence of information in the report on specific requirements should not be construed as an absence of state requirements. NCAL reported "None specified" where state licensing regulations did not address a specific topic.

The end of each state summary has citations to state licensure requirements and, where applicable, the state Medicaid website for assisted living or long term care coverage. More information and state-specific links regarding Statewide Transition Plans for the HCBS final rule are at: https://www.medicaid.gov/medicaid/hcbs/transition-plan/index.html.

The information in this report is not intended as legal advice and should not be used as or relied upon as legal advice. The report is for general informational purposes only and should not substitute for legal advice. This report summarizes key selected state requirements for assisted living licensure or certification and, as such, does not include the entirety of licensure requirements for assisted living and residential care communities.

Prior annual publications of NCAL Assisted Living State Regulatory Review are available on NCAL's web site at: www.ncal.org.

We are deeply grateful to state agency officials and NCAL state affiliates who provided information for this report and reviewed its contents.

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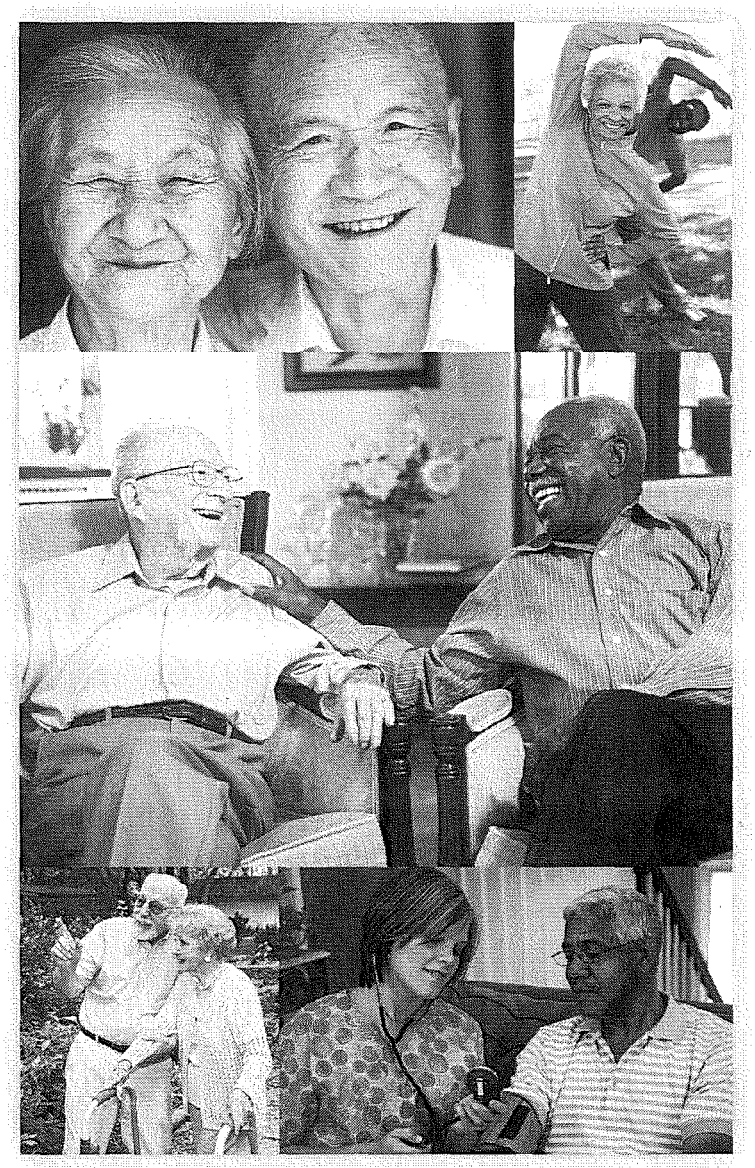
2016 State Regulatory Review©

OCTOBER 2016



NCAL®
NATIONAL CENTER FOR ASSISTED LIVING

Executive Summary

This report summarizes key selected state requirements for assisted living licensure or certification. For every state and the District of Columbia, this report includes information on topics such as which state agency licenses assisted living, recent legislative and regulatory updates affecting assisted living, and requirements for resident agreements, admission and discharge requirements, units serving people with Alzheimer's or dementia, staffing, and training.

States use several different terms to refer to assisted living, such as residential care and shared housing. This report includes requirements for those types of communities that offer seniors housing, supportive services, personalized assistance with ADLs, and some level of health care.

More than half the states reported no recent regulatory changes affecting assisted living. Specifically, twenty-seven states and the District of Columbia reported no substantive changes to statutes or regulations between January 2015 and June 2016 that affected assisted living communities.

Twenty-three states reported some change to requirements during that time period. Those states that did make changes reported a variety of types of requirements that were affected. This indicates that assisted living providers and states are focused on a range of issues. Staffing and training, dementia care, and medication management were the most common policy areas addressed by states. Most of the changes were targeted, and only a few states made significant, broad changes to their regulations affecting assisted living. Over time, states are generally increasing the regulatory requirements for assisted living communities.

Nine states reported that proposed regulations for assisted living communities are being reviewed for an update: California, Colorado, Florida, Hawaii, Maryland, New York, North Carolina, Virginia, and Wyoming. California and Florida's regulations are being updated to reflect legislative changes that have already been enacted.

Eight states—California, Florida, Iowa, Idaho, Louisiana, Massachusetts, Minnesota, and South Carolina—reported changes to requirements for staffing and training, three of which were for dementia-specific training.

Examples of dementia-specific training requirements:

- California enacted several statutes that changed staffing and training requirements, including requiring that administrator certification include training on managing Alzheimer's disease and related dementias, as well as including nonpharmacologic, person-centered approaches to dementia care.
- Iowa amended its dementia-specific training rules to include eight hours of training for direct care contract staff and two hours for non-care contracted staff.
- Minnesota established required dementia training for staff, as well required training of managers. For example, direct care employees of a housing with services establishment that has a special program or special care unit must receive eight hours of initial training within 160 hours of the employment start date and two hours of additional training for each 12 months of work thereafter.

Examples of other training requirements:

- Florida updated its requirements to include additional pre-service training requirements for staff prior to interacting with residents and an increase in training from four hours to six hours for unlicensed staff who assist residents with self-administration of medications.
- Idaho made a number of changes, including requirements for executive directors/administrators, staffing, and training.
- Louisiana mandated that direct care staff complete 12 hours of in-service training each year, in addition to dementia specific training requirements.
- Massachusetts made revisions to require that at least one hour of general orientation must be devoted to the topic of elder abuse, neglect and financial exploitation. Additionally, no more than 50 percent of training requirements can be satisfied by un-facilitated media presentations.
- South Carolina now requires staff and direct care volunteers actively on duty to be in the facility, awake, and dressed at all times. Staff and direct care volunteers must demonstrate a working knowledge of the training received.

Five states—Iowa, Louisiana, Massachusetts, Nebraska, and Oregon—reported changes to requirements for units that serve people with Alzheimer's or other dementias, though the level and types of changes were different across these five states.

Examples of new regulatory framework for serving persons with Alzheimer's or dementia

- Louisiana promulgated new regulations to establish specialized dementia care programs for assisted living communities, which the state refers to as adult residential care providers.
- Nebraska created a voluntary state endorsement for memory care units, and will be further defining the requirements.

Examples of new or additional requirements for serving persons with Alzheimer's or dementia

The other three states already have requirements for special care programs or units that serve people with Alzheimer's or dementia, and reported creating new or changing existing requirements for such providers.

- Iowa instituted many changes, such as: (1) requiring a policy addressing sexual relationships between tenants with a Global Deterioration Scale greater than five, or between staff and tenant; (2) amending dementia-specific training rules to include eight hours of training for direct-care contract staff and two hours for non-care contracted staff; and (3) requiring dementia-specific programs to develop procedures concerning tenants at risk for elopement.
- Massachusetts added requirements for Special Care Residences in regards to the physical environment and activity programs, as well as requiring at least two awake staff on duty at all times.
- Oregon changed requirements to comply with the Medicaid HCBS waiver final rule, which includes new expectations for memory care facilities.

Delaware, South Carolina, and Tennessee reported different kinds of changes to requirements related to medication management.

- Delaware created requirements for Limited Lay Administration of Medications for unlicensed assistive personnel to administer medication, which replaced its previous training course.
- South Carolina's new regulations included a provision that self-administration is permitted if specific written orders are obtained on a semi-annual basis or staff document the resident demonstration to self-administer medication.
- Tennessee revised the definition of medication administration, and requirements regarding influenza vaccination, administration of IV medications, and medication disposal.

Several states reported finalizing state regulatory changes necessary for the 2014 HCBS waiver final rule ("the Rule"), which is relevant for assisted living communities that are Medicaid providers. To comply with the Rule's new home and community-based settings requirements, all states must conduct a systemic review of its statutes and regulations to assess whether its standards for such settings comply with the new regulations.[6] Consequently, most states are in the process of reviewing and possibly revising requirements that might affect assisted living Medicaid providers.

[6] Centers for Medicare and Medicaid Services, Department of Health and Human Services. *Home and Community-Based Settings Requirements: Systemic and Site-Specific Assessments and Remediation.* December 9, 2015, at 17.

Methodology

To update its 2013 regulatory review, between March 2016 and June 2016 the National Center for Assisted Living (NCAL) reviewed each state and the District of Columbia's assisted living regulations and statutes using the resources published on state licensure agency webpages. In addition, NCAL consulted the Office of the Assistant Secretary for Planning and Evaluation's (ASPE) *Compendium of Residential Care and Assisted Living Regulations and Policy: 2015 Edition* and updated state summaries incorporating ASPE's findings where information was not readily available in state regulations or statutes.[7] NCAL did not review sub-regulatory guidance, which are either not available or not easily found online. NCAL did not review regulations and statutes outside of the licensure requirements from the state agency overseeing assisted living.

To verify its summaries, NCAL sent each state's updated summary to both the state official responsible for assisted living licensure or certification and NCAL's state affiliate chapter staff. While one or both officials responded for a majority of states, the summary was not verified by one or both in six states: Connecticut, Kentucky, Montana, New Mexico, North Carolina, and Rhode Island.

NCAL also distributed a survey to state officials asking about legislative or regulatory changes to state licensure between January 2015 and June 2016, the results of which are reported above.

NCAL did not harmonize assisted living terminology across states, and therefore each state's summary conveys the terminology adopted by that state. NCAL did attempt to present a consistent level of information across states. The absence of information in the report on specific requirements should not be construed as an absence of state requirements. NCAL reported "None specified" where state licensing regulations did not address a specific topic.

At the end of each state summary, NCAL provided citations to state licensure requirements.

The information in this report is not intended as legal advice and should not be used as or relied upon as legal advice. The report is for general informational purposes only and should not substitute for legal advice. This report summarizes key selected state requirements for assisted living licensure or certification and, as such, does not include the entirety of licensure requirements for assisted living/residential care communities.

Prior annual publications of NCAL Assisted Living State Regulatory Review are available on NCAL's web site at: www.ncal.org.

We are deeply grateful to state agency officials and NCAL state affiliates who provided information for this report and reviewed its contents.

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[7] Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. *Compendium of Residential Care and Assisted Living Regulations and Policy: 2015 Edition*. June 6, 2015.

PROPUBLICA

LIFE AND DEATH IN ASSISTED LIVING

Elderly, At Risk, and Haphazardly Protected

A ProPublica and "Frontline" examination of the multibillion-dollar assisted living industry reveals a mishmash of minimal state regulation and no involvement by federal officials.

by **A.C. Thompson**, Oct. 29, 2013, 10:56 a.m. EDT

A version of this story was co-published by "Frontline."

Workers found 82-year-old Vincenzina Pontoni submerged in a deep whirlpool bathtub. She had drowned.

Pontoni, a resident of an assisted living facility near Cleveland, wasn't supposed to be left alone; her care chart stated that facility workers were to stand by while she was bathing "for safety." But records show she had been unsupervised for at least an hour that day in 2010, with deadly consequences.

State law in Ohio does not require assisted living facilities to alert regulators at the Ohio Department of Health when a resident dies under questionable circumstances, so administrators at Pontoni's facility never did. While law enforcement did an investigation – ruling the death an accident – the people actually charged with safeguarding seniors in

assisted living never so much as visited the facility in response to Pontoni's death. Indeed, the Department of Health was unaware of how Pontoni died until notified by a reporter investigating assisted living for ProPublica and "Frontline."

When asked about Pontoni's death, and whether the Department of Health feared other care issues had been overlooked, Tessie Pollock, a department spokeswoman, said it did not appear that any regulation had been violated by the Cleveland facility. She encouraged the families of residents in the state's assisted living facilities to be vigilant on behalf of their loved ones.

Ohio's hands-off approach to regulating assisted living is hardly an aberration.

Over the past two decades, assisted living has undergone a profound transformation. What began as a grassroots movement aimed at creating a humane and innovative alternative to nursing homes has become a multibillion-dollar industry that houses some 750,000 American seniors. Assisted living facilities, at least initially, were meant to provide housing, meals and help to elderly people who could no longer live on their own.

But studies show that increasing numbers of assisted living residents are seriously ill and that many suffer from dementia. The workers entrusted with their care must manage complex medication regimens, safeguard those for whom even walking to the bathroom can be dangerous, and handle people so incapacitated they can be a threat to themselves or others.

Yet an examination by ProPublica and "Frontline" found that, in many states, regulations for assisted living lag far behind this reality.

Despite the growing demands on care in assisted living, most states set the entry bar low for facility workers, requiring little in the way of education or qualifications. In Minnesota and 13 other states, administrators don't need high school diplomas. Caregivers can be as young as 16 in Illinois. Facilities in some states, Colorado among them, are not required to have even one licensed nurse on staff.

Under most state regulatory schemes, assisted living companies are also free to decide how much staff their facilities should have. Just 14 states set staffing ratios; in Mississippi, facilities must have at least one staffer on duty for every 15 residents during daytime hours and one per 25 at night. In California, by contrast, facilities housing as many as 200 seniors need no more than two workers on the overnight shift. Neither of them is required to have any medical training. And one of them is allowed to be asleep.

Compared with nursing homes, assisted living facilities in many states receive relatively little outside monitoring. Under federal guidelines, nursing homes are supposed to be inspected at least once every 15 months. For assisted living, the interval between inspections can be five years in some states. South Carolina and five other states require no regular inspections.

In many parts of the country, assisted living operators face few consequences for even the most serious lapses in care. All states have the power to shut down troubled facilities, but they typically do so only as a last resort and after years of problems. Most states can impose fines for violations of safety standards, but they seldom carry much sting – in California, facilities routinely pay as little as $150 in cases in which the state found residents had died as a result of poor care.

While consumers can go online and compare the track records of nursing homes on a government web site, few such resources exist for assisted living. Twenty-two states still don't post inspection records online, requiring residents to visit state offices to view them on paper or file public records requests.

ProPublica set out to compile the key rules and regulations governing assisted living in all 50 states and the District of Columbia. See what we found »

The Texas Department of Aging and Disability Services collects and posts a rich array of data on assisted living facilities. But after five years, the records are destroyed, making it tough for the public or regulators themselves to identify long-term patterns and problems.

The jumble of state laws governing assisted living reflects, in part, the industry's efforts to fight off tougher regulation.

It has done serious combat in Washington to ward off federal oversight, insisting that states are best-suited to oversee the varied senior living environments that co-exist under the assisted living label. Simultaneously, the industry has conducted highly effective campaigns at the state level, from Iowa to Florida to Pennsylvania, to keep rules regarding training and inspection, staffing levels and fines, to a minimum.

"We absolutely support the idea of regulation," said Mark Parkinson, a former governor of Kansas who is now the president of the American Health Care Association and the National Center for Assisted Living, an industry trade group. "The issue then becomes at what level do you regulate it? Do you regulate at the federal level? Or you do at the state level? And our position has been that it's better to do it at the state level."

Parkinson and others say the ability of individual states to craft their own oversight policies makes sense given the great variety of assisted living settings – from rooms in private homes to 200-bed facilities run by national chains. And he says the absence of strict federal involvement allows consumers to have a greater voice in how assisted living is regulated in their local communities.

All of that, Parkinson said, helps explain why industry research shows a high level of satisfaction with assisted living care.

"Ninety-one percent of the country that has a mom or dad in assisted living facility would recommend that facility to someone else," he said. "That's a pretty important data point."

To many -- advocates for the elderly, researchers, lawyers for victim families -- the hodgepodge of state rules present a real peril, one that is only likely to grow as the population in assisted living becomes more fragile. Some have called for federal regulation of assisted living similar to what exists for nursing homes.

"If you look at the history of assisted living, it sort of emerged like a hernia. It pushed through a soft spot in oversight," said Richard Mollot, executive director of the Long Term Care Community Coalition, a national advocacy organization based in New York.

Federal rules would be no panacea, Mollot and others acknowledge – there are still plenty of problems with nursing home care. The federal government has exercised more authority over nursing homes because it pays many of the bills, chiefly through Medicare. Most residents in assisted living pay out of their own pockets.

Still, proponents say, federal regulation could at least make care standards more consistent nationwide and aid in the collection of basic information about assisted living that does not exist today.

Leaders in the assisted living industry deride the idea that federal oversight would improve residents' circumstances and say that allowing standards to vary state to state allows for more flexibility and options in assisted living settings. They say they have adapted to the more serious needs of their residents, but continue to insist that assisted living has not become an actual health care enterprise, and does not need to be regulated like one.

"We think that the regulations are working well in each of the states," said Richard Grimes, president of the Assisted Living Federation of America, a prominent trade group.

Chapter 1: In California, A Major System's Considerable Failure

There are nearly 8,000 assisted living facilities in California today, roughly 25 percent more than there were a decade ago. But as the number of residents in these settings has swelled, the state's system for ensuring their welfare has been slow to adapt. And by some measures, it's been in retreat.

The Department of Social Services admits that it has failed to adopt new rules and requirements to better oversee the increasing percentage of assisted living residents who need substantial medical care. The state has also relaxed the requirements for facilities to show they can meet certain care and safety standards prior to admitting bedridden residents and those suffering from memory loss.

Since 2001, the department has cut its staff of inspectors by nearly 9 percent, and lengthened the timetable for how often facilities must be inspected from every year to every five years.

"There's no question oversight is worse now than it was 10 years ago," said Pat McGinnis, executive director of California Advocates for Nursing Home Reform, a nonprofit organization. "The current system is a recipe

for neglect and abuse. Care standards are almost meaningless. Facilities can flout the law without facing serious consequences."

An examination of California's regulatory system – inspection filings, investigation reports, lawsuits and data from the state ombudsman's office -- reveals the consequences of the cutbacks: Routine inspections are sometimes delayed and death investigations can take months to complete; even facilities with track records of repeated violations tend to receive slap-on-the-wrist punishments.

Irving Weinberg, 98, died in 2010 when his motorized wheelchair tumbled down a staircase at an Escondido, Calif., facility operated by Emeritus Senior Living, the country's largest assisted living company and the dominant chain in California. It took regulators eight months to complete an investigation. When the state finally cited the facility for not having enough staff in place to prevent the fatal accident, the company was fined $150.

"We were not at fault for this extremely unfortunate and unforeseeable accident," Emeritus stated in response to written questions. "There is no evidence that Emeritus at Escondido caused or contributed to this tragic incident in any way."

A review of state inspection reports revealed that the state had cited the same facility just months before Weinberg's death for failing to provide adequate medical attention for a resident who died of sepsis, a shock-like condition brought on by severe infection. In that case, too, the facility was fined $150.

Emeritus said the resident "was taken care of appropriately."

"A hundred and fifty dollars for someone's life?" asked Leslie Weinberg, Irving's daughter-in-law. "I don't think that is adequate." The Weinberg family sued and settled with the facility's owner.

In 2012, a worker at Gold Age Villa, a small assisted living facility in Placer County, picked wild mushrooms and put them in gravy she fed to five seniors. Unfortunately, the fungi were toxic. Four residents eventually died. The incident generated headlines around the country. The government response, however, was largely overlooked: The state barred the caregiver from working in the industry, but did not revoke the facility's license or fine its owner.

The owner of Gold Age Villa did not respond to requests for comment.

In 2011 an inspector concluded that workers at an Attitudes Senior Care facility, in Del Mar, had "neglected" a bed-ridden resident, causing the person to suffer from "severe malnutrition" and "numerous" pressure ulcers, or bed sores, including a wound that eroded the flesh all the way down to the coccyx bone. State officials handed out a $150 fine and crafted a plan to bring Attitudes into compliance with California law. Records show the facility – part of a modest three-facility operation -- had been put on just such a plan a few years earlier, in 2008, when another resident "did not receive the required care."

Karen Kelly, president of Attitudes Senior Care, said in a brief interview that she did not want to discuss the case, saying, when asked about the state's sanctions, "The department is the department."

"We have been providing excellent care for many years as any of our residents and family members can attest," Kelly said in an email.

Pat Leary, chief deputy director of the Department of Social Services, said in an interview that fines alone were not a meaningful curb on facilities with dangerous gaps in care. But she said the department was armed with the power to shut facilities permanently, or to scrutinize them more closely by placing them on probationary status.

However, Leary couldn't say how frequently the state was using these enforcement tools. Leary said even determining how many facilities, at any given time, had been deemed "out of compliance" with state regulations was "a hard statistic to get."

Leary said improving oversight was imperative and that the department is working to make inspections more targeted, aiming to put inspectors inside problem facilities with greater regularity.

"How can we assure residents are safe and how do we know what's going on? That's the challenge," Leary said. "We know we have a lot of catching up to do."

But it's not likely to be easy, for, as Leary admits, the department is trying to do more with less. Last year, the state broadened the workload for inspectors, tasking them with inspecting facilities for the physically and developmentally disabled in addition to assisted living facilities. When they are alerted to cases in which assisted living residents might be at risk of harm, they can take as long as 10 days to start an investigation.

Even then, their inquiries are often perfunctory, said Chris Murphy, whose group, Consumer Advocates for RCFE Reform, tracks deaths, neglect and mistreatment in Southern California assisted living facilities.

Murphy, who has a master's degree in gerontology, said she started her organization after witnessing problems at a facility where her mother lived. She said she has only become more disturbed with California's lack of oversight over time.

"Nobody's accountable," she said. "The citations are meaningless. It's a charade, in my view."

In 2007, workers at an Emeritus assisted living facility in Oceanside, Calif., found Irene Elliott, 98, lying in the dirt beneath her window, cold to the touch. It appeared she had jumped or fallen. The drop from her second floor window had fractured her pelvis, two vertebrae, left elbow and multiple ribs.

State investigators were called to look into the death. After a one-day probe, an inspector decided that the facility was in "substantial

compliance" with the law. The facility, which insisted it had done nothing wrong, was not cited by the state.

According to court documents and the Medical Examiner's report, however, Elliott, who suffered from dementia, had been exhibiting increasingly erratic behavior. Her family contends that the facility was aware of her issues, but didn't take action to prevent the fatal incident from occurring. Despite her deteriorating mental condition, Elliott wasn't moved into the building's memory care wing, a secure space for people with Alzheimer's and dementia.

In court papers, the company maintained it had responded promptly to the changes in Elliott's condition and said there was "no basis" for transferring Elliott to the memory care wing.

Elliott's family sued the company that owned the facility, reaching a settlement in 2008.

One of the central challenges for families searching for appropriate assisted living facilities in California is the dearth of information about their regulatory histories.

The state doesn't post inspection reports or complaint investigations online.

In 2009, University of California-San Francisco professor Bob Newcomer received a roughly $600,000 grant to overhaul the Department of Social Services' information technology systems. The goal was to improve how the agency collected data on assisted living, and to make that data more accessible to the public.

Newcomer and his team designed a new coding language that would make it easier for the department to pinpoint the most troubled facilities and track the most persistent types of violations across the state. The new system would also allow the department to post inspection results online, giving the public instant access to crucial information about facilities.

Today, some four years later, the department has yet to implement the system, making it difficult for the state to analyze even the most basic data.

"It's a complete embarrassment," said Newcomer, now a professor emeritus at UCSF.

Leary, who was appointed to her position in 2011, said she was unaware of Newcomer's efforts and does not know why they stalled. She said she supports updating the department's information systems.

"We have to have a system that's actually in real time, and up to date, regarding a facility's status," she said. "Currently, we can't do that."

As assisted living facilities take in increasing numbers of sicker, frailer residents, Leary also acknowledged that her agency needs to do more to set and enforce staffing requirements.

State officials say they want to draw upon the wisdom of families, the industry and experts in senior care in determining what needs to be done. But to date, there's little evidence that such a conversation has begun, and as a result officials have not proposed any significant legislative changes to enhance regulatory oversight.

Advocates for the elderly are frustrated by the lack of action, and furious about some of the pullback.

Murphy is proposing a radical revamping of California's oversight apparatus. The first step: To place regulation of assisted living with the state Department of Public Health, which monitors hospitals and other medical facilities.

The California Advocates for Nursing Home Reform, in a soon to be published paper, are calling for wholesale reforms.

"The only thing that has ever worked with the department is lawsuits," said McGinnis, who heads the advocacy group. "And that's a hell of a way to make public policy."

Chapter 2: "The Industry is Smart"

A decade ago, the assisted living industry was exploding in Iowa much as it was in California. But problems had been emerging, and to many it became clear the state's Department of Elder Affairs was not up to the task of overseeing the care being delivered to thousands of seniors.

The Des Moines Register reported in 2002 that caregivers at some facilities had physically abused residents. At one, reports showed, an incontinent resident was left to wear the same adult diaper for five days. The paper also documented that the Elder Affairs agency had not imposed penalties on any assisted living facilities for violating standards of care, and that it had sanitized inspection reports to hide deficiencies before releasing them to the public.

Two successive governors, Tom Vilsack and Chet Culver, moved to get more serious about regulating the industry. In 2002, Vilsack shifted responsibility for overseeing assisted living to the Department of Inspections and Appeals, which already oversaw nursing homes and hospitals in the state. Culver, who took over as governor in 2007, appointed a lawyer who had once worked in the attorney general's office to serve as the agency's director.

The lawyer, Dean Lerner, was no stranger to taking on influential industries, having gone after petroleum companies for the cost of cleaning up underground gasoline leaks.

"I knew what I was getting into," Lerner, in a recent interview, said of his dealings with the assisted living industry. "I knew that the industry was very powerful politically in the state."

If forewarned, Lerner said he still was not fully prepared for what became four years of grueling confrontation.

During his tenure, Lerner said he tried to both enhance the regulations themselves and embolden enforcement of them.

He had some successes. He helped persuade legislators to close a loophole that delayed the posting of state inspection reports for months, even years, while facility operators appealed the findings. He took swift legal action against an assisted living company for false advertising and launched an investigation into consumer fraud in the industry.

But some of his efforts ran into stiff resistance. For instance, proposed legislation aimed at preventing elected officials, industry representatives and others from interfering with investigations of assisted living and other senior homes went nowhere.

The battles left Lerner exhausted and fatalistic.

"In every meeting I ever had with them, they would fight tooth and nail against any enhanced regulatory oversight or any public disclosure," Lerner said of the industry and its lobbyists. "Their goal in every meeting? More money, less regulation, minimal public disclosure."

Today, the central regulations governing assisted living in Iowa are much as they were when Lerner took over. The state is required to conduct inspections of assisted living facilities every two years and can assess civil penalties of up to $10,000 for neglect or abuse that results in fatal injuries. Iowa also requires assisted living facilities to be overseen by a registered nurse and that caregivers working with people with Alzheimer's and dementia receive a minimum of eight hours of specialized training within 30 days of employment.

Even though the rules are more demanding than those of many other states, Lerner and other advocates say they remain inadequate to meet the growing challenges in assisted living.

In a statement, the Iowa Health Care Association, the trade group that represents assisted living companies, said Lerner was biased against the industry, exaggerating its problems and turning a deaf ear to its legitimate needs and concerns. The association said it has always welcomed responsible oversight, and has worked in good faith with legislators and others to define and enact practical and effective regulation.

But others, and not just Lerner, say the industry has worked hard to keep regulations superficial. Over the years, nursing homes and assisted living facilities have banded together, impressing upon lawmakers their status among the state's largest employers. Too much regulation, they have made clear, could drive those jobs out of the state. Today, more than 50,000 people are employed in Iowa in what are known as long-term care facilities.

"The industry is smart," said Brian Kaskie, associate director of the University of Iowa Center on Aging, who has closely followed long-term care issues in the state. "If you look at campaign contributions, they're not huge. They keep a low profile. They don't spread a lot of cash around. When they do, it's very targeted. They spend as little possible in order to

have the capacity to stop [tough regulation]. They frame it as, 'We're your city's largest employer.' In Iowa, long-term care is a $2 billion industry."

James C. Larew served as general counsel to Culver, and said he heard often from the industry about its unhappiness with tough regulation.

"I didn't see a more powerful interest group in Iowa than the nursing home and assisted living industry," Larew said. "They are very effective and there's simply no countervailing weight on the other side."

The Iowa Health Care Association rejects any suggestion that it has exerted undue influence on state legislators, saying the notion that votes regarding nursing home or assisted living regulation can be bought is "offensive."

"We are proud to be among the many stakeholders who offer input on long-term care issues to policymakers," the association's statement said.

One former legislator thinks otherwise.

"Our state has sold out to the assisted living and nursing home industry," said John Tapscott, a former state representative who now serves as a volunteer advocate for the elderly. "Everything introduced that is seen as positive for senior citizens is beaten back because the lobbyists are there with open pocket. And the people who suffer the most are those who have the least voice."

Similar fights over regulation have played out in other states, with similar results.

In 2011, a Florida task force proposed higher standards for licensing and inspecting assisted living facilities, but the measures died in the state legislature.

New York spent four years crafting a battery of enhanced standards and enforcement tools. But in 2008, just as the measures were going into effect, the industry successfully sued to void some of the more rigorous regulations, such as requiring a nurse to be on staff if a facility was providing dementia care, and mandating that there be emergency call systems in resident bedrooms. A state judge ruled that the measures were unnecessary and too expensive.

"On the one hand, they're telling consumers, 'We'll take care of you; You'll be safe; We have trained staff and dementia care,'" Mollot, the executive director of New York's Long Term Care Community Coalition, said of the industry. "With policymakers, they say, 'We're not a nursing home. We don't need that kind of oversight or those kinds of requirements.'"

Industry executives in New York said they support exacting regulation, and that their successful court fight was only to eliminate what they regarded as needlessly onerous demands.

In Iowa in 2010, Lerner's efforts to oversee assisted living became an issue in the race for governor. On the campaign trail, Republican candidate Terry Branstad criticized Lerner's tactics and promised to replace him with someone who would work in a more "collaborative" and "cooperative"

manner with the industry. After winning the election, Branstad named Rod Roberts, a former state legislator, to replace Lerner.

In a written statement, Roberts said politics and special interests had not influenced his ability to enforce assisted living regulations. Roberts said his department has an "open door policy with constituents, stakeholders, and all interested parties."

Roberts also maintains that enforcement has been vigilant during his tenure.

"Incidents are down, investigation times remain constant, and department citations reflect a robust enforcement effort" Roberts wrote in a 2011 opinion article in the Des Moines Register. "What has changed, however, is the attitude and approach we take with our regulated facilities. Mutual respect has replaced 'gotcha,' and all those in our care facilities are better served as a result."

Though out of office, Lerner was nonetheless drawn into the latest development in regulating assisted living, voicing strong opposition to an industry-supported piece of legislation this year that established a new process for appealing assisted living and nursing home violations. The new rules require outside attorneys – not the Department of Inspections and Appeals – to hear appeals.

Lerner testified against the legislation.

"This bill's passage and the rulemaking represents further evidence of the industry's clout to affect the regulatory process and frequently influence an agency charged with protecting the health, safety, and welfare of Iowans," Lerner said at a public hearing.

But in the end, he lost. Again.

The legislation is not yet in force, but for Lerner it is another sign of the industry's grip on the state.

"I absolutely, positively believe that the federal government has a role and needs to step up to the plate."

Chapter 3: In Washington, a Lack of Will

National lawmakers have taken up the issue of assisted living several times. But those hoping Congress would go ahead and intervene have been disappointed.

In 2001, the Senate Special Committee on Aging was concerned enough to hold formal hearings, and Hillary Clinton appeared before her colleagues to articulate her worries about the inconsistent quality of care being offered around the country.

"Do consumers receive enough information to make wise choices?" Clinton, then a newly minted senator from New York, asked at the time. "I think we all understand that they don't. What assurances do consumers have that the care will be adequate?"

The senators saw to it that a working group of industry representatives, advocates, experts and regulators was formed and charged with making recommendations for how conditions in assisted living facilities could be made safer.

A year and a half later, the group produced more than 100 recommendations. Virtually nothing got done. Congress, for example, did not allocate money to sufficiently fund ombudsman programs in the states, offices that act as advocates for those in assisted living and other long term care facilities.

"It was preposterous," recalled Toby Edelman, an attorney with the Center for Medicare Advocacy who participated in the work group. "There wasn't even any agreement on what assisted living was. We couldn't agree on whether it was intermediate step for people before they went to nursing homes or whether it was an alternative to a nursing home."

A decade later, after the Miami Herald exposed widespread abuse in Florida facilities, the issue was back in front of Congress. Concern was again expressed. And with it, some frustration about what hadn't happened.

Florida Sen. Bill Nelson noted at a 2011 hearing of the Senate Special Committee on Aging that it wasn't just his home state that had problems. In Pennsylvania, emergency room workers removed 50 maggots from a resident's open facial wound, he said. In New York, a senior died after caretakers mistakenly gave her someone else's medication. In Virginia, police responded to a 911 call and found one resident lying on the floor calling for help while another was struggling with a catheter.

"So, we're going to have to ask ourselves in this hearing if we've been talking about the same problems for over 10 years, why are we still talking about it?" Nelson said. "What are the solutions?"

The committee itself ultimately offered no solutions.

To date, the federal government has stayed out of regulating assisted living. This is as the industry wants it.

"I know there are some very sincere people that would like to see federal regulation of assisted living," said Richard Grimes, president of the Assisted Living Federation of America, the industry group. "They would like to have a very simple definition of assisted living that everyone could live with that, that every community would look the same. And there would be one set of regulations to govern them. But that's just antithetical to what the philosophy of what assisted living is all about."

Assisted living, the industry maintains, should be about flexibility: the ability to tailor, state by state, community by community, the kinds of residential settings offered and the levels of care promised. Assisted living facilities can run the gamut from private homes converted to care for a handful of residents to more institutional facilities as large or larger than traditional nursing homes.

"It is about choice, and I just believe that choice is one of the biggest components to quality of life there is," said Granger Cobb, the chief executive officer of Emeritus.

If the federal government assumed responsibility, Cobb said, "they would have to approach it like they did skilled nursing and put everyone into the same box and say these are now the regulations. One size fits all. Everybody has got to do it this way."

Some advocates for the elderly say such claims are misleading. Federal rules for nursing homes take into account that not all homes are identical, they say.

"This is a false choice," said Eric M. Carlson of the National Senior Citizens Law Center. "Establishing basic consumer rights, and establishing some common-sense requirements for 'assisted living,' does not mean that operators are put into a one-size-fits-all box."

Still, over the years industry leaders have pressed this argument, turning out in force to make it in person in Washington.

Last month, for instance, more than 140 industry executives flew to Washington to meet with some 300 members of Congress and their staffs.

Their message:

"We're doing a great job," said Grimes, whose group spearheaded the effort. "Assisted living is working. And we're very pleased about the future."

Some regulators with experience at the state level agree that federal intervention could be a mixed blessing. State workers, their ranks already thinned by budget cuts, could wind up overwhelmed if asked to monitor assisted living facilities like nursing homes, even if the mandate comes with some financial aid from Washington.

"I'm not disparaging of nursing home regulation," said Rick E. Harris, a former regulatory official in Alabama who served on the national work group a decade ago. "It's not been a bad thing. It's been reasonably successful in improving quality of care in nursing homes. But state regulatory agencies have to have some flexibility because you only have so many resources."

Whatever the impact of the industry's lobbying in Washington, the lack of involvement by the federal government in overseeing assisted living is in many ways, not surprisingly, about money.

"A lot of this has to do with how this industry evolved," said Don Redfoot, a senior strategic policy advisor with AARP. "The high percentage of nursing homes receiving federal subsidies meant that federal government had a bigger obligation to step in and regulate. Assisted living evolved not out of a federal program, but rather largely as a private pay industry."

Barbara Edwards, director of Disabled & Elderly Health Programs for the Centers for Medicare & Medicaid Services (CMS), told lawmakers at the 2011 hearing in Washington that her agency has not taken a stance on the

issue of whether the federal government should take a more active role in regulating assisted living. She noted that CMS does require states to report on their systems of oversight and asks states to survey whether residents are getting appropriate care.

Those who favor a greater role for federal regulators see several ways they could help: by requiring minimum standards for staffing, resident rights, administration, and medication management; by stepping up enforcement for false advertising and consumer fraud; by enhancing state inspection and enforcement programs; and even by funding research on quality standards and their impact on outcomes in assisted living.

Some think federal involvement of some kind is just a matter of time. While most people in assisted living pay for their own care, the amount of federal money going into the industry has been ticking upwards. Today Medicaid helps to pay the bills for nearly 20 percent of assisted living residents nationwide, according to a 2010 survey by the U.S. Department of Health and Human Services.

"We are at a point where we need federal regulation of assisted living," said Lori Smetanka, director of the National Long-Term Care Ombudsman Resource Center. "First, because of the increasing frailty of people in assisted living. Second, because of the increasing federal money going into assisted living. As more federal dollars go for assisted living services, it's only reasonable to expect federal standards to go along with that."

ProPublica's Hanna Trudo contributed to this story.

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510-990-6317

SENIOR REACH®

Reaching Out ◆ Meeting Needs

Senior Reach: Serving Older Adults Since 2005

Amy Miller, LCSW
Senior Reach Coordinator &
National Consultant
(720) 595.0880
amym@jcmh.org
www.seniorreach.org

Growing Senior Population

- Senior population increased 30% from 2005-2015
- Projected to more than double by 2060
  - From 47.8 million to 98 million
- 14.9% of the US population is older American
- Average life expectancy = 84 years
- 85+ population to triple by 2040

Administration on Aging; Profile of Older Americans, 2016

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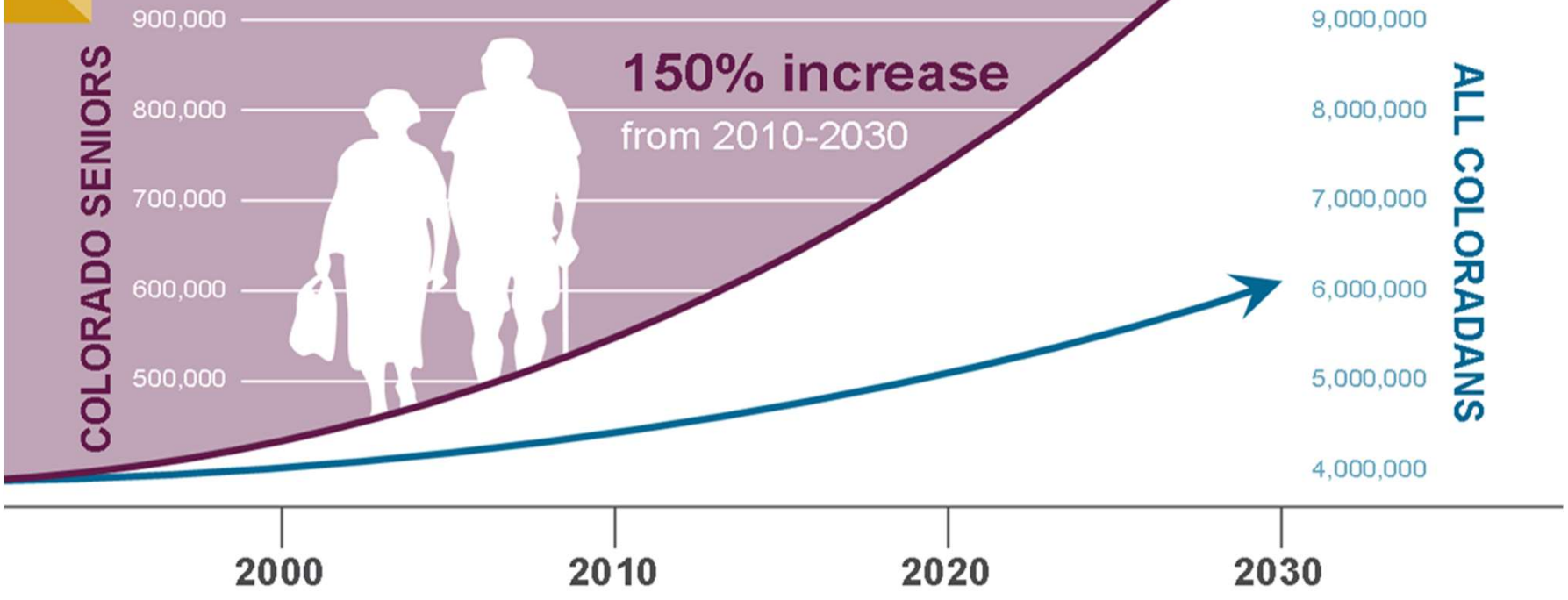
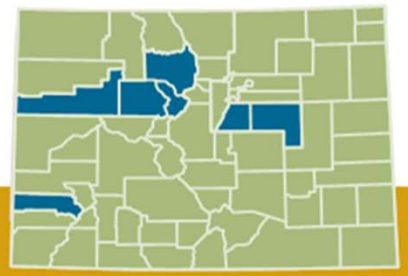
Colorado's senior population is **growing faster than all other age groups**



Some counties will see a **250% increase** by 2030:

Douglas, Eagle, Elbert, Garfield, Grand, San Miguel & Summit



Older Adult Behavioral Health Needs:	Prevalence
% of older adults with clinically significant ***depression***	**15-31%**
% of older adults with clinically significant ***anxiety***	**14-27%**
% of older adults using psychoactive ***prescription medication*** (pain, sleep, anxiety medications) that have substance abuse potential:	**25%**
% of older adults at risk of ***problem drinking***	**16%**
% of older adults affected by the combination of ***alcohol and medication misuse***	**19%**
% of older adults affected by ***post traumatic stress disorder***	**15%**

Substance Abuse and Mental Health Administration Issue Brief 2013

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The mission of Senior Reach is to support the well-being, independence and dignity of older adults by educating the community, providing behavioral health, care management services, and connecting older adults to community resources.

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Senior Reach – The Beginning

SENIORS' RESOURCE CENTER

Mental Health Partners
Healthy Minds, Healthy Communities

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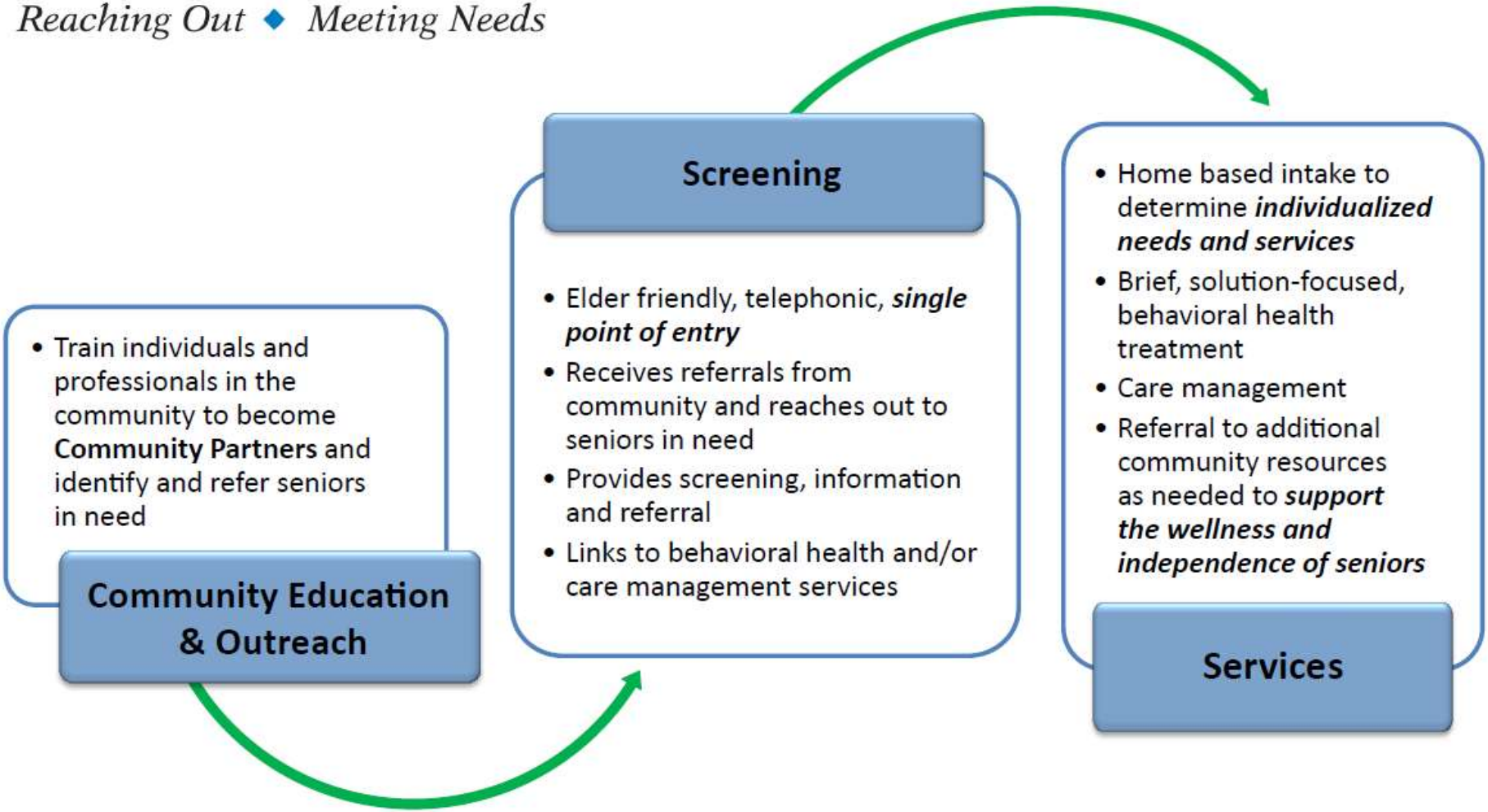
Reaching Out ◆ Meeting Needs

Key Components



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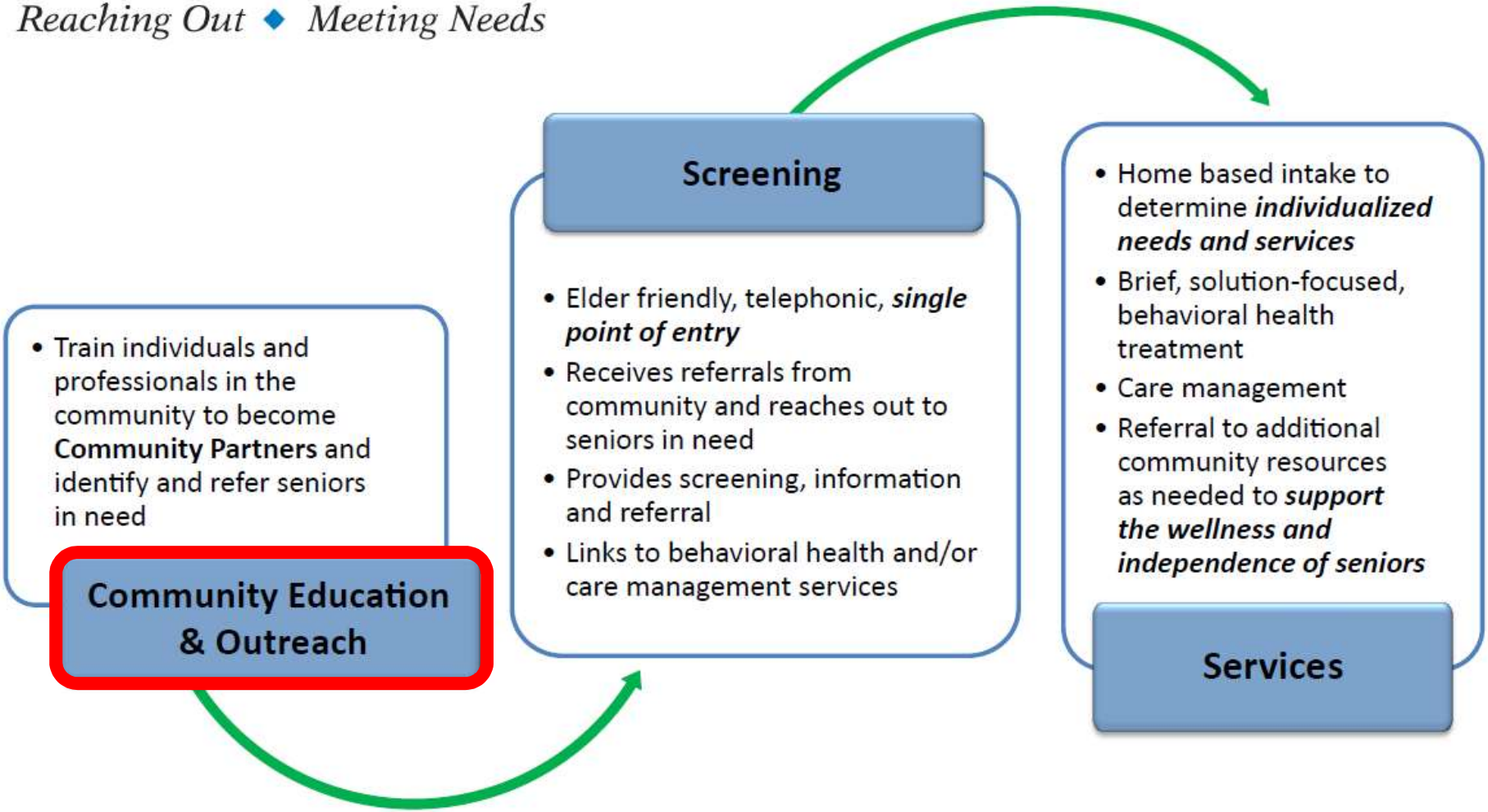
Key Components



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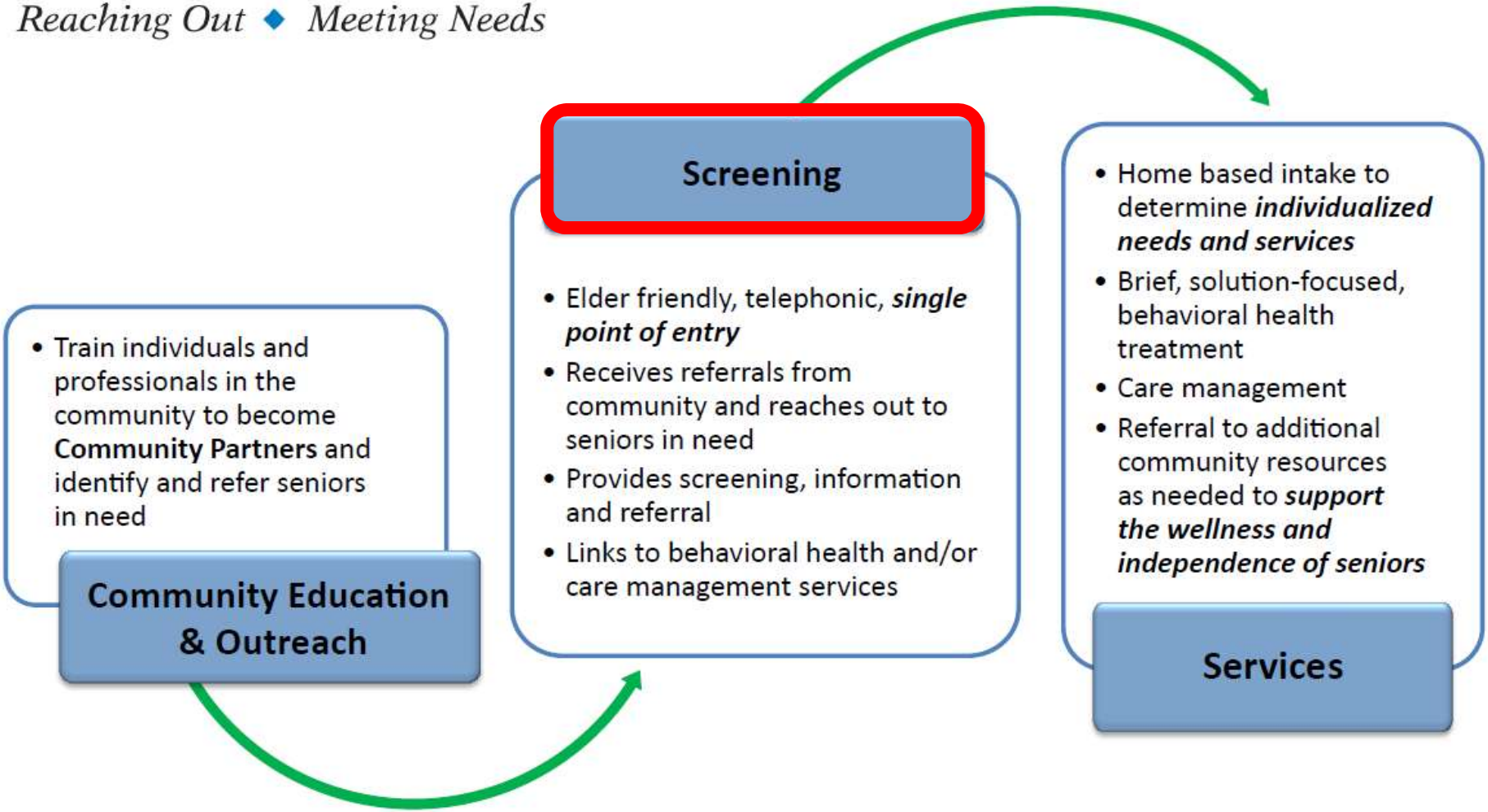

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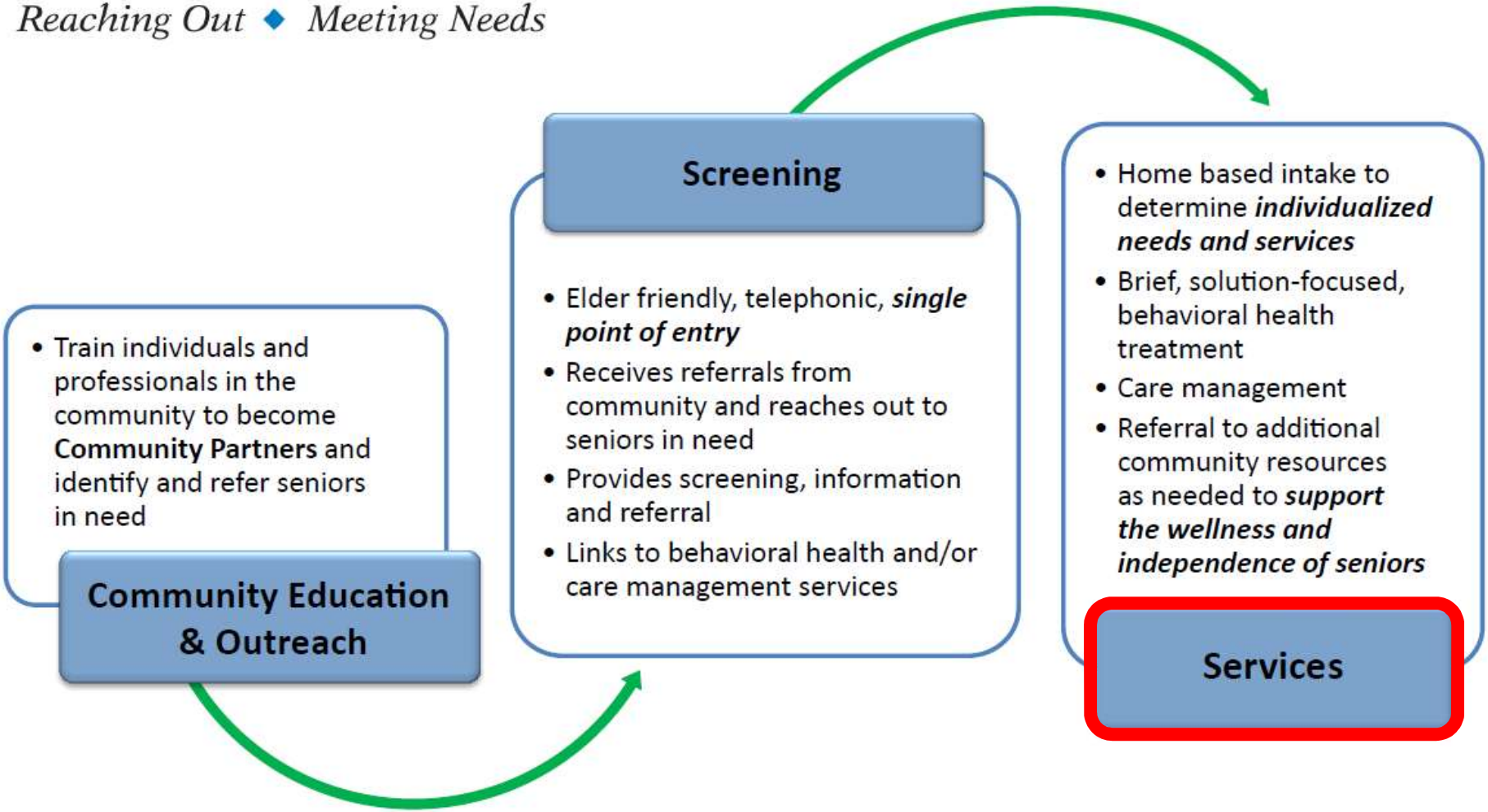
Key Components

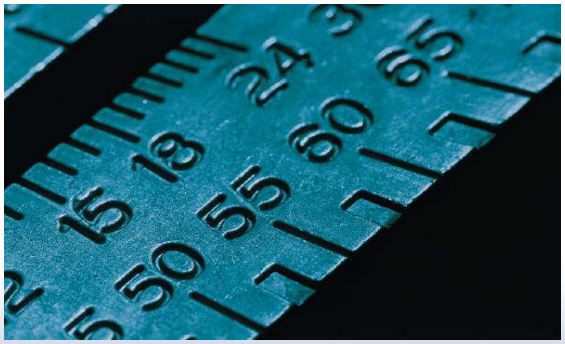


Senior Reach Sites

- Colorado
  - Jefferson Center/Mental Health Partners/Seniors' Resource Center
  - Community Reach Center
  - Axis Health System
- New Jersey
  - NORWESCAP
- Michigan
  - Copper Country
  - Easter Seals: Oakland
  - Easter Seals: West Michigan
  - Lapeer County
  - Livingston County
  - Northeast Guidance Center
  - Northern Lakes
  - Ottawa County
  - Saint Joseph County
  - Services to Enhance Potential
  - Van Buren County

Research Data- 14 Statistically Significant Outcomes

- Decrease in **depression**
- Decrease in **anxiety**
- Increase overall level of **functioning**
- Increase in **interpersonal relationships**
- Increased **social supports**
- Decrease in **emotional disturbance**
- Decreased **risk of suicide**

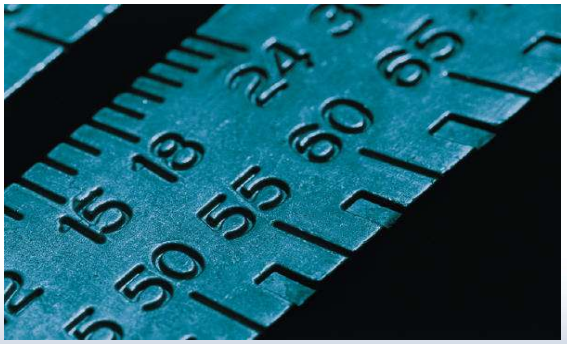


*Indicates statistically significant change at p< .05 from time of enrollment to discharge- paired sample t-tests.

Bartsch, D.A., & Rodgers, V.K. (2009). Senior Reach Outcomes in Comparison with the Spokane Gatekeeper Program. *Care Management Journals*, 3(10), 82-88.

Research Data- 14 Statistically Significant Outcomes (Continued)

- Increase in **overall recovery**
- Decrease in **overall mental health severity**
- Increase in **empowerment**
- Increase in functioning regarding **attention issues**
- Increase in **self-care/ basic needs**
- Increase in **hopefulness** about the future
- Decrease in **social isolation**



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Senior Reach: A Solution for Communities

- ✓ Reduced service fragmentation
- ✓ Proven engagement rate
- ✓ Proven population- based, health intervention that focuses on prevention
- ✓ Access to behavioral health and other community based services
- ✓ Proven clinical outcomes
- ✓ Proven customer experience/satisfaction
- ✓ Improving the lives of Seniors and their communities

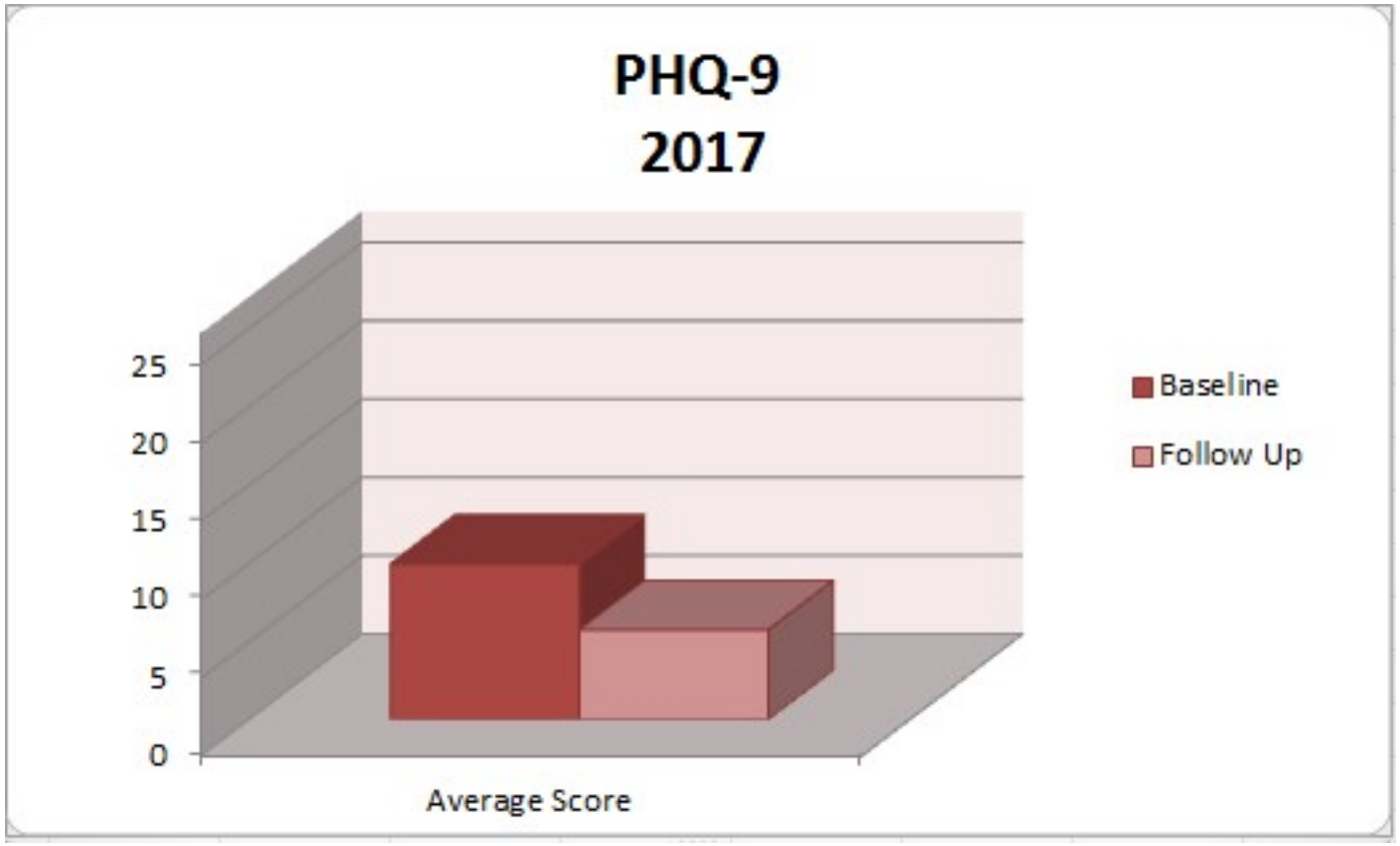
Senior Reach Impact 2005-2018
Jefferson, Clear Creek, Gilpin, Boulder, & Broomfield Counties

Community Partners Trained	36,000
Seniors Receiving a Behavioral Health Episode of Care	3,600
Number of Seniors Who Have Received Wellness Services	7,901

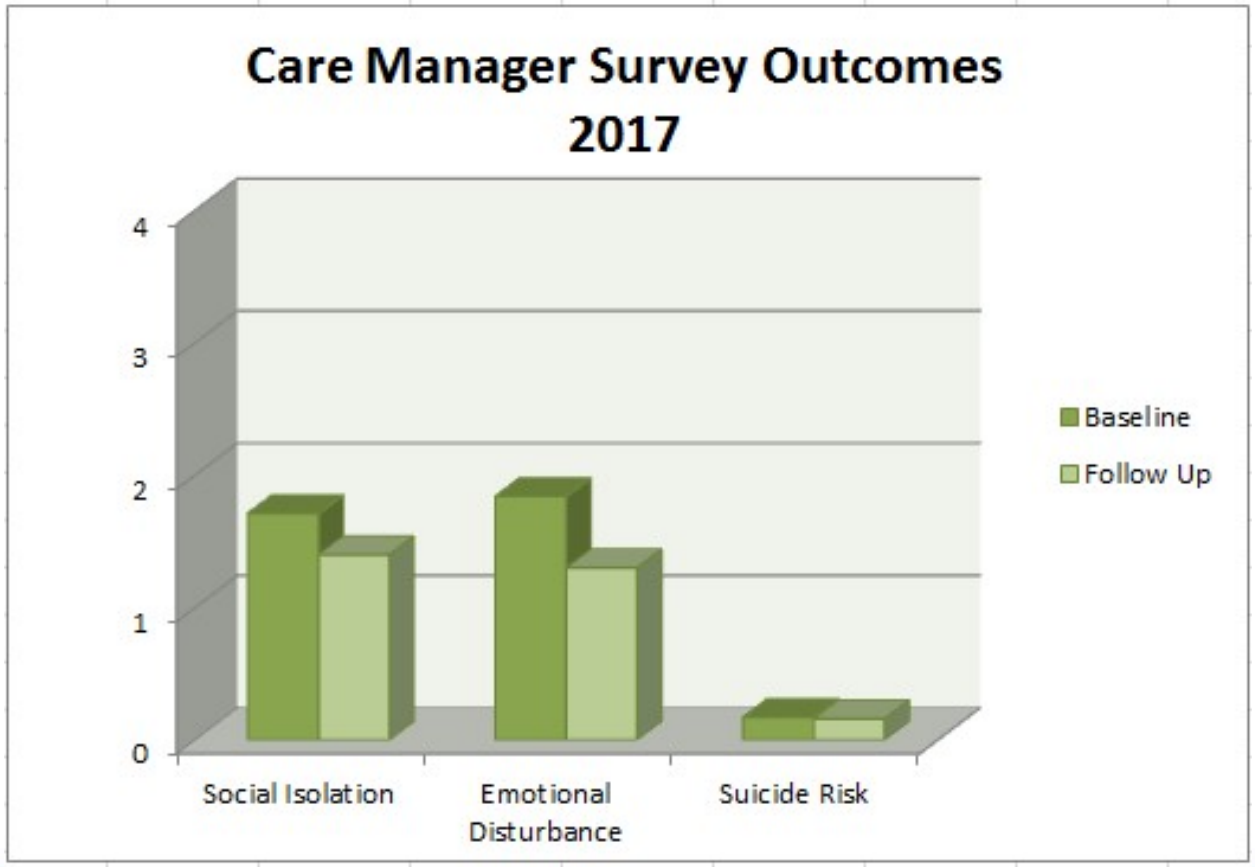
Jefferson Center/Mental Health Partners/Seniors' Resource Center Senior Reach Program Outcomes: 2017

- 458 Clients Served
- Average age = 73
- Average Treatment Length = 78 Days

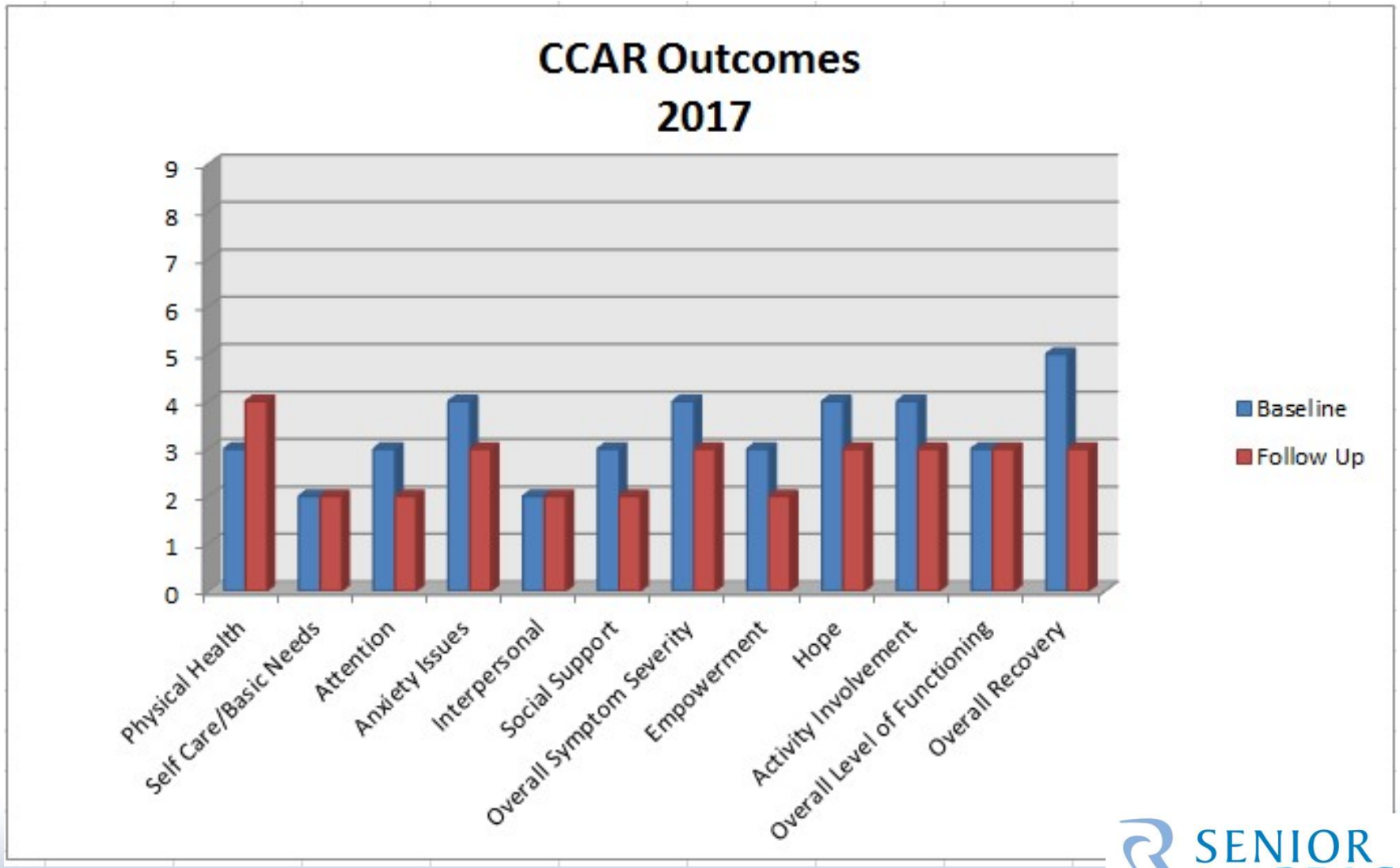
JC/MHP/SRC Program Outcomes: 2017 Depression



Program Outcomes: 2017
Social Isolation, Emotional Disturbance, Suicide Risk



JC/MHP/SRC Program Outcomes: 2017



Client Satisfaction Surveys – 2017

- 59 Responses
- 98% would recommend SR to someone they know
- 98% would call SR if they needed help again.
- 100% said SR helped their situation.
  - 83% said it made a big difference
- 85% said it was “Important” or “Extremely Important” for SR staff to be able to meet them in their home.
- “As a result of my work with the Care Manager/Clinician, my situation improved.”
  - 20% - Some
  - 80% - A Lot

Quotes from Senior Reach Clients:
"What did you like best about the services you received?"

- "She helped with my depression, isolation, and feelings of loss. She let me talk about things that important to me and had resources at hand that helped me be more self-sufficient."
- "My counselor was amazing - so knowledgeable, and sincerely caring. I could ask her anything and valued and trusted her opinion. It was a blessing to have her in my life at that time I needed her."
- "Very important that she came to my home. She was a great listener & she was able to tell me about other senior resources. I am just starting therapy, without these sessions I don't think I would be in therapy now - I didn't know any therapists."
- "Helped maintain my routine with Bipolar and kept me out of hospital or crises."
- "The therapist was extremely professional and compassionate. She truly helped me through one of the most difficult times in my life."
- "My counselor was always willing to listen without judging - offering other views when appropriate and offering a book with outstanding resources. Loved her! She was excellent."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drvr
Program of DRCOG

Visualize regional data stories

Looking for local insights and regional context on economic, demographic and transportation topics? Check out the Denver Regional Council of Governments Denver Regional Visual Resources (DRVR) site for interactive, data-driven visualizations.

Start exploring at **drcog.org/DRVR**

We make life better!
drcog
DENVER REGIONAL COUNCIL OF GOVERNMENTS

Open data for the Denver region

The Regional Data Catalog is a repository of open data managed by the Denver Regional Council of Governments. The data sets support communities in making informed, data-driven decisions related to mobility, land use and changing demographics. Start exploring at **data.drcog.org**

SENIOR REACH®

Reaching Out ◆ Meeting Needs

Jefferson/Clear Creek/Gilpin/Boulder/Broomfield

866-217-5808

Adams County

303-853-3657

Amy Miller, LCSW, Senior Reach Coordinator and National Consultant

amym@jcmh.org; 720-595-0880

AAA Director's
Activity Summary
February 15 – March 15, 2018

Advocacy, Education and Policy:

- Presentation on Aging Well at Zion Baptist Church
- Presented "What DRCOG AAA is Up to" to several students in the Knoebel Health Institute on Aging at DU
- Attended 2 phone meetings with Innovations subcommittee of Mission Forward the national committee working on the reauthorization of the Older American's Act.
- Provided an onboarding presentation to two new ACA members

Coordination and Outreach

- Met with Bonnie Silva the Deputy Director of Community Living and Policy, Innovation and Engagement to talk about what DRCOG is doing and how we might partner in the future.
- Conducted and hosted the first planning meeting of the SAPGA Transportation subcommittee.
- Conversation with Therese Ellery about applying for $15,000 from the Rose Foundation for Network of Care.
- Attended the Older Adults community/HCPF/State Unit on Aging meeting
- Participated in an all-day strategic planning meeting for the Veterans Directed-HCBS program.
- Meeting with Nashville AAA and COG staff to talk about the growth and success of our AAA.
- Meeting with TerraFrame to talk about partnering on an application to Intel to support the AHC models data integration challenges.
- Meeting to discuss a statewide Aging Summit with Governor's Senior Policy Advisor, State Unit on Aging staff, members of SAPGA and the Colorado Commission on Aging.
- Meeting with Wade Buchanan, Governor's Senior Policy Advisor and Brad Calvert Director of Planning and Development, DRCOG on helping Colorado become a senior friendly state.
- Meeting with Executive Director of Next Fifty and the No Copay Radio guys to talk about sponsorship of the Radio program.

Compliance and Management

- One on one meetings with direct reports
- Meeting with Sharon to discuss AAA contracts and finances
- Met with Trilogy to discuss the launch of new models of Network of Care
- Hosted Pizza with Jayla a time for AAA staff to get together ask me Questions and tell positive work stories
- Conducted a new hire orientation

- Attended DRCOG division director's meetings
- Attended DRCOG Board Orientation
- Attended Tier 1 Score Card objectives
- Attended Division Directors meeting and DRCOG Board meetings
- Conducted a monthly AAA staff meeting
- Reviewed parking at the new building for staff and ACA
- Participated in the DRCOG legislative breakfast at the Capitol
- Attended several meetings on the new building and the move

Partnership Development and Special Projects:

- Meeting with A&F to talk about AHC and how we will pay providers for data, track and verify data and report to CMS.
- Attended the AHC advisory committee.

Media

- Co-hosted No Copay radio – taped 4 programs guest included Bob Wells, and Dave Johnson the founders and writers of Chicken Lips an acclaimed improv/comedy theater show. They talked about the value of humor and the positive effects of laughter on health. Kim Curtis the CEO of Wealth Legacy Institute who talk about retirement,
- 9 News interview with Sonia Gutierrez about closures of assisted living in the region