

Building Adult Foster Care: What States Can Do

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Research Report

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AARP's Public Policy Institute informs and stimulates public debate on the issues we face as we age. Through research, analysis and dialogue with the nation's leading experts, PPI promotes development of sound, creative policies to address our common need for economic security, health care, and quality of life.

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EXECUTIVE SUMMARY

People who need long-term services and supports (LTSS) want more options to live outside institutions. To create choices for persons who prefer more homelike support in small residential settings, pioneering states such as Oregon and Washington established adult foster care (AFC) for both private pay and publicly subsidized persons more than 30 years ago. AFC homes operate in local communities, where people engage in social interactions as they get help with personal care, medications and health-related activities, money management, housekeeping, and transportation to appointments.

To help state policymakers consider ways to make AFC available to more people, the AARP Public Policy Institute (PPI) conducted the first national review of AFC more than a decade ago.¹ That report remains the only comprehensive review of AFC. As more states attempt to balance LTSS to offer consumers a broader array of services,² they need to consider how to develop, regulate, and fund an array of home and community-based services (HCBS), which might include AFC. This study offers an update of the 1996 review of AFC regulations, and public and private approaches to developing and funding AFC.

The study seeks to better understand the role of AFC within the array of LTSS, presents a summary of each state's regulations or standards that apply to small residential settings, examines the role of the Nurse Practice Act on the scope of services available in AFC, and explores trends and the issues facing providers. It focuses on homes that provide care to older adults and adults with physical disabilities. The report enhances our understanding of the factors that influence the supply of AFC and offers policy recommendations to address the needs of providers and consumers by promoting the expansion of consumer choice in long-term care.

KEY FINDINGS

As of 2008, states reported that 18,901 licensed and certified facilities were operating, with a capacity to serve 64,189 residents. States regulate AFC through general licensing/certification regulations for small residential settings; Medicaid participation standards or regulations; and assisted living regulations, which apply to facilities that serve more than a specified number of residents.

While state policy environments and related marketplaces vary greatly, our general findings include the following:

- ***AFC is an attractive option for many.*** Despite market contraction in several states, state officials, long-term care advocates, and AFC providers view AFC as an important facet of the long-term care landscape. AFC offers a more homelike setting than large residential care options. Anecdotal evidence suggests that many older adults prefer a small setting rather than nursing homes or large assisted living facilities.

¹ Folkemer, D., A. Jensen, L. Lipson, M. Stauffer, and W. Fox-Grage, *Adult Foster Care for the Elderly: A Review of State Regulatory and Funding Strategies* (Washington, DC: AARP Public Policy Institute, 1996).

² Kassner, E., S. Reinhard, W. Fox-Grage, A. Houser, J. Accius, B. Coleman, and D. Milne, *A Balancing Act: State Long-Term Care Reform* (Washington, DC: AARP Public Policy Institute, 2008).

- ***States use a variety of regulatory frameworks.*** Twenty-nine states have regulations to license or certify AFC; 6 states have regulations or standards for AFC to participate in the Medicaid program; and 17 states cover AFC through assisted living regulations. Texas licenses AFC and sets additional standards for providers that serve Medicaid beneficiaries. Two states (Hawaii and Texas) use multiple approaches, depending on the size of the facility or the number of licensing categories. Provider perspectives on licensing and oversight are mixed; however, several providers suggested a bifurcation in state oversight, perhaps depending on resident characteristics. For example, some providers suggested a certification program with ongoing training requirements for those who serve lower acuity residents and licensure for those who serve higher acuity residents.
- ***Many AFC providers started out as family caregivers.*** Many of the providers in the studied states are former registered nurses, licensed practical nurses, or certified nursing assistants. Some providers started out caring for a relative or a spouse and recognized the potential to use these skills to care for others in their own home while earning a living. The majority of providers enjoy providing this service, but many stress the need for respite services and state support. Most important is access to adult day care and assistance with ongoing training, particularly related to geriatric care and care of persons with complex needs.
- ***Few AFC providers make a profit; most break even.*** Services in AFCs are covered by Medicaid §1915(c) and §1115 waivers in 14 states; under the Medicaid state plan in 7 states; and through general revenues or state supplements to the federal Supplemental Security Income (SSI) in 16 states. In general, AFC providers break even; few said they make a profit, with the exception of one privately owned group of homes and two commercially operated chains. Most of the revenue (approximately 80 percent) comes from service payments, with the remainder coming from room and board payments. Many providers noted the need to carefully balance the proportion of private pay residents with Medicaid residents to ensure viability.
- ***Availability of AFC has declined. In some states, such as Arizona, the number of AFCs has declined over the past decade, mainly due to competition from other HCBS options.*** Expansion of both market rate and affordable assisted living appears to be driving AFC market contraction. In some states, such as Washington and Oregon, inadequate payment appears to be responsible for market contraction. AFC providers continue to offer services, but fewer accept Medicaid beneficiaries because of concerns about adequate reimbursement. Both states have taken steps to address Medicaid reimbursement challenges. Officials in Oregon and Washington are recruiting new providers to reverse the gradual decline in recent years. Other states, such as Wisconsin, are trying to spur the development of AFC by promoting tax incentives for AFCs that serve five or fewer residents.
- ***AFC provides services to people with substantial disabilities.*** Despite the expansion of assisted living, the AFC literature and state case studies document the willingness and capacity of AFC providers to serve people with high levels of need. Assisted living providers may not consider higher need individuals to be attractive clients because of low Medicaid rates, staffing ratio challenges, and, in commercial chains, the visual and psychological impact on prospective clients. Nevertheless, the increase

in acuity among residents affects the number of persons AFC providers can serve in their homes.

- ***Access to nursing care services for AFC providers is a problem.*** Many providers reported challenges accessing nursing care for residents with more intense health care needs. In some states, private duty nursing is available under the state Medicaid plan or under the same §1915(c) waiver that provides AFC Medicaid funding. In other cases, the state or a local authority coordinates the delivery of nursing care in AFC. Regardless of the source, however, AFC providers reported difficulty securing nurses' time. There is a serious need to examine the extent to which nurses can delegate some tasks to others who can safely perform them.
- ***Most AFC providers are small operators and need more training and assistance.*** Providers need appropriate training to serve higher acuity residents, respite services to avoid burnout, and assistance with developing appropriate business tools. Most AFC providers are single-home operators and use very rudimentary business tools, such as Quicken or a homemade Excel tool. The majority of single-home or small multihome operator interviewees expressed the need for assistance with business practices, including start-up, ongoing operations in response to market changes, and expansion. Few AFC providers are owned or managed by commercial chains; those that are expressed less need for business supports. All providers emphasized the need to achieve and maintain a private-Medicaid payer mix to ensure viability.
- ***Leveraging natural supports and community connections can help AFC providers.*** Many providers noted the value of engaging family members to assist with care, such as transportation to doctor appointments or to provide respite care. Additionally, providers realized the value of local or state strategies that link them with other services, such as volunteer organizations, Area Agencies on Aging (AAA) services, additional Medicaid benefits, and other public benefits.

CONCLUSIONS AND RECOMMENDATIONS

In the current economic environment, states are facing major budget shortfalls and are looking for viable options to provide services and supports to older adults and people with disabilities. In comparison with knowledge about nursing homes, the role of adult foster care as a viable home and community-based option in the long-term care landscape is not well understood. From the state budgetary perspective, AFC may be a cost-effective alternative to institutional care. From the perspective of consumers, AFC can enhance their ability—regardless of age or income—to participate as fully as possible in all aspects of community living. This report aims to increase awareness about and knowledge of adult foster care. It makes the following recommendations to states that are considering developing or expanding AFC:

- Ensure that the single point of entry (SPE) system for long-term care services and supports provides information on AFC. Information should include a clear description of AFC compared with board and care homes and assisted living residences. Adult foster care can be an affordable LTSS option for those who can pay privately, at least for several months or years.
- Educate consumers about AFC, and develop a matching strategy to ensure that providers can meet the needs of AFC residents.

- Create a uniform disclosure form to provide consumers with comparable information among providers on services and rates.
- Develop clear nurse delegation policies to support AFCs' ability to provide care to residents. Possible strategies include using contract nurses or embedding nursing in the AFC Medicaid program to provide clinical assistance to providers. Better training, consulting, and oversight by nurses can improve the viability of AFC as a service delivery model.
- Implement training programs for providers, resident managers, and family caregivers as a state service within an AFC program.
- Consider developing a tiered reimbursement rate system based on operational costs rather than basing rates on a percentage of nursing home or assisted living payments.
- Establish appropriate case management resources for AFC residents, and develop caseload parameters.
- Develop a systematic, objective mechanism to screen AFC provider applicants for licensure.
- Provide respite personnel or substitute caregivers for AFC providers and resident managers.
- Develop a proactive recruitment process for AFC providers.
- Consider limits on multiple home ownership by an individual provider.
- Consider specialized licensing to address the needs of special populations and residents with higher acuity.
- Consider targeted financial assistance for AFC providers and other small HCBS providers.

INTRODUCTION AND BACKGROUND

People who need long-term services and supports (LTSS) want more choices for homelike support in small residential settings. More than 30 years ago, pioneering states such as Oregon and Washington established adult foster care (AFC) for both private pay and publicly subsidized individuals. AFC homes operate in local communities; they offer help with personal care, medications and health-related activities, money management, housekeeping, and transportation.

The AARP Public Policy Institute (PPI) conducted the first national review of AFC more than a decade ago to help policymakers consider ways to make it more available.³ That report is still the only comprehensive review of AFC. Today, more states are attempting to balance LTSS to offer consumers a broader array of services.⁴ To do this, they need to consider how to develop, regulate, and fund an array of home and community-based services (HCBS), which might include AFC. This study offers an update of the 1996 review of AFC regulations and suggests approaches to developing and funding it.

The 1996 AARP Public Policy Institute report found wide variations across states in terminology, definition, and regulation of AFC. For example, states use various terms for adult foster care, including adult family care, adult family care home, and domiciliary care. Several notable themes emerged from the 1996 report:

- AFC homes provide supervision, oversight, and personal care.
- AFC homes serve a small number of persons. Most states set the limit at five or fewer older adults.
- Operators include homes owned by families as well as by corporations (authorized in 11 states). Corporate homes account for most of the expansion in states that are increasing the supply of AFC.
- In states that do not have well-established provisions in the Nurse Practice Act, AFC homes are sometimes unable to serve people who need assistance with administration of medications.
- AFC homes are sometimes unable to serve persons who display disruptive behaviors.
- Recruiting and training providers are critical to expand the supply and maintain a high quality of care.

There has been a lack of research on AFC since the PPI report 13 years ago. Recently, Mollica and colleagues (2008) examined AFC policies and practices in Arizona, Maine, Oregon, Washington, and Wisconsin. They found that AFC is still a viable alternative to nursing home care for older adults and people with disabilities who prefer to live in the

³ Folkemer et al., 1996.

⁴ Kassner et al., 2008.

community.⁵ However, in comparison with nursing homes, there is a lack of awareness of AFC among many policymakers and practitioners.⁶ At the same time, states are facing budgetary shortfalls and are cutting back on services. Furthermore, an aging America, rising demand among consumers to receive LTSS in their homes and communities, and initiatives at both the federal and state levels to shift resources from institutional care toward HCBS have increased the need for expanded alternatives to institutional care.

These dynamics are revolutionizing the delivery of LTSS as a way to delay or even prevent the need for institutional care. However, there is a mixed view of the need and demand for AFC. Some states are expanding AFC, others are reinvesting in and rebuilding these programs, and some are contracting this model of service delivery.

METHODOLOGY

The AARP Public Policy Institute (PPI) contracted with the National Academy for State Health Policy (NASHP), the Rutgers Center for State Health Policy (CSHP), and NCB Capital Impact to update the 1996 PPI report on AFC and inform our understanding of emerging issues in AFC. In particular, we offer recommendations that would be useful for state policymakers, providers who are interested in AFC, and consumers who are interested in this model of service delivery.

This report reviews the current regulatory, licensure, and reimbursement policies of AFC within the array of long-term care services and supports. Data sources included state Web sites, telephone interviews, and emails with key contacts from licensing, aging, and Medicaid agencies in each state. Because many people who need LTSS also need help with medications and other health-related tasks, the report analyzes Nurse Practice Act statutes and regulations and their applicability to AFC settings. In August 2008, the PPI convened a Policy Innovations Roundtable with thought leaders, state officials, and consumer advocates to explore these issues. We incorporate the themes that emerged from this meeting throughout the report.

The report has a strong focus on both public and private sector development of AFC. States cannot develop a full array of LTSS options alone, and pioneer states such as Oregon and Washington have found that private pay and family support funds two-thirds of AFC.⁷ To achieve a mix of sizes and types of providers, we examine the operations, challenges, barriers, and opportunities of AFC providers in 11 states. The study team divided states into two groups: states that have had large AFC programs for a number of years (e.g., early implementers) and states that are implementing or significantly expanding AFC (see table 1). In each state, the study team interviewed at least one state official, a community informant (typically an advocacy organization), and several individual providers (8–10 providers per state).

⁵ Mollica, R., M. Booth, C. Gray, and K. Sims-Kastelein, *Adult Foster Care: A Resource for Older Adults* (New Brunswick, NJ: Rutgers Center for State Health Policy, 2008).

⁶ Reinardy, J., and R. Kane (1999), "Choosing an Adult Foster Home or a Nursing Home: Residents' Perceptions about Decision Making and Control," *Social Work* 44(6): 571-585.

⁷ Ibid.

Table 1	
Study States	
Early Implementer	
State	Market Trend
Arizona	Contracting – Assisted living expansion
Massachusetts	Expanding – Changes in policy related to the Community First effort
Minnesota	Expanding – Strong commercial chain presence
Oregon	Contracting – Assisted living expansion
Pennsylvania	Expanding -- Change in another program led to AFC expansion
Washington	Expanding – Strategy to meet demographic trends with an emphasis on supporting more intensive care providers
Wisconsin	Expanding – Rebalancing effort
Rationale for Adding or Expanding AFC	
Arkansas	New residential care option
Hawaii	Expanding AFC as part of a strategy to expand home and community based services
Indiana	New Residential Care Option as part of Nursing Home Rightsizing
South Carolina	Possible “qualifying residence” for Money Follows the Person transitions

WHAT IS ADULT FOSTER CARE?

The 1996 PPI report found little consensus on an appropriate AFC definition. In fact, the authors found great variation across the states in program definitions, regulatory mechanisms, administrative approaches, and funding sources. As a result, for state comparison purposes, the authors of the study used the following operational definition of AFC:

Adult foster care offers a community-based living arrangement to adults who are unable to live independently because of physical or mental impairments or disabilities and are in need of supervision or personal care. Homes providing adult foster care offer 24-hour supervision, protection, and personal care in addition to room and board. They may provide additional services. Adult foster care serves a designated, small number of individuals (generally from one to six) in a homelike and family-like environment where one of the primary caregivers resides in the home.⁸

The 1996 study identified 26 states with programs that met this operational definition and 8 others with more limited activities. States use various terms for AFC, including adult family care, adult family care home, and domiciliary care. The interviews with state officials highlighted the variations in defining and labeling AFC homes. Given the variation in responses, the authors focused on *how states treat homes that serve one or more persons*. Framing the question around homes that serve one or more persons enabled

⁸ Folkemer et al., 1996.

us to include states that do not typically use the term AFC but rather “residential care for older adults” or “assisted living residencies.”

Similar to the 1996 report, great variation exists among the states in rules for certification, licensure, and thresholds. The mixture of funding sources (i.e., private pay and Medicaid) in one home often complicates these rules. For example, Maine does not mandate licensure of providers who serve one or two people; however, providers must be licensed as a residential care facility if they serve three to six people.

To disentangle some of these variations, table 2 compares AFCs with similar service arrangements.

Table 2	
Adult Foster Care and Similar Residential Care Settings	
Settings	Characteristics
Adult foster care homes, adult residential care homes, small group homes	<ul style="list-style-type: none"> • Private home in a residential-zoned neighborhood • No more than five or six older adults or persons with physical disabilities per facility • No more than two residents to a room • Nonmedical services such as meals, medication supervision or reminders, or help with some activities of daily living (ADLs) • May provide some skilled nursing services, but not 24-hour skilled nursing care
Board and care facilities, large group homes	<ul style="list-style-type: none"> • Dormitory-style or ward-type facility • Four or more beds per facility • Three to four people may share a room • Mixed population • Nonmedical services such as meals, medication supervision or reminders, or help with some ADLs • May provide some skilled nursing services, but not 24-hour skilled nursing care
Assisted living facilities with private or semiprivate rooms	<ul style="list-style-type: none"> • Facility with private or semiprivate rooms • Each facility has four or more residents • Lockable room doors are permitted • Mainly serve only frail older adults • Freestanding facility • Basic level of care: provides meals, medication supervision, personal care, leisure activities, housekeeping, and laundry services • High level of care: provides RN/LPNs on staff. Extensive admission and retention criteria and high resident acuity
<p>Source: Adapted from the Inventory of Long-Term Care Residential Places Project (Han, Sirrocco, and Rensbury 2003). In Spillman, B., and K. Black, <i>The Size of the Long-Term Care Population in Residential Care: A Review of Estimates and Methodology</i> (Washington, DC: U.S. Department of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation, 2005).</p>	

Adult foster care can fall into three categories (see table 3). **Single home, owner-occupied “mom and pop” residences** are arrangements in which a person or household has become an AFC provider. These homes typically accept self-referrals and referrals from state or county agencies, or they might work with a referral entity. **Corporate chains** are arrangements in which a company, for-profit or nonprofit, owns or rents the property and is responsible for all business operations. Services are delivered by staff who live onsite. Corporate arrangements are feasible only in states that do not require the owner/operator to be a resident. **Agency-sponsored homes** are arrangements in which the home owner/operator is in residence but relies on an agency for referrals, training, oversight, and some business functions. While corporate ownership of multiple homes is increasing, family-owned and -operated homes are still the dominant provider type. Thus, this report primarily focuses on single-home operators and the motivations for such people to become AFC providers.

Table 3 Adult Foster Care Models and Related Resources						
Model	Referrals	Revenue	Respite for Owner/ Operators	Business Supports	Clinical Care	Property Ownership
Single-home owner/operator	Direct from community, generated by word of mouth or advertising; referrals from locality or state	Payments made directly to AFC from state or residents	Arranged by provider	Arranged by provider or state	Arranged by provider or state	Resident owner/operator
Corporate homes	Referrals routed to homes through central administrative unit	Payments made to homes by corporate entity	Arranged by corporate entity	Arranged by corporate entity or state	Arranged by corporate entity or state	Corporate entity
Agency-sponsored homes	Referrals routed to homes through sponsor agency	Payments made to agency	Arranged by agency	Arranged by agency or state	Arranged by agency or state	Resident operator

All three AFC models often require the presence of an adult caregiver 24 hours a day. Typically, AFC homes operate in their communities and provide a range of services, including social activities, assistance with personal care, transportation to appointments, assistance with money management, housekeeping services, supervision, oversight, and help with medications.

WHAT ARE THE CHARACTERISTICS OF AFC RESIDENTS?

Adult foster care serves a heterogeneous population of persons who can no longer live alone. Residents may have varying levels of need for supervision and assistance with bathing, eating, dressing, as well as with shopping, cooking, and housekeeping. Research

indicates that AFC providers serve residents with high-acuity needs⁹ and that a disproportionate number of residents are very frail and low-income older adults.¹⁰ Some state officials interviewed for this report said that AFC providers are more willing to take high-acuity people than are nursing homes or assisted living providers.

Furthermore, AFC residents may not need or prefer the level of care provided in an institutional setting. For example, an empirical study that surveyed Oregon residents in AFC and nursing home settings regarding their decision to relocate found that AFC residents valued the homelike atmosphere, privacy, and flexible routine. Nursing home residents indicated that medical care and physical rehabilitation influenced their decision to choose that option. Interestingly, the study found that more AFC residents than nursing home residents considered their move to have been a good choice.¹¹

To create and maintain a family-like environment, most AFC providers serve a small number of residents—up to six in some states. The small setting and personal atmosphere can be beneficial for residents. Some researchers suggest that persons with early to mid-stage dementia can benefit from a family-like setting,¹² and a study that compared AFC settings with nursing homes found that residents in AFC settings had more favorable social and psychological outcomes.¹³

HOW MANY PEOPLE ARE SERVED IN AFC?

Thirty states reported a total of 18,901 AFC facilities, with a capacity to serve 64,189 residents (see table 4). However, these data underestimate the number of AFCs and the total capacity. For example, owing to variations in regulatory practices across states, small facilities licensed as assisted living are not included in the totals or in table 4. Twelve states license small and large facilities under assisted living regulations.¹⁴ Oregon reported the largest number of licensed AFC providers (3,235), yet Washington reported the highest capacity (15,205 beds). Oregon licenses homes that serve one to five residents, while Washington's rules apply to homes serving two to six residents. States that license small AFC-like settings under assisted living regulations are in italics in the table, and data on the supply of small homes are not included.

⁹ Curtis, M., A. Kiyak, and S. Hendrick (2000), "Resident and Facility Characteristics of Adult Family Home, Adult Residential Care, and Assisted Living Settings in Washington State," *Journal of Gerontological Social Work* 34 (1): 25-46.

¹⁰ Carder, P., L. Morgan, and K. Eckert (2006), "Small Board-and-Care Homes in the Age of Assisted Living," *Generations*.29 (4): 24-31.

¹¹ Reinardy, J., and R. Kane (1999), "Choosing an Adult Foster Home or a Nursing Home: Residents' Perceptions about Decision Making and Control," *Social Work* 44(6): 571-585.

¹² Stark, A., R.I. Kane, R.A. Kane, and M. Finch (1995), "Effect of Physical Functioning of Care in Adult Foster Homes and Nursing Homes," *The Gerontologist*.35 (5): 648-655.

¹³ Ibid.

¹⁴ In the absence of a standard for the size of an AFC home and the difficulty of obtaining data based on the size of facilities, states that cover AFC under assisted living regulations are not included.

Table 4			
Adult Foster Care Supply			
State	Licensing Range	Licensed AFCs	Capacity
AL	Not specified	72	95
AK*	3+	NA	NA
AZ	1-4	92	361
AR	1-3	Start-up	-
CA	<i>Not specified</i>	NA	NA
CT	1-2	Phasing out	-
CO	3+	NA	NA
DE	2-3	120	360
DC	1+	NA	NA
FL	1-5	491	2,172
GA	2-6	553	1,826
HI	1-5	420	2,105
	1-3	869	NR
ID	1-2	1,675	2,551
IL	3+	NA	NA
IN	1-4	39	50
IA	3-5	9	45
KS	1-8	74	480
KY	1-3	93	272
LA	2-8	32	213
ME*	3-6	463	1,826
MD	<i>Not specified</i>	NA	NA
MA	1-3	NR	1,500
MI*	1-6	1,199	5,651
MN	1-6	928	3,374
MO	3+	NA	NA
MS	Not specified	Start-up	-
MT	1-4	95	246
NE	1-3	100	NR
NV	1-2	205	410
NH	1-2	NA	15
NJ	1-3	30	34
NM	2+	NA	NA
NY	1-4	500	1,500
NC	2-6	631	3,513
ND	1-4	70	90
OH	1-2	80	160
	3-6	407	1,916
OK	2+	NA	NA
	1-3	NA	NA
OR	1-5	3,235	9,249
PA	1-3	648	1,813
RI	2+	NA	NA
SC	2+	NA	NA
SD	1-4	32	78
TN	NR	NR	NR

Table 4 (continued)			
Adult Foster Care Supply			
State	Licensing Range	Licensed AFCs	Capacity
TX*	1–8	163	NR
UT	1–3	0	0
<i>VT</i>	3+	<i>NA</i>	<i>NA</i>
VA	1–3	NR	NR
WA	2–6	2,747	15,205
WV	1–3	271	372
WI	1–2	1,145	4,414
	3–4	1,413	2,293
WY	1–5	NR	NR
Total	–	18,901	64,189

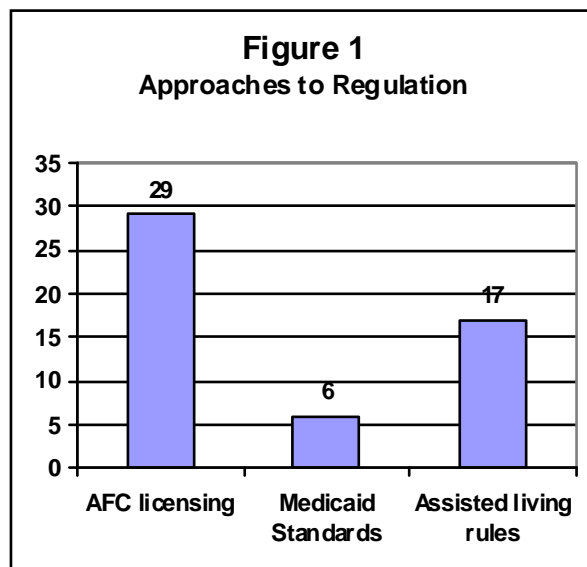
Notes: States that cover adult foster care under assisted living regulations are in italics. Data for the number and capacity of licensed facilities were not included because they include all facilities.
 Georgia, Louisiana, and North Carolina license homes under rules that are part of the assisted living regulations.

AK: Licensing is voluntary for homes serving 1–2 residents.
 DC: Community residence facilities serve 1 or more persons—the assisted living regulations do not specify the number.
 IL: Shelter care establishments serve 16 or fewer residents.
 ME: Licensing is voluntary for homes serving 1–2 residents.
 MI: Michigan’s rules contain 4 levels of adult foster care based on size.
 MN: Maximum of 4 residents may have functional impairments.
 TX: Homes serving 1–3 residents must meet Medicaid provider standards; homes serving 4–8 residents must meet licensing standards.

THREE APPROACHES TO REGULATING AFC

States use three different approaches to regulate AFC: licensing requirements, Medicaid standards, or assisted living regulations (see figure 1). The number of residents or units served by an AFC provider is the primary factor in whether it must be licensed or certified, and in which rules apply in states with multiple licensing categories. States design licensing and certification requirements specifically for small residential settings or for all residential settings with the capacity to serve more than a specified number of residents. States typically license providers, although a few states certify them. Licensing rules are usually more extensive than certification standards, and licensed facilities may receive more oversight and monitoring.

While regulations are a key indicator for ensuring some level of quality, the literature reflects mixed findings regarding which regulatory approach is most effective in improving the quality



of care for residents¹⁵ and how policymakers decide on the number of residents for these facilities.¹⁶ Most of the state officials and Policy Innovation Roundtable participants in this report noted the lack of clarity or rationality in how states choose the number of residents that will be permitted in each kind of facility.

The report found that 29 states license or certify AFC providers. Florida licenses facilities that serve one or more persons. Michigan licenses four kinds of AFC providers on the basis of the number of beds: family homes, small group homes, large group homes, and congregate facilities. Family homes are owner-occupied and serve six or fewer residents. Nebraska certifies rather than licenses providers. Wisconsin certifies providers that serve one or two residents, and licenses those that serve three or four residents (see table 5).

Six states (Arkansas, Connecticut, Indiana, Massachusetts, North Dakota, and Texas) established AFC as a Medicaid service. Providers in these states meet Medicaid standards and are not licensed.

Seventeen states cover AFC under broader assisted living regulations. However, there are variations in the requirements based on the size of the facility. For example, assisted living regulations in five states—Georgia, Louisiana, North Carolina, Ohio, and Oklahoma—contain provisions that vary by size of the facility. Residential care homes in Oklahoma that serve three or fewer residents must comply with different rules for staffing, training, and assistance with medications than larger facilities.

State	Terminology	License/ certify AFC	Medicaid standards	Assisted living rules
AL	Adult foster care	●*		
AK	Assisted living homes			●
AZ	Adult foster care	●		
AR	Adult family home		●	
CA	Residential care facilities for the elderly			●
CT	Adult family living		●	
CO	Assisted living residence			●
DE	Family care rest homes	●		
DC	Community residence facility			●
FL	Adult foster homes	●		
GA	Personal care homes			●
HI	Adult residential care home	●		●
ID	Adult family home care	●		
IL	Assisted living establishment			●
IN	Adult foster care home		●	
IA	Elder group home	●		
KS	Home plus	●		
KY	Family care home	●		

¹⁵ Lyon, S. (1997), "Impact of Regulation and Financing on Small Board and Care Homes in Maryland," *Journal of Aging and Social Policy* 9 (2): 37-50.

¹⁶ Carder, P., L. A. Morgan, and K. Eckert (2006), "Small Board-and-Care Homes in the Age of Assisted Living," *Generations* 29 (4): 24-31.

Table 5 (continued)				
State Approaches to AFC Regulation				
State	Terminology	License/ certify AFC	Medicaid standards	Assisted living rules
LA	Personal care home			•
ME	Residential care facility			•
MD	Assisted living program			•
MA	Adult foster care		•	
MI	Adult foster care family homes	•		
MN	Adult foster care	•		
MO	Assisted living facility			•
MS	Adult foster care facility	•		
MT	Adult foster homes	•		
NE	Adult family home	•		
NV	Home for individual residential care	•		
NH	Adult family care residence	•		
NJ	Adult family care	•		
NM	Adult residential care facility			•
NY	Adult care facility	•		
NC	Family care homes			•
ND	Family foster home		•	
OH	Adult foster homes	•		
	Adult family homes	•		
OK	Assisted living center			•
OR	Adult foster home	•		
PA	Domiciliary	•		
RI	Assisted living residence			•
SC	Community residential care facility			•
SD	Adult foster care home	•		
TN*	Family home for adults			
TX	Adult foster care home	•	•	
UT	Adult foster care	•		
VT	Assisted living residence			•
VA	Adult foster care	•		
WA	Adult family home	•		
WV	Health care homes	•		
WI	Adult family home	•		
WY	Adult foster care home	•		
Total		29	6	17

Notes: Arizona, Idaho, Nebraska, New York, and Ohio certify adult foster homes.
 AL: Operates as a protective services program.
 DC: Also licenses assisted living residences
 IL: Also licenses shared housing establishments serving 16 or fewer individuals.
 LA: A subcategory of adult residential care homes.
 NC: A subcategory of adult care homes.
 TN: AFC is a resource for Adult Protective Services participants. The state operates a “program,” and none of the categories in the table apply.
 WI: Certifies homes serving 1–2 residents; licenses homes serving 3–4 residents.
 WY: A pilot program was authorized.

There is also great variation in state regulations regarding admission and retention criteria, assessment and care planning tools, regulation of services, nurse delegation, the role of AFC providers in administering medication, resident agreements, staffing, and training requirements.

The following sections describe these topics, with examples from the states.

ADMISSION/RETENTION CRITERIA

State regulations typically specify who may be admitted to and retained by licensed AFCs. These provisions are design to protect the health and welfare of residents whose needs exceed the services that licensed AFCs may provide. Aligning the needs of the resident and the capacity for providers to meet those needs is important to both the resident and the provider. Adult foster care is often a “bounded choice” under state regulations, in that parameters define the level of need that providers may address in these settings. States set criteria for the types of residents providers may or may not serve. Persons who are interested in AFC should consider whether the licensed provider can meet their needs and address their conditions.

While state regulations establish the criteria and set the parameters within which operators may serve residents, operators may decide to serve lower acuity residents. Providers that accept Medicaid HCBS waiver¹⁷ participants agree to serve residents who meet at least the minimum qualifications for nursing home care. Each state sets its own criteria for admission to a nursing home and, as a result, the minimum requirements vary from needing assistance with activities of daily living (ADLs) to requiring treatment for a health condition.

Admission criteria can be general or specific. For example, Alabama allows providers to serve adults who need protective services and cannot live in their own homes. Residents in Delaware must be able to perform all their ADLs at the time of admission, but the rules allow residents to age in place and receive more services over time. Alabama, Delaware, Idaho, Indiana, Kentucky, Virginia, and West Virginia describe the people providers may serve in general terms and frequently reference the provider’s ability to meet each person’s needs.

AFC homes in four states (Arkansas, Maine, Minnesota, and Wisconsin) prepare a description of the people they will serve and submit the description to the licensing agency. Minnesota’s rules do not contain specific admission or retention criteria. Operators submit a plan that describes the type of functionally impaired adults they will serve. A person is appropriate for AFC home placement if he or she is an adult; is functionally impaired; has requested (or the legal representative has requested) foster care

¹⁷ In 1981, Congress amended the Social Security Act to allow states to add home and community services as an alternative to institutionalization for older adults and people with disabilities. This authority provided states with discretion to develop programs, including case management, homemaker, home health aide, personal care, adult day care, habilitation, respite and other services for persons who would otherwise require institutional care. Under a waiver program, states may target individualized services to a particular group (e.g., elders and adults with disabilities, children with developmental disabilities), expand income limitations (up to 300 percent of Supplemental Security Income); and apply geographic limitations.

placement; has demonstrated a need for foster care based on the assessment; and does not require continuous medical care or treatment in a facility licensed for acute care.

On the other hand, admission requirements exclude residents with specific conditions in seven states. Florida, Iowa, Kansas, Mississippi, New Hampshire, New York, and Wyoming prohibit homes from serving residents with specific conditions.¹⁸

ASSESSMENT AND CARE PLANNING PROCESS

Most states require an assessment and care planning process as part of the requirements for serving AFC residents. However, there are variations as to who, when, and how often care and services are provided to AFC residents.

The assessment often includes the functional, social, and health needs and preferences of the consumer, and the role of the AFC provider in meeting those needs. The assessment may occur before or immediately after admission to an AFC home. Care managers, nurses, or other professionals may conduct the assessment; however, the resident should play an integral role in the development of the care plan. For example, Massachusetts and New Jersey require that a registered nurse conduct the assessment and develop the care plan. In Arkansas, the case manager conducts the assessment, while the provider and resident develop the care plan. Providers in Indiana use the initial assessment as a baseline for providing services and addressing the needs of the consumer, although providers are required to revise the care plan in response to the consumer's expressed preferences and care needs. The case manager reviews the revised care plan.

In Pennsylvania, Area Agencies on Aging (AAAs) are responsible for the development and implementation of a care plan for each resident. Care plans are developed in consultation with the resident and indicate problems and needs, desired outcomes (long- and short-term goals), services and providers (informal or formal), pattern of service delivery, follow-up monitoring, and reassessment updates. Arrangements for supplemental service are included in the care plan. Supplemental service addresses special client needs, providing the support necessary for the client to remain in the care home. Table 6 shows assessment and care planning requirements in states that license AFC separately from assisted living facilities.

In some states, physicians have a role in determining whether a provider may care for a person in an AFC setting. For example, physicians in Indiana may determine that placement in an AFC is unsafe. Louisiana mandates that residents be discharged if a physician certifies that a resident needs more than 90 days of continuous care. In Hawaii, physicians or advance practice registered nurses must determine the level of care needed for each resident before admission to an adult residential care home or expanded adult residential care home. Massachusetts requires that physicians authorize AFC and that the services delivered by providers are under the supervision of a multidisciplinary team that includes a registered nurse and a social worker. Case managers in Nebraska monitor

¹⁸ Conditions typically listed in the regulations include skilled needs, bedbound, part-time or intermittent nursing services, stage 3 or 4 pressure sores, residents who are a danger to themselves or others, and residents who require chemical restraints.

Table 6			
Assessment and Care Planning			
State	Not Specified	Completed by Provider	Completed by Case Manager/RN/SW
AL	•		
AZ		•	• ¹
AR			•
DE	• ²		
FL	•		
GA		• ³	
HI		•	• ¹
ID		•	
IN			•
IA		•	
KS		•	
KY	•		
LA		•	
ME		•	
MA			•
MI		•	
MN			•
MS		•	
MT	•		
NE		• ⁴	
NV	•		
NH		• ⁵	•
NJ			•
NY		•	
NC		•	
ND	•		• ¹
OH	•		
OR		•	
PA			•
SD	•		
TN	•		
TX		• ⁶	•
UT	•		
VA			•
WA		•	
WV			•
WI		•	
WY	•		
Total	12	18	13

Notes: Totals include multiple responses in some states.

1. Completed for Medicaid beneficiaries.

2. DE: RN from the Department of Public Health completes a level of care statement.

3. GA: Provider conducts an interview to determine if it can meet the resident's needs.

4. NE: The care manager assists the provider with the process.

5. NH: Provider and sponsor agency complete the assessment and care plan.

6. TX: Assessment and care plan are completed jointly by the provider and a case manager.

residents to ensure that they do not have a condition that requires ongoing medical treatment and supervision.

STATES REGULATE SERVICES THAT CAN BE PROVIDED

State regulations often include a description of the services provided by an AFC provider. Typically, these services reflect the state's policy about the role of AFC within the array of long-term care services and supports. For example, Indiana's Medicaid standards support and promote independence and decision making by the consumer. Providers must offer services "in a manner and in an environment that encourages maintenance or enhancement of each consumer's quality of life, and promotes the consumer's privacy, dignity, choice, independence, individuality, and decision-making ability." Wisconsin adopted a similar philosophy, in which services are directed to the goal of assisting, teaching, and supporting the resident to promote his or her health, well-being, self-esteem, independence, and quality of life.

Adult foster care can provide a range of health and support services, and is an alternative to nursing facilities. It is also a housing resource for persons who are ambulatory but need supervision or limited assistance with ADLs or health conditions. Nearly all states require or allow providers to offer personal care, supervision, and transportation to medical and other appointments.

States approach the health care needs of residents in AFC in different ways. For example, Florida requires that a home health agency rather than the AFC provider contract nursing services. Providers in Louisiana must plan or arrange for health assessments, health care monitoring, and assistance with health tasks but may not provide these services directly. Providers in Oregon must obtain consultation and assessment from a medical professional when they need to provide a skilled nursing care task or when the resident has a health concern or behavioral symptom that may benefit from a nursing assessment and provider education. Nurses may then delegate health related tasks (see next section).

NURSE DELEGATION: THE ROLE OF AFC PROVIDERS IN ADMINISTERING MEDICATION

To ensure public safety, states license nursing professionals through Nurse Practice Acts (NPAs). These laws restrict unlicensed assistive persons (UAPs) from providing nursing care but recognize some cases in which care by unlicensed persons is appropriate, typically unpaid care by family members.

Demographic changes and advanced health technology present a challenge to current restrictions on providing care. The recent Institute of Medicine report—*Retooling for an Aging America*—acknowledges the need to promote the effective use of all members of the health care workforce—including direct care workers—to care for the aging population (2008, pg.13).¹⁹ In addition, people with chronic conditions and disabilities

¹⁹ Institute of Medicine. 2008. *Retooling for an Aging America: Building the Health Care Workforce*. Washington, DC: The National Academies Press.

often prefer to live in a community setting such as AFC rather than seeking institutional care. At the same time, smaller and more mobile families and the increased employment of women have reduced the pool of traditional family caregivers. A nationwide nursing shortage means that licensed nurses may not be available (particularly in dispersed community settings) to perform frequent health maintenance tasks, or their services may be prohibitively expensive. For consumers with stable chronic conditions, it may not be necessary to have a nurse perform health maintenance tasks, though nursing oversight may be beneficial. Several states consider nurse delegation to be appropriate for AFC settings (see appendix A for more information on nurse delegation).

Nurse delegation laws allow nurses to delegate specific tasks to unlicensed AFC staff after the nurse performs an assessment of the resident's condition and, if necessary, confirms the ability of the AFC provider to perform specific health-related tasks, usually medication administration. Medication administration may be an important determinant of an AFC provider's ability to serve residents with higher levels of need. Almost all state policies on nurse delegation have some overall guidance for the delegation process. This process generally includes requiring nurses to make an initial assessment of the person's condition and the unlicensed assistant's competence to assist. The nurse retains responsibility for any actions that require nursing knowledge or judgment. However, policies differ with respect to language on accountability, nurse authority to decide to delegate, specific task prohibitions, consideration of setting, and process details.

Probably the biggest barrier to delegation is nurses' perception that in delegating they are allowing someone else to practice on their license and that any bad outcomes will reflect directly on them.²⁰ Some state laws or regulations seem to validate this concern, either by having strict language or by having vague language that could be interpreted strictly.^{21,22} Other states have defined accountability in detail—nurses are responsible for appropriate assessment, teaching, observation, and follow-up but are not held responsible if an unlicensed assistive person fails to follow the nurse's instructions. Washington and Oregon—states that use AFC as an option for HCBS—are primary examples of this approach.^{24,25}

²⁰ Kane, R., C. O'Conner, and M. Baker, M. *Delegation of Nursing Activities: Implications for Patterns of Long-term Care* (Washington, DC: AARP Public Policy Institute, 1995).

²¹ A June 2004 white paper on delegation from the Wisconsin Board of Nursing states, "Under the legal concept of *respondeat superior*, the RN-delegated acts performed by LPNs or less-skilled assistants are the acts of the RN." Accessed December 5, 2008, at <http://drl.wi.gov/boards/nur/pap/pap05.pdf>. We do not agree with this interpretation of *respondeat superior*, which means "let the master answer" and is generally seen as assigning civil liability for torts (harms) to employers for acts of their employees under some circumstances, and assuming a greater degree of control than a nurse would generally have over an unlicensed assistant. Civil liability is different than the control over professional licenses held by the Board of Nursing. We present this example to show that the idea is out there—fear of civil liability as a barrier to delegation may have motivated Oregon's enactment of the statute immunizing nurses from such liability as long as they properly instructed the unlicensed person.

²² Reinhard, S., *Consumer-Directed Care and Nurse Practice Acts* (New Brunswick, NJ: Rutgers Center for State Health Policy, 2001).

²³ Reinhard, S., H. Young, R. Kane, and W. Quinn, *Nurse Delegation of Medication Administration for Elders in Assisted Living* (New Brunswick, NJ: Rutgers Center for State Health Policy, 2003).

²⁴ Reinhard, S., and H. Young, *Washington's Nurse Practice Policies for Home and Community Living* (New Brunswick, NJ: Rutgers Center for State Health Policy and National Academy for State Health Policy: Community Living Exchange, 2006).

²⁵ Reinhard, S., and W. Quinn, *Oregon's Nurse Practice Policies for Home and Community Living* (New Brunswick, NJ: Rutgers Center for State Health Policy and National Academy for State Health Policy: Community Living Exchange, 2004).

Washington, for example, explicitly addresses the question of liability for both nurses and aides:

- Nurses acting within the protocols of their delegation authority are immune from liability for any action performed in the course of their delegation duties.²⁶
- Nursing assistants following written delegation instructions from registered nurses in the course of their accurately written, delegated duties shall be immune from liability.²⁷

Oregon goes beyond the question of professional liability to address civil liability. Nurses who delegate nursing care to an unlicensed person “shall not be subject to an action for civil damages for the performance of a person to whom nursing care is delegated unless the person is acting pursuant to specific instructions from the nurse or the nurse fails to leave instructions when the nurse should have done so.”²⁸

The individual nurse’s authority to decide whether to delegate is another important issue. Several states have taken extra steps with their regulations to ensure that the decision is truly the nurse’s. For example, Texas rules require that “If the RN is employed, the employing entity must have a written policy acknowledging that the final decision to delegate shall be made by the RN in consultation with client or client’s responsible adult.”²⁹ The Wisconsin Nurses Association adopted the Washington state language: “No person may coerce the registered nurse delegator into compromising consumer safety by requiring the nurse to delegate if the registered nurse delegator determines it is inappropriate to do so. Nurses shall not be subject to any employer reprisal or disciplinary action by the nursing care quality assurance commission for refusing to delegate tasks or refusing to provide the required training for delegation if the nurse determines delegation may compromise patient safety.”³⁰

Almost all states have some kind of description of the kinds of tasks that can be delegated; they generally prohibit the delegation of tasks requiring nursing judgment or ongoing assessment and those with potentially serious health consequences. Most states allow AFC providers to assist with self-administration of medications. However, the scope of the assistance varies. Alabama, for example, allows providers only to remind residents to take a medication. Arkansas allows reminders and oversight. Florida considers administration of medications to be a nursing service but defines “assistance with self-administration” so broadly that it appears to include medication administration. For example, the following tasks are classified as assistance with self-administration: reminders; preparing and making available liquids, cups, and spoons; providing the medication to the resident; observing the resident taking the medication; and verifying that the right dosage was taken as prescribed. Idaho and Indiana require that a physician give written approval that a resident is capable of self-administration. Kansas allows residents to self-administer

²⁶ RCW 18.79.260 (3)(e)(vii), accessed December 4, 2008, from <http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79.260>.

²⁷ RCW 18.88A.230(1), accessed December 4, 2008, at <http://apps.leg.wa.gov/RCW/default.aspx?cite=18.88A.230>.

²⁸ ORS §678.036, accessed December 4, 2008, at <http://www.oregon.gov/OSBN/pdfs/npa/ORS.pdf>.

²⁹ See Rules and Regulations (chapter 224 for acute and 225 for independent living) at <http://www.bon.state.tx.us/about/pdfs/bon-rr-0808.pdf>, accessed December 5, 2008.

³⁰ RCW 18.79.260 (3)(d), accessed December 4, 2008, at <http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79.260>.

medications unless a physician determines that it is not safe for them to do so. In Louisiana, providers may assist residents only if the residents are aware of what they are taking and why. Nebraska allows only temporary assistance approved by a physician.

Georgia allows AFC staff to assist with self-administration, but only licensed professionals from outside agencies may administer medications. Hawaii allows AFC staff who are licensed to administer medications. In North Carolina, staff must complete training and pass an examination.

Eight states do not allow the provider to administer medications and only allow residents to self-administer their medications. AFC homes in Ohio may only admit residents who are capable of administering their own medications.

Some states go farther in creating lists of prohibited or allowed tasks. Both Oregon and Washington—the states with most delegation in community settings—have a few prohibitions. Oregon puts restrictions on the delegation of intravenous medications and intramuscular injections.³¹ Washington specifically prohibits injections (other than insulin, approved in some instances in 2008), sterile procedures, and central line maintenance.³²

Table 7 provides a summary of state approaches to administering medication in AFC. Detailed information is available in the state summaries (appendix A).

State	May Administer with Training	Licensed Professionals May Administer	May remind or Assist with Self-Administration	Self-Administration Only	Not Specified
AL			•		
AZ	•*	•			
AR			•		
DE				•	
FL			•		
GA		•	•		
HI		•			
ID			•		
IN			•		
IA	•				
KS				•	
KY				•	
LA			•		
ME	•*				
MA			•		
MI					
MN	•				

³¹ See OAR 851-047-0010(22) and OAR 851-047-0030 (8), (9) and (11), accessed August 4, 2008, at <http://www.oregon.gov/OSBN/adminrules.shtml>.

³² See WAC 246-840-910 (accessed December 5, 2008, at <http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840-910>) for prohibitions; regarding insulin, see RCW 18.79.260(3)(e)(iv), accessed December 5, 2008, at <http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79.260>.

Table 7 (continued)					
AFC Providers' Role with Medications					
State	May Administer with Training	Licensed Professionals May Administer	May remind or Assist with Self-Administration	Self-Administration Only	Not Specified
MS		•			
MT			•		
NE			•*	•*	
NV				•	
NH	•				
NJ	•				
NY				•	
NC	•				
ND					•
OH			•		
OR	•				
PA			•		
SD					•
TX	•				
UT				•	
VA					•
WA	•				
WV	•				
WI	•				
WY		•	•		

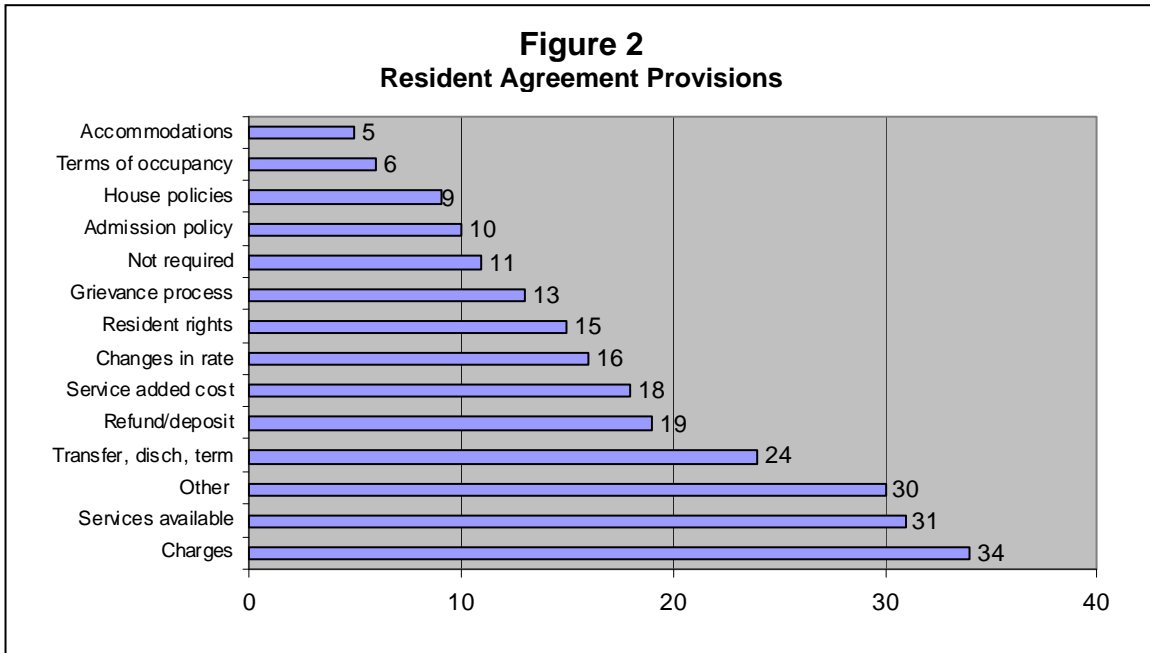
Notes:
 AZ: Employees may administer medications if authorized by law or if designated to do so by the person's physician.
 ME: Unlicensed trained personnel may administer medications in Level III facilities.
 NE: Facilities may assist with self-administration for temporary periods when approved by a physician.
 WY: Nurses aides may assist with self-administration.

RESIDENT AGREEMENTS

Before choosing to move into an AFC home, prospective residents need detailed information about services, costs, discharge and transfer policies, and other issues (e.g., terms of occupancy, house policies). Thirty-nine states require resident agreements that describe the arrangement between the AFC provider and the resident. These contracts are also required in most states with assisted living facilities. The items included in the agreement vary by state but generally cover admission policies, the services AFC operators will provide to the resident, charges, residential rights, and other expectations and obligations of the resident and the provider.

Agreements are primarily used in states that serve a private pay market. States that regulate AFC through Medicaid provider standards rather than licensing regulations do not usually include these requirements, mainly because case managers are involved in the assessment and plan of care. Since public funds pay providers for services, Medicaid policies establish the parameters in a resident agreement. However, even in states that use Medicaid to pay for services in AFC, residents must pay for room and board.

A review of state regulations found a number of common topics that must be included in the resident agreement (see figure 2). The contracts frequently address the cost of care and other financial issues. Agreements in 34 states must specify the rate providers will charge to residents, and 31 states list the services that are included in the rate. Providers who set a basic rate for a specific set of services may offer additional services; these services and their cost are included in the agreement in 18 states. Rates charged to residents can change over time; agreements in 16 states describe this process and the notice that residents must receive before the implementation of a rate change. Nineteen states require providers to include information about refunds and deposits in the agreement.



Many consumers, family members, and policymakers describe aging in place as a goal in long-term services and supports. When consumers move to a new setting, they need to know the level of care that providers can offer and the circumstances that might require transfer to another setting or another provider. Agreements in 23 states require that the provider describe the transfer/discharge criteria. In addition to the resident agreement, regulations may also describe resident protections and residential rights.

STAFFING

Staffing is a critical element of the AFC setting. States tend to require that providers have sufficient staff available to provide 24-hour supervision and to meet the needs of residents. For example, providers in Georgia and Montana must have someone onsite at all times. Providers in New Jersey must live in the home and be deemed by a physician capable of meeting the needs of residents. Indiana and New York also specify that the AFC provider must live in the home. New York’s rules note that providers must not rely on income from residents to cover household expenses. This requirement attempts to reduce the likelihood that providers will focus mainly on addressing their financial problems and not on the needs of the residents. Administrators in North Carolina must

either be onsite or within 500 feet of the home, with a reliable means of communication with the staff in the home. Providers in Oregon must have a resident manager onsite around the clock. States with owner-occupied models may require that the licensee arrange for substitute care providers when the primary provider is out of the home for a certain period and ensure that the substitute care provider meets the qualifications to care for residents. Ohio providers submit contingency plans for absences.

TRAINING

Training is an important element in operating an effective AFC home. Training creates an opportunity for providers to increase their knowledge base and skill sets, which can increase the provider’s level of confidence and decision-making abilities, and thereby improve the level of care provided to residents. States use an array of AFC training approaches, ranging from simple overviews of licensure to operational and business training for providers. Washington, for example, has a robust training strategy. The state contracts with several third party entities to deliver ongoing training for AFC providers. Providers pay a fee to participate. Recently, the state implemented management and administration training. The weeklong course addresses the basics of operating a small business. The state instituted this requirement in response to the number of homes that closed in the first 18 months because of small business management challenges.

Eight states do not specify training requirements in their regulations. Table 8 lists the training requirements for states with AFC licensing regulations. States that cover small facilities under assisted living regulations are not included in the table.

Table 8		
Adult Foster Care Training Requirements		
State	Initial training	Ongoing training
AL	Orientation	Topics that must be covered
AK	Orientation and 12 hours	
AZ	6 hours	
AR	12 hours with a test	
DE	Not specified	
FL	12 hours on listed topics	3 hours annual training
GA	Topics	16 hours annually
HI	12 hours annually	
ID	Topics	8 hours annually
IN	General requirements	
IA	Complete a course	12 hours annually
KS	Complete 60-hour nurse aide course	
KY	Not specified	
LA	Orientation on list of topics	
ME	Submit satisfactory evidence regarding education, experience, and training	Attend any training determined by the licensing agency to be necessary
MA	Orientation on list of topics; 8 hours annually	8 hours annually
MI	Not specified	
MN	Orientation: 3 hours	6 or 12 hours (depending on experience) on list of topics

Table 8 (continued)		
Adult Foster Care Training Requirements		
State	Initial training	Ongoing training
MS	Quarterly meetings with state staff	
MT	Not specified	
NE	Not specified	
NV	Topics	
NH	Orientation on list of topics	6 hours CEUs
NJ	Graduate from a training program for Certified Nursing Assistants, Home Health Aides, Licensed Practical Nurses or Registered Nurses	
NM	Orientation on listed topics	
NY	Orientation	
NC	25 hours and competency test; 80 hours for some personal care tasks	List of topics
ND	Professional verifies the provider's competency	
OH	6 hours every 2 years	
OR	Complete a curriculum	12 hours annually
PA	Complete course materials on listed topics	
SD	Not specified	
TX	Orientation on list of topics; 16 hours on-the-job supervision	6 hours annually with additional 4 hours depending on the type of home
UT	Not specified	
VA	Orientation on listed topics and basic training	10 hours annually
WV	6 hours	
WA	Orientation and basic training	10 hours annually
WY	Not specified	

Additionally, in all 11 experienced states studied for this report, providers and community informants strongly recommended that states offer training on elements of successful AFC providers (e.g., providers that have developed sustainable, high-quality homes). Table 9 provides an overview of interviewee recommendations. Interviewees also recommended that state training programs include a visit to an operating AFC so prospective providers can experience the environment and speak with current operators, residents, and family members.

Table 9
Training Recommendation
Time management, including a respite strategy—might include using a senior center or adult day care.
Licensing and working with state and local officials, including the fire marshal.
Development and implementation of a resident support plan, including age-appropriate social and recreational activities.
Geriatric health care—a basic orientation including medications overview.
Nutrition and geriatric dietary considerations.
Financial management, including understanding tax advantages (see below) and small business accounting.
Basics of staff management, including working with health care professionals and supervision (as appropriate).

Table 9 (continued) Training Recommendation	
Leveraging community resources and benefits for which residents may be eligible, such as senior centers, adult day care and adult day health care, Area Agency on Aging services, Medicare benefits, and Medicaid benefits.	
Physical maintenance, including housekeeping and fire safety.	
Legal issues.	
<i>Elements of Success as a Result of Training</i>	
<ul style="list-style-type: none"> • Satisfied residents and families • Well-defined business plan that will ensure sustainability • Good organizational skills • Time management skills • Good stress management techniques • Money management skills • Clear understanding of public and local community resources to augment AFC services and enhance residents’ home and community-based living experience. 	

DEVELOPMENT OF AFC: THE PROVIDER’S PERSPECTIVE

A substantial amount of time is required to operate an AFC home, and providers are responsible for ensuring some level of supervision around the clock. In addition, operating an AFC home—depending on its size and scope—may reduce social activities with family and friends, and increase isolation for single-home operators. What motivates a person to become an AFC provider? According to case studies and the literature, people become AFC providers for a variety of reasons, including previous experience in health care, a career change, or a desire to be self-employed. Table 10 provides a list of typical responses.

Table 10 Reasons to Become an AFC Provider	
Key Drivers	Examples
Social services orientation	<ul style="list-style-type: none"> • Interest in supporting older adults • Encouraged or mentored by an aging professional
Social/personal	<ul style="list-style-type: none"> • Was lonely and had room in his or her home • Family member needed services and the provider saw AFC as a natural addition to care already being delivered
Connection to aging services	<ul style="list-style-type: none"> • Worked in another AFC • Parents, other relatives, or friends owned or operated an AFC • Licensed registered nurse (RN) or certified nursing assistant (CNA) who formerly worked in assisted living or a nursing home
Financial/career	<ul style="list-style-type: none"> • Became unemployed and saw AFC as a job opportunity • Wanted to be self-employed • Wanted to supplement income

In the study states, AFC providers noted that people who are interested in becoming AFC providers generally have a genuine interest or “calling” to support older adults, and that “the work becomes their life.” Providers had a clear understanding that “people shouldn’t go into [the AFC] business with profit in mind.” Many of these providers are CNAs, LPN, or RNs. Some providers started out caring for a relative or a spouse; when they became aware of AFC as a business model, they branched out by accepting other residents.

Many providers stress the need for respite services and support. Providers are often unable to take a vacation or even a day off because of the structure and nature of their work. Access to adult day care can be an important source of respite for AFC operators. Providers also need assistance with training, particularly related to acuity increases and clinical training around geriatric care. Many providers are dealing with increases in the acuity of residents, which may affect the number of residents providers can serve in their homes. Providers also need help developing business tools (e.g., feasibility models) and adjusting to marketplace changes. Anecdotal evidence suggests that most providers just break even financially and are very sensitive to changes in overhead expenses. They need training on how to manage the changing base of residents and on the proper caseload mix (Medicaid and private pay) to cover their overhead costs.

HOW DO RESIDENTS PAY FOR ADULT FOSTER CARE?

AFC is a residential option in the HCBS menu. States cover services in AFC through the Medicaid §1915(c) home and community-based services waiver of the Social Security Act, the Medicaid state plan, and state general revenues and state supplements to the federal Supplemental Security Income (SSI) payment. The resident is responsible for paying for room and board, as Medicaid may not pay for this service. Public resources subsidize the majority of users of AFC services.

State SSI Supplements. Low-income beneficiaries often qualify for SSI and rely on this income to pay for room and board in AFC. In 2008, SSI was \$637 a month. States may elect to supplement the federal payment with state general revenues to provide additional income to help people meet their living expenses. Benefits are based on a payment standard, which is the payment for a person with no other income. Fifteen states reported that they supplement the federal SSI payment for low-income persons in AFC.³³ Many SSI beneficiaries have income from other sources—Social Security, pensions, and veterans benefits—but still qualify for SSI. The actual SSI payment is the difference between the person’s income, less exemptions, and the payment standard. The combined federal and state payment standards in states that offer a supplement range from \$668.25 a month in New Jersey to \$1,278.90 in Hawaii. The payment standard includes the federal SSI payment. Standards in New York and Virginia vary by area of the state. New York provides \$903.48 a month in New York City and Long Island, and \$865.48 elsewhere in the state. Virginia’s standard is \$1,276 in northern areas of the state and \$1,075 in southern areas (see table 11).

³³ Information for Idaho, Iowa, and Montana was obtained from “State Programs for SSI Recipients,” Social Security Administration, January 2007. Available at http://www.socialsecurity.gov/policy/docs/progdesc/ssi_st_asst/2007/index.html.

State	Standard	State	Standard
Florida	\$715.00	New York	\$903.48 (NYC area)
Hawaii	\$1,278.90		\$865.48 (rest of state)
Kentucky	\$809.00	North Carolina	\$1,173.00
Maine	\$871.00	Ohio	\$1,143.00
Michigan	\$794.50	Pennsylvania	\$1,071.30
Minnesota	\$776.00	South Dakota	\$947.00
Montana	\$689.75	Virginia	\$1,226.00 (No. VA)
New Jersey	\$668.25		\$1,075.00 (So. VA)
		Wisconsin	\$816.77

Medicaid Funding. The §1915(c) waiver authority allows states to offer services that are not covered by a Medicaid state plan.³⁴ States are able to cover AFC under a phrase that allows the Secretary of Health and Human Services to approve “other services” that are not specifically listed in the statute.³⁵ States can also cover services under the Medicaid state plan. Personal care can be covered in a home “and, at the State’s option, in another location.”

States have several options to pay for services in AFC settings. Twenty-one states reported that Medicaid reimbursed services in AFC settings for beneficiaries. Nine states vary their Medicaid payment on the basis of the resident’s level of impairment. Three states establish the payment on a base rate with adjustments based on the service needs of the resident. For example, Montana’s basic service payment of \$652 a month covers meal service, homemaking, socialization and recreation, emergency response system, medical transportation, and 24-hour availability of staff for safety and supervision. State officials include additional payments on the basis of points for ADL and other impairments. The provider receives an additional payment of \$32 a month for each point. The maximum reimbursement for services is \$61.80 a day. North Carolina offers a base rate of \$17.50 a day, supplemented by additional amounts for assistance with eating, toileting, ambulation, and transportation.

Some states differentiate rates on the basis of the relationship between the provider and the resident. Oregon, for example, sets rates for relative and nonrelative providers. Relative providers receive a base rate of \$1,000 a month, while nonrelative providers receive \$1,229 a month. Oregon also “adds on” payments for each person’s needs. The maximum rate is \$1,711 for relative providers and \$1,940 for nonrelative providers.

Rates in Idaho and Kansas reflect the care plan developed by a case manager following an assessment. Providers in Florida, Georgia, and Michigan receive a flat rate for services. Florida pays providers \$9.28 a day for assistive care services that fall under the Medicaid

³⁴ Services include personal care not covered by the state plan, home-delivered meals, adult day care, personal emergency response systems, respite care, environmental accessibility adaptations, and other services that are required to keep a person from being institutionalized.

³⁵ Information about HCBS waivers and state plan services was adapted from Mollica, R. and K. Sims-Kastelein, *Residential Care and Assisted Living Compendium: 2007* (Washington, DC: U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, 2007).

state plan. The state also supplements the federal SSI payment, which covers some of the service costs. The total (state and federal) SSI payment in Florida was \$715 a month in 2008. Michigan pays a flat rate of \$192 a month under the personal care state plan option, in addition to a combined federal and state SSI payment of \$794.50 a month (less a \$44 personal needs allowance). Georgia’s rate under an HCBS waiver is \$35.04 a day.

States can negotiate rates with providers. For example, Arizona contracts with managed care organizations to deliver services for members of the Arizona Long-Term Care System (ALTCS). The managed care organizations negotiate rates with each home. Wisconsin’s county-based system manages home and community-based services. The county and the provider negotiate the rates for licensed and certified adult family homes. Other states pay for services in small and large settings licensed as assisted living, residential care facilities or by other names, but these are not included in this report. Table 12 shows the sources of AFC coverage in states that license these settings separately from assisted living categories.

Table 12				
Sources of AFC Payment				
State	Medicaid Waivers	Medicaid State Plan	General Revenues	SSI State Supplement
AL			•	
AK				
AZ	•*			
AR	•			
DE			•	
FL		•		•
GA	•			
HI	•			
ID	•	•		
IN	•			
IA				
KS	•			
KY				•
LA				
ME		•		•
MD		•		
MA		•		•
MI		•		•
MN	•			•
MS				
MT	•			
NE				
NV				
NH				•
NJ	•			•
NM	•			
NY				•
NC		•		•

Table 12 (continued)				
Sources of AFC Payment				
State	Medicaid Waivers	Medicaid State Plan	General Revenues	SSI State Supplement
ND				
OH				•
OR	•			
PA				•
SD	•			•
TX	•			
UT				
VA				
WV				
WA	•	•		
WI	•			•
WY				

* Arizona uses §1115 waiver authority.

PROVIDER BUSINESS PRACTICES AND OPERATIONS

Provider interviews revealed that some operators of individual homes had a business plan but most did not, while all operators of multiple homes had a business plan. Many providers of individual homes tend to combine business earnings and expenses with their household budget.

Recall that the state sets Medicaid and other public program rates. Among agency-sponsored and corporate arrangements, market analysis and business needs drive the rates. Some single-home operators use a form of market analysis, but the majority of interviewees base their rates on people’s ability to pay. Like other providers of long-term supports, most AFC home operators make sure the private rate is higher than the Medicaid rate.

In terms of start-up costs, providers typically incur expenses to modify an existing home to comply with licensure or certification requirements. These changes may be costly. Providers may need to leverage their home equity—most providers interviewed said they had great difficulty securing a small business loan. Typical physical changes include:

- Expanding the home to meet square footage requirements.
- Adding bedrooms.
- Adding a bathroom.
- Widening doorways.
- Building wheelchair ramps and making other accessibility modifications, such as a roll-in shower.
- Meeting life-safety code requirements (e.g., fire alarms and extinguishers).

- Adding a private apartment for the owner/operator (if permitted by state regulations).

To shed more light on operational costs, appendix B presents a business model for a new single-home operator.

SINGLE-HOME OPERATORS HAVE TROUBLE SECURING LOANS

In 2008, the lending market for real estate purchase or development and for new businesses became extremely tight. The National Investment Center for the Senior Housing and Care Industry (NIC) reported in October 2008 that the slowdown in commercial and private lending would affect lending to senior housing and service providers.³⁶ NIC projected that providers and projects in desirable locations with strong management teams or experienced managers would fare reasonably well; less experienced and poor-performing providers will have more difficulty securing financing.

However, NIC pointed out that once the credit markets settle, the senior housing with services sector likely will be very attractive, because of demographics, awareness of and preference for residential care over nursing homes, and more cautious growth in the senior housing with services market than in the past. NIC projects that larger commercial entities will be more likely than single-home AFC providers to secure investment.

Securing a 30-year mortgage on an AFC home was easier before the 2008 mortgage crisis, particularly in states with long-standing AFC programs, such as Oregon and Washington. In the past, Fannie Mae was willing to buy an AFC mortgage, provided the home was not substantially altered. However, even though Fannie Mae bought the mortgages, few lenders are willing to initiate a loan because of the business risk (i.e., reliance on Medicaid), servicing requirements, and risk of foreclosure. Business loans are less common and very difficult to find for start-up AFCs; experienced AFC operators with existing, well-performing homes have a somewhat better chance of securing a business loan.

TOOLS TO REDUCE OPERATING EXPENSES

AFC providers could benefit from certain tax provisions,³⁷ but they are only applicable in specific circumstances, and few providers understand how to take advantage of them. Foster care providers can deduct foster care payments if detailed expense records support the deductions. However, in lieu of extensive record keeping, Section 131 of the Internal Revenue Code permits certain foster care providers to exclude payments for providing adult foster care services from their taxable income. Room and board payments may not be excluded. Eligibility for the foster care service payment exclusion depends on three factors: (1) the age of the foster care recipient; (2) the type of foster care entity; and (3) the source of the foster care payment.

³⁶ While NIC primarily focuses on for-profit providers, the organization's observations on the long-term care market offer insights into the broader provider arena as well.

³⁷ Owner-occupied providers serving no more than five residents are eligible for the IRS tax exemption (IRS Code, Title 26, Chapter 1, Subchapter B, Part III, Section 131).

For adults age 19 and older, Title 26, §131 of the Internal Revenue Code permits foster care providers to exclude payments from taxable income only if a state or a political subdivision places the person and makes the foster care payments. Providers must pay taxes on all other foster care payments. For foster care delivered to children under 19 years, income may be excluded if referrals and payments are made by a charitable tax-exempt placement agency. In states that base state income tax on the Internal Revenue Code, such foster care payments also may be excluded from state income tax filings. In states where referrals are not made by the state or a political subdivision, income from AFC payments may not be exempted.

HOW CAN STATES EXPAND AFC AS AN HCBS OPTION?

Generating interest in AFC as a potential business model and service delivery option for providers and consumers can pose a challenge for some states. A few states are watching their programs disappear. Connecticut, for example, conducted a study several years ago and found that only two providers remained. There are no providers in Utah. Furthermore, states that license AFC providers do not usually have active marketing and recruitment strategies to expand the AFC supply.

It takes substantial state investment to make AFC a viable service option. Challenges facing states that would like to recruit providers include lower reimbursement rates, difficulty finding a “champion” among state officials, and an exodus of providers into the assisted living market for business reasons. Oregon and Ohio both have waiting lists for foster care—an indication of consumer demand. However, officials in Ohio reported difficulty recruiting new homes into the market. Oregon and Washington have experienced a decline in the supply of providers over the past few years and are reinvesting in AFC. Officials in both states said that AFC plays an integral part in their HCBS options and that it serves older people with higher levels of impairment than assisted living facilities do.

Reimbursement issues for Medicaid residents and the aging of providers in Oregon caused a massive exodus of AFC providers from the market. To address the decline in providers who will take Medicaid residents, Oregon now bases its Medicaid rates on the private pay population. In addition, state officials are using part of the Money Follows the Person grant³⁸ to help fund recruitment strategies. Oregon recently hired a full-time employee to work on recruitment, using innovative venues such as Craigslist and personal ads to recruit AFC providers. Staff plan to build on successful local recruitment efforts and offer training sessions to improve quality and retain current providers. State officials created online training modules and self-training manuals to address the needs of providers in rural areas and those who do not have time to attend onsite sessions. State officials also plan to reexamine the rate structure, which many believe is the major contributor to the decline in providers.

In 2007, officials in Washington began a concerted outreach and recruitment effort to reverse the high turnover rate among providers. State officials hired a staff person to help recruit providers in rural areas. State staff organized orientation sessions and preapplication training

³⁸ As a result of the Deficit Reduction Act of 2005, the Money Follows the Person (MFP) Rebalancing Demonstration will help states provide more home and community-based options while reducing their reliance on institutional care. In 2007, the Centers for Medicare and Medicaid Services (CMS) awarded \$1.4 billion in MFP grants to 30 states and the District of Columbia.

to help applicants understand the state's requirements and expectations for providers, as well as the business implications of being an adult family home.

Potential providers in Washington learn how to determine whether there is a market for the service in their area, how to balance public and private pay residents to produce sufficient revenues to maintain the business, and what services they need to deliver. State staff request that potential providers interview possible sources of referrals—discharge planners, HCBS case managers, and community and faith-based organizations that serve older people—to estimate the potential demand and determine the right case mix of residents. The orientation session and the preapplication process give potential providers a better understanding of their roles and responsibilities, and tend to screen out applicants who are not seriously interested in pursuing this business option. To get licensed, providers must complete 48 hours of training on management and running a business. Providers who want to admit individuals with dementia or other cognitive impairments must acquire an additional designation with special training in caregiving and geriatrics. Before these efforts, Washington had a 22 percent turnover rate in an 18-month period among providers who received a business license to operate an AFC.

Officials in Wisconsin believe that word of mouth is the most effective strategy for recruiting providers. County officials also promote the IRS tax code as an incentive to recruit potential providers of AFC services.³⁹ Officials in Maine created a strategy based on the successful implementation of their recruitment pilot program. Through partnerships with the State Housing Authority, the Department of Health and Human Services, and a private foundation, the Genesis Fund hosted orientation sessions that provided potential applicants with information about licensing requirements, tools for creating a business plan, resources for obtaining financing, and information on conducting care assessments and care plans.

Indiana developed a strategy to stabilize and expand the supply of providers. The Indiana Division of Aging created an AFC Advisory Board for providers. The board's goal is to find ways to enhance services, supply technical assistance to providers, and increase the number of providers. According to a news release from the Division of Aging, the agency created the board to engage stakeholders and collaborate with providers on a statewide basis and to receive ideas and suggestions on how to improve programs and services.⁴⁰

Many states are using the Internet to recruit providers and increase awareness about adult foster care among consumers. In the past few years, the information on assisted living and other residential care settings on Web sites hosted by state agencies has increased considerably. A review of licensing agency Web sites identified a wide range of information (e.g., licensing regulations, survey guidelines, and incident reporting forms) useful to consumers and their families, owners, operators, and developers:

- Thirty-five states post links to their licensing regulations and statutes.
- Nine states post a list of licensed AFC providers.
- Nine states post additional information, primarily for AFC licensees.

³⁹ Title 26, §131 of the code exempts income for owner-occupied foster care providers serving no more than five residents.

⁴⁰ <http://www.in.gov/fssa/ddrs/2872.htm>.

- Four states post a consumer guide or a list of questions to help consumers and family members understand AFC.
- Three states include information from survey reports and complaint investigations.

Links to each Web site are included in the state summaries. States post information to help consumers and family members determine whether residential care will meet their needs, as well as tools for comparing facilities (e.g., guides, disclosure forms, and survey findings). Table 13 is an overview of information available on the Internet from states that regulate AFC as a separate category. States that include small providers under assisted living regulations are not included in the table.

Table 13						
AFC Information Available on the Internet						
State	Regulations	List of AFCs	Provider Tools	Consumer Information	Survey Findings	Other
AL						
AZ	•	•	•	•		
AR						
DE	•					
FL	•		•			
GA	•		•		•	
HI	•	•				
ID	•					
IN	•		•			
IA	•			•		
KS	•	•				
KY	•	•				
LA	•					
ME	•					
MA	•					
MI	•	•			•	
MN	•					
MS	•					
MT	•	•	•			
NE	•					
NV	•					
NH	•					
NJ	•					
NM						
NY	•					
NC	•	•	•			•
ND	•					
OH	•					
OR	•			•		
PA	•		•			•
SD	•					•
TN						
TX	•					
UT	•					•
VA	•					
WA	•	•	•	•		
WV	•					

Table 13 (continued)						
AFC Information Available on the Internet						
State	Regulations	List of AFCs	Provider Tools	Consumer Information	Survey Findings	Other
WI	•	•	•		•	
WY	•					
Total	35	9	9	4	3	
Other: NC: General information. PA: Forms, training guide. SD: Application. UT: Checklist.						

CONCLUSION

In the current economic environment, states are facing major budget shortfalls and are looking for viable options to provide services and supports to older adults and people with disabilities. In comparison to nursing homes, there is a lack of knowledge of the role of adult foster care in the long-term care landscape and how AFC can be a viable home and community-based option. From the state budgetary perspective, adult foster care may be a cost-effective alternative to institutional care. From the perspective of consumers, AFC can enhance their ability, regardless of age or income, to participate as fully as possible in all aspects of community living. As states consider the future of their AFC programs, the following are policy and programmatic elements that can foster marketplace development and identify resources.

POLICY RECOMMENDATIONS

SINGLE POINT OF ENTRY SYSTEM

Ensure that the single point of entry (SPE) system for long-term care services (i.e., Aging and Disability Resource Centers) provide information on AFC, including a clear description of AFC compared with board and care and assisted living. The SPE should serve all people, regardless of income. Adult foster care can be an affordable LTSS option for those who can pay privately, at least for several months or years.

The single point of entry is particularly helpful to avoid inappropriate institutional placement when a consumer is in crisis and care decisions must be made quickly. Some SPEs conduct assessments; counsel Medicaid-eligible consumers on LTSS options, including in-home care and AFC; and provide case management to ensure that consumers can make a choice that is available and appropriate.

CONSUMER EDUCATION

Educate consumers about AFC, and develop a matching strategy.

AFC will be most successful if older adults understand how the setting and services operate, and if they are a good match with the provider. Because AFCs are small businesses, revenue decreases when residents leave can affect business viability. Without

a strategy to refer and match residents with providers, the number of Medicaid participants will decline.

UNIFORM DISCLOSURE

Create a uniform disclosure form to provide consumers with comparable information among providers on services, discharge triggers, and rates.

Clearer consumer information will help potential residents evaluate their options. Uniform disclosure forms have been used effectively in other LTSS settings to provide consistent information across providers in a particular category. Disclosure categories could include discharge triggers, services offered, house rules, spend-down policies, rates, refund policies, private occupancy, and other issues.

NURSE DELEGATION AND OTHER STRATEGIES FOR ENHANCING ACCESS TO NURSING SERVICES

Develop clear nurse delegation statutes and systems to support AFC's ability to provide care to residents. Possible strategies include using contract nurses or nurses employed by the Medicaid program to provide clinical assistance. Better training, consulting, and oversight by nurses will improve the viability of AFC as a service delivery model.

For AFCs to meet the state's goal of providing noninstitutional care settings for very frail older persons, providers and caregivers who are not registered nurses must be able to conduct delegated nursing tasks, when appropriate. Nurse delegation allows a nurse to train AFC staff to provide certain traditional nursing services to a specific individual with stable needs. This delegation allows lower cost personnel to deliver ongoing services that would otherwise be unavailable or too costly in the small-scale AFC setting. The absence of such delegation either increases the operating costs for AFC providers or eliminates AFC as a choice for consumers.

Other strategies for enhancing access to nursing services are to incorporate contract nurses in the AFC Medicaid program. Contract nurses can train providers and staff on specific care techniques required by a resident, help providers set up required systems and records, and identify delegation needs. Contract nurses can provide critical clinical knowledge in a lay system that is providing care to persons with disabilities.

PROVIDER TRAINING

Implement training programs for providers, resident managers, and caregivers as a state service within an AFC program.

Training for all staff providing care to AFC residents is critical to ensure an acceptable standard of care. However, ensuring consistent delivery, accessibility, and acceptability of training among providers, resident managers, and caregivers is a significant challenge. Washington and Oregon have robust training programs—other states could use these as models to design or strengthen their own training programs.

Washington and Oregon officials believe that providing clear standards and alternative sources of training—including self-study and Web-based training—can increase the effectiveness of training, increase compliance, and reduce the cost to the state and providers.

STRATEGIES TO ENHANCE AFC FINANCING OPTIONS

Consider targeted financial assistance for AFC providers and other small HCBS providers.

Securing business loans is difficult for AFCs, and home loans for the renovations required by licensure will be challenging for the foreseeable future. The Iowa Finance Authority (IFA) administers two programs aimed at expanding HCBS options. First, IFA administers a Senior Living Revolving Loan Fund to support nursing home operators who are interested in converting their facilities to affordable assisted living and other models of service-enriched housing for elders and persons with disabilities. Iowa also maintains an HCBS Revolving Loan Fund to foster the development of programs such as adult day care, respite care, and congregate meals. Loans under the second initiative are at 1 percent interest for 20 years; if a provider repays the loan early, IFA will forgive the interest.⁴¹ States can also target certain housing financing programs at AFC.

REIMBURSEMENT RATES

Consider developing a tiered reimbursement rate system based on operational costs rather than basing rates on a percentage of nursing home or assisted living payments.

States use different methodologies to pay providers: flat rates, tiered rates, case mix rates, payments based on a care plan, and negotiated rates. Rates that vary depending on the assessed care needs of the resident create incentives for providers to continue to serve residents as their care needs increase. Tiered payments typically include three to five payment levels; case mix rates use multiple payment levels. Flat rates may be higher than necessary for residents with few needs and too low for those with many needs.

CASE MANAGERS – ROLE AND CASELOAD

Establish appropriate case management resources for AFC residents, and develop caseload parameters.

Case management is a critical part of making the day-to-day AFC system work and providing quality outcomes for residents. Case managers should conduct the initial assessment through the state's single point of entry and help match the resident to an AFC that will be a good fit. Case managers should monitor the care provided in the AFC at regular intervals. Case managers can reassess residents as needed, help residents negotiate with providers, and help residents move when necessary or preferred.

PROVIDER SCREENING

Develop a systematic, objective mechanism to screen AFC provider applicants for licensure.

Some states require that providers be “of good moral character,” undergo a criminal background check, provide references, and demonstrate experience with caregiving. These screening requirements aim to protect consumers from abuse and neglect, and can also reduce the state's liability.

⁴¹ Interview with Carla Pope, director of IFA Housing with Services, July 25, 2008.

RESPIRE FOR PROVIDERS

Provide respite personnel or substitute caregivers for AFC providers and resident managers.

Research has identified the availability of and reimbursement for respite personnel as a critical element in preventing provider burnout and turnover (a major resource and quality issue). This provision would ensure that AFC residents would experience seamless caregiving with a certified person, while allowing the provider to take time off. Substitute caregivers should receive specific instructions on care responsibilities from the provider/resident manager.

RECRUITMENT AND RESOURCE DEVELOPMENT

Develop a proactive recruitment process for AFC providers.

The potential benefits of AFC depend on the availability and supply of high-quality providers. States can play a key role in expanding the availability of AFC and providing the necessary tools to recruit new providers.

MULTIPLE FACILITIES

Consider limits on multiple home ownership by an individual provider.

Some states allow providers to operate multiple facilities with the caveat that they must be able to show financial solvency and management expertise for all the homes under their ownership. Some states require that providers operate a single facility for a minimum of a year before applying for a license for an additional facility. Because of the high failure rate when providers grow too fast, advocates in all states strongly suggested that the policy should be to allow providers to add only one site at a time, up to a maximum of three locations.

SPECIALIZED LICENSING

Consider specialized licensing to address needs of special populations and residents with higher acuity.

Many states require specialized licenses for AFCs that serve persons with developmental disabilities, mental illness, or cognitive disabilities, or those with caregiving needs beyond the needs of a typical frail elder. Under these licenses, AFCs that care for defined special populations must have staff with documented training in the needs of the population they serve. States can link specialized licensing—especially for higher acuity residents—to higher reimbursement rates.

APPENDIX A: NURSE PRACTICE ACTS: POLICY AVENUES TO PERMIT ASSISTANCE BY UNLICENSED PERSONS

This section outlines three policy models—exemption, delegation, and certification of unlicensed assistive personnel (UAP)—that allow unlicensed personnel to assist in performing nursing tasks. Because nurse practice policy regarding delegation is especially applicable to adult foster care settings, this section describes state policies on delegation in some detail, with particular attention to policies that help overcome barriers to delegation, such as fear of discipline, coercion, or unclear processes. Nurses can be involved in teaching tasks without formally delegating them. This section describes strategies that are available to interested parties to change nurse practice in their states. Strategies include attention to official policies and to the norms that affect nursing practice and the stakeholders that influence these norms.

MODELS FOR DEALING WITH UNLICENSED PERSONNEL

Three models allow unlicensed persons to assist with health maintenance tasks: exemption, delegation, and UAP certification. The models are not mutually exclusive; a state may use more than one model.

Exemption

Exemption occurs when a state defines its practice regulations as not applying to some categories of unlicensed persons. The traditional exemption policy model excludes family and friends who provide free care; in some cases, it excludes paid domestic assistants if their primary purpose is not to provide assistance with health-related tasks. Recently, states have used exemptions to allow consumer direction of aides (paid or unpaid) performing health maintenance tasks.¹

While several states require some initial medical or nursing oversight of the unlicensed assistant,² a hallmark of this model is the lack of explicit medical or nursing oversight.

¹ In addition to aides, some states use other terms such as personal care attendant or unlicensed assistive personnel (UAP).

² North Dakota's Medicaid program requires a physician's determination that a person is medically stable and capable of directing his or her care before allowing participation in consumer-directed programs (ND Century Code 50-24.1-18.1, accessed December 4, 2008, at <http://www.legis.nd.gov/cencode/t50c241.pdf>). New York's exemption for home care aides to Medicaid recipients requires that consumers be determined capable of self-direction by a registered professional nurse or that the aide's instructions come from a licensed nurse (see §6908 (1)(a)(iii), accessed December 4, 2008, at <http://www.op.nysed.gov/article139.htm>). Arkansas requires that aides demonstrate task proficiency to a nurse or doctor and limits the tasks that aides may perform (see http://www.arsbn.org/pdfs/rules_regs/2006/RR_Chapter5.pdf, which is authorized by statute (17-87-103(11), accessed November 29, 2008, at http://www.arsbn.org/pdfs/NURSEPRACTICEACT_2007__5_.pdf). The Arkansas program was based on Nebraska's language, though Nebraska has no requirement of medical personnel and no limit to tasks that may be performed. Nebraska's language was created in the mid-1990s but recently renumbered: "38-2219. Health maintenance activities; authorized.

- (1) The Nurse Practice Act does not prohibit performance of health maintenance activities by a designated care aide for a competent adult at the direction of such adult or at the direction of a caretaker for a minor child or incompetent adult.
- (2) Health maintenance activities are those activities which enable the minor child or adult to live in his or her home and community. Such activities are those specialized procedures, beyond activities of daily living, which the minor child or adult is unable to perform for himself or herself and which the attending physician or registered nurse determines can be safely performed in the home and community by a designated care aide as directed by a competent adult or caretaker.
- (3) A competent adult is someone who has the capability and capacity to make an informed decision.

This model provides maximum freedom for consumers who want to direct their own care and those who have a surrogate to direct their care if they are unable to do so. However, the model does not address the needs of consumers who are uncomfortable directing their own care.

Delegation

With delegation, regulations allow nurses to delegate specific tasks to unlicensed persons after performing an assessment of the consumer and verifying the competence of the aide. State regulations differ in whether they restrict the nursing tasks that can be delegated and in how much responsibility is assigned to the nurse for actions taken by the aide. Restrictive language can be a barrier to delegation, but even states with permissive regulatory language have found that nurses may not want to delegate without explicit permission or procedures supplied by their employers or state boards of nursing.

Delegation maximizes nursing oversight of consumers' care and provides maximum flexibility in determining the kinds of tasks an unlicensed person can safely perform. However, this model locates decision-making power with the nurse rather than with the consumer.

UAP Certification

With certification, unlicensed persons become paraprofessionals with their own scope of practice, although they may operate under the close supervision of nurses or other licensed professionals.³ Certified aides have existed in institutional settings for decades and are found in group settings such as assisted living.

Where aides are repeatedly doing similar tasks, certification can help nurses avoid reinventing the wheel with respect to training. Certification can also benefit the unlicensed person professionally, although turnover rates of certified aides are quite high because of low wages and poor working conditions. On the other hand, certification can increase costs without increasing the quality of care if nurses train aides to do tasks that they never actually perform. Also, some people have voiced concern that the division of labor created by such paraprofessionalization can result in the loss of an overall assessment of the consumer.

(4) For purposes of this section, caretaker means a person who (a) is directly and personally involved in providing care for a minor child or incompetent adult and (b) is the parent, foster parent, family member, friend, or legal guardian of such minor child or incompetent adult.

Source: Laws 1995, LB 563, § 9; Laws 1997, LB 66, § 1; Laws 1999, LB 594, § 41; R.S.1943, (2003), § 71-1,132.30; Laws 2007, LB463, § 775. Operative date December 1, 2008." Accessed September 9, 2009, at <http://www.dhhs.ne.gov/crl/statutes/Nursing-Nurse%20Practice%20Act.pdf> (The law was formerly numbered 71-1,132.30).

³ Certification is different from registries for background checks and the like. Most states that require certification also require background checks, but some states (Oregon, for example) require only background checks.

SUMMARY OF POLICY MODELS—POTENTIAL ADVANTAGES AND DISADVANTAGES

Policy	Potential Advantages	Potential Disadvantages
Exemption—practice laws do not apply to certain categories of unlicensed assistive personnel (UAP)	Maximizes consumer freedom.	Does not serve consumers who cannot or do not want to self-direct. No medical or nursing oversight
Delegation—nurses delegate tasks to UAP after assessing consumer and verifying aide competence	Maximizes nursing oversight while allowing flexibility of UAP to perform day-to-day tasks	Puts decision making in hands of nurse rather than consumer
Certification—UAP has standard curriculum and own scope of practice (Note: certification is not the same as registries that simply require background checks)	Keeps nurses from reinventing the wheel in training UAP	If not targeted appropriately, may increase costs without increasing quality Care may become over-compartmentalized and overall picture of consumer lost

TYPES OF POLICIES FOR ADULT FOSTER CARE SETTINGS

States use different methods to set policy, from formal legislation to the informal publication of guidelines. The following is a list of the types of policies we will consider, ranging from hardest to modify to easiest to modify:

- Laws—statutes must be passed through state legislatures.
- Regulations—rules and regulations are typically set by State Boards of Nursing or other state agencies, but may have to comply with public notification, hearing, and other requirements as required by state law.
- Advisory opinions—State Boards of Nursing can generally issue these at any time; requirements may be set in regulations.
- General procedural guidelines—may be put out by any organization at any time; influence depends on the legitimacy of the organization.

DELEGATION POLICY EXAMPLES

Almost all state policies on delegation include some overall guidance for the delegation process; generally, the guidance covers requiring nurses to make an initial assessment of the individual’s condition and the unlicensed assistant’s competence to assist, and retaining responsibility for any actions that require nursing knowledge or judgment. Policies differ with respect to language on accountability, the nurse’s authority to decide to delegate, prohibition of specific tasks, consideration of setting, and process details. We highlight interesting examples below, with comprehensive reference information in the notes to allow readers to find the relevant regulations.

Accountability

One of the biggest barriers to nurse delegation is nurses’ perception that delegating means allowing someone else to practice on their license, so that they will be personally

responsible for any bad outcomes.⁴ States attempt to address this issue through statutory language that defines or details the scope of accountability between the nurse and the unlicensed assistive person (UAP). In addition to the examples cited in Oregon and Washington, the following states have been explicit in their definitions of accountability.

Hawaii

Hawaii has the following language on accountability for delegation: “When the registered nurse delegates the responsibility to perform a special task to an unlicensed assistive person, the nurse shall be held accountable for the decision to delegate. The registered nurse shall be accountable for the adequacy of nursing care to the client, provided that the unlicensed assistive person performed the special task as instructed and directed by the delegating registered nurse.”⁵

North Dakota

North Dakota’s rules⁶ state that unlicensed persons are responsible for their own actions,⁷ while nurses are responsible for their delegation decisions and evaluation of outcomes,⁸ and retain professional accountability for nursing care when delegating.⁹

Maine

Maine has very general language about nurse accountability (“responsible for the nature and quality of all nursing care that a patient receives”) but specifies that “the nursing assistant shall be personally responsible and accountable for all actions taken by such nursing assistant in carrying out the tasks delegated to her/him under this chapter.”¹⁰

Nurse’s Decision to Delegate

Several states have taken extra steps with their regulations to ensure that the decision to delegate is truly the nurse’s. The following is some of the statutory language:

Oregon

Oregon’s language makes clear that nurses have the sole responsibility to delegate or rescind delegation based on their professional judgment and further clarifies the right of

⁴ Kane, R., M. O’Conner, and M. Olsen Baker, *Delegation of Nursing Activities: Implications for Patterns of Long-Term Care* (Washington, DC: AARP Public Policy Institute, 1995).

⁵ §16-89-112, accessed December 5, 2008, at http://hawaii.gov/dcca/areas/pvl/main/har/har_89-c.pdf (p.44).

⁶ See Title 54, Board of Nursing, accessed December 4, 2008, at <http://www.legis.nd.gov/information/acdata/html/Title54.html>.

⁷ Section 54-05-04-04.4a.

⁸ Sections 54-05-04-04.2e and 54-05-04-04.3e.

⁹ Section 54-05-02-03.2 for RNs and 54-05-01-03.12 for LPNs.

¹⁰ See 02-380 Chapter 5 (1) for nurses and subsection (C) for aides. Accessed December 5, 2008, at <http://www.maine.gov/sos/cec/rules/02/380/380c005.doc>.

the nurse to refuse to delegate.¹¹ The state makes nurses the mandated reporters of unsafe conditions, but nursing rules do not explicitly protect them from retaliation for doing so.¹²

Texas

In independent living settings, the rule states, “If the RN is employed, the employing entity must have a written policy acknowledging that the final decision to delegate shall be made by the RN in consultation with client or client’s responsible adult.”¹³

Wisconsin

The Wisconsin Nurses Association, facing a lack of state guidance on delegation, developed “Guidelines for Registered Nurse Delegation to Unlicensed Assistive Personnel,” in which it adopted the Washington state language: “No person may coerce the registered nurse delegator into compromising consumer safety by requiring the nurse to delegate if the registered nurse delegator determines it is inappropriate to do so.”¹⁴

Task Specification

Almost all states describe the kinds of tasks that may be delegated and generally prohibit the delegation of any tasks that require nursing judgment or ongoing assessment, as well as those with potentially serious health consequences. Some states go further, creating lists of permitted or prohibited tasks. Oregon and Washington—which probably have the most delegation in community settings, including AFC—have prohibitions. Oregon puts restrictions on the delegation of intravenous medications and intramuscular injections.¹⁵ Washington specifically prohibits injections (other than insulin, approved in some instances in 2008), sterile procedures, and central line maintenance.¹⁶

Setting Considerations

Several states treat delegation differently in different settings. The primary differentiation is whether the purpose of the setting is to provide health care services (e.g., hospitals, nursing homes) or not (e.g., schools, prisons, other community settings). Rules are often more liberal in community settings—this may be a way for states to allow more flexibility for consumers in community settings without allowing opportunistic behavior by institutions that deal with resource constraints. The National Council of State Boards of

¹¹ “(d) The decision whether or not to delegate a task of nursing care, to transfer delegation and/or to rescind delegation is the sole responsibility of the Registered Nurse based on professional judgment. (e) The Registered Nurse has the right to refuse to delegate tasks of nursing care to unlicensed person if the Registered Nurse believes it would be unsafe to delegate or is unable to provide adequate supervision.” OAR 851-047-0030(1). Accessed August 4, 2008, at <http://www.oregon.gov/OSBN/adminrules.shtml>.

¹² OAR 851-047-0000: “The Registered Nurse is responsible for: (a) Assessing a client situation to determine whether or not delegation of a task of nursing care could be safely done; (b) Safely implementing the delegation process; (c) Following the Board’s process for delegation as described in these rules; and (d) Reporting unsafe practices to the facility owner, administrator and/or the appropriate state agency(ies).” Accessed August 4, 2008, at <http://www.oregon.gov/OSBN/adminrules.shtml>.

¹³ See §225.9(c), <http://www.bon.state.tx.us/nursinglaw/pdfs/bon-rr-0309.pdf>, p. 142. Accessed September 9, 2009.

¹⁴ Published in 2002. See http://www.wisconsinnurses.com/work_advoc/pdf_files/uaps.pdf. Accessed September 9, 2009. The 2004 Wisconsin Board of Nursing white paper referenced in note 3 does not reference this document.

¹⁵ See OAR 851-047-0010(22) and OAR 851-047-0030 (8), (9) and (11). Accessed August 4, 2008, at <http://www.oregon.gov/OSBN/adminrules.shtml>.

¹⁶ See WAC 246-840-910 (accessed December 5, 2008, at <http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840-910>) for prohibitions; regarding insulin, see RCW 18.79.260(3)(e)(iv), accessed December 5, 2008, at <http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79.260>.

Nursing guidelines differentiate between settings that have a “structured nursing organization” and those in which “health care plays a secondary role.”¹⁷

- **California** prohibits nurse delegation in acute care settings.¹⁸
- **Texas** differentiates between acute care and independent living environments (independent living environments include a lack of continuous nurse staffing and clients who have stable conditions and are willing to participate in decision making).¹⁹
- **Oregon** has separate rules for delegation in acute care environments and in community environments in which nurses are not regularly scheduled.²⁰
- **Washington’s** delegation rules apply only to community-based settings, such as residential programs for people with developmental disabilities, adult family homes, and boarding homes or in-home settings where people reside. Acute care and skilled nursing facilities are explicitly excluded.²¹
- **Hawaii’s** rules on delegation apply “only in settings where a registered nurse is not regularly scheduled and not available to provide direct supervision”—for example, supervised group living settings, supervised or sheltered work settings, independent living or assisted living settings, schools, and day care centers. “Acute care or long-term care settings or any other setting where the regularly scheduled presence of a registered nurse is required by law” are explicitly excluded.²²
- **Alaska** allows delegation of medication administration only to providers of home and community-based services or residential supported living services who have completed specialized training.²³
- **Minnesota** limits assistive roles differently for different settings,²⁴ as does **Ohio**.²⁵
- **Maine** differentiates home care settings from settings with an organized nursing service.²⁶
- The **Wisconsin** Board of Nursing white paper on delegation notes that in community settings—such as “self-care residential settings; for example, community-based

¹⁷ See “Working With Others” (2005), accessed December 5, 2008, at https://www.ncsbn.org/Working_with_Others.pdf.

¹⁸ See <http://www.rm.ca.gov/pdfs/regulations/npr-b-29.pdf> (accessed December 5, 2008).

¹⁹ See Rules and Regulations (chapter 224 for acute and 225 for independent living) at <http://www.bon.state.tx.us/nursinglaw/pdfs/bon-rr-0309.pdf> (accessed September 9, 2009).

²⁰ See “RN Delegation in Settings other than Community-Based Care,” accessed December 5, 2008, at <http://www.oregon.gov/OSBN/pdfs/policies/NurseDelegation.pdf>, as well as chapters 45 and 47 (community settings) of the rules at <http://www.oregon.gov/OSBN/adminrules.shtml>.

²¹ See <http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79.260> (accessed December 5, 2008).

²² See §16-89-102, accessed December 5, 2008, at http://hawaii.gov/dcca/areas/pvl/main/har/har_89-c.pdf.

²³ Per 12 AAC 44.965, accessed September 9, 2009, at http://www.commerce.state.ak.us/occ/pub/NUR_delegation_regs.pdf

²⁴ See <https://www.revisor.leg.state.mn.us/rules/?id=9555.6225>, <https://www.revisor.leg.state.mn.us/rules/?id=4655.7860>, <https://www.revisor.leg.state.mn.us/rules/?id=4668.0855>, and <https://www.revisor.leg.state.mn.us/rules/?id=4668.0100>.

²⁵ See summary at <http://www.cshp.rutgers.edu/cle/Products/NDIFAppendixWEB.pdf>, p.56 (accessed December 5, 2008).

²⁶ See 02-380 Chapter 5 (1). Accessed December 5, 2008, at <http://www.maine.gov/sos/cec/rules/02/380/380c005.doc>.

residential facilities, prisons, or some school settings”—nurses may provide consultation regarding activities such as medication administration. However, the responsibility for making sure the activity happens resides elsewhere (e.g., with the physician, the resident, or a parent), so the nurse is not really delegating.²⁷

Process Details

In most cases, rules provide only general guidelines for the delegation process, which can leave questions in nurses' minds about acceptable methods of verifying competence and documenting training. States in which delegation is widely practiced have developed tools and guidelines to help nurses put processes into practice.

Documentation

Both Oregon and Washington have developed forms for their contract nurses to document delegation activities.²⁸ The forms enable nurses to document that they have assessed the consumer, taught the task, verified the competence of the unlicensed person, and supervised or taken other actions.

Supervision

What is acceptable supervision? Many states leave this entirely up to the nurse's professional judgment, but Oregon and Washington offer explicit guidelines.

- Oregon requires a reassessment of delegation no more than 60 days after initiation and 180 days at any point thereafter (the nurse may assess more frequently).²⁹
- Washington requires “reevaluation and documentation” at least every 90 days for all tasks.³⁰ For insulin injections (authorized by legislation in March 2008), supervision must occur weekly for the first four weeks and at least every 90 days thereafter.³¹

Teaching Tools

Oregon has developed many resources for its community-based nurses:

- A Web page of tools for community nursing³²
- A self-study course for delegation in community settings³³
- A community health support program manual (formerly known as the contract nursing program manual)³⁴ and updates for providers³⁵

²⁷ See <http://drl.wi.gov/dept/papers/pap05.pdf> (accessed December 5, 2008).

²⁸ Oregon plans to reduce the number of forms; see <http://www.dhs.state.or.us/spd/tools/cm/crn/l.htm#1>.

For Washington, see <http://www.aasa.dshs.wa.gov/Professional/ND/forms.htm> (accessed December 5, 2008).

²⁹ See OAR 851-047-0030(4). Accessed August 4, 2008, at <http://www.oregon.gov/OSBN/adminrules.shtml>.

³⁰ See WAC 246-840-930 (18). Accessed December 5, 2008, at <http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840-930>.

³¹ See RCW 18.79.260(3)(e)(v). Accessed December 5, 2008, at <http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79.260>.

³² See <http://www.oregon.gov/DHS/spd/provtools/nursing> (accessed December 5, 2008).

³³ See http://www.oregon.gov/DHS/spd/provtools/nursing/study_guides/rn_delegation.pdf (accessed December 5, 2008).

³⁴ See <http://www.oregon.gov/DHS/spd/provtools/nursing/chsp0708manuall.pdf> (accessed December 5, 2008); see the old manual at http://www.dhs.state.or.us/spd/tools/cm/crn/manual_index.htm (accessed December 5, 2008).

Washington has developed training for nurses³⁶ and aides.³⁷ As part of the nurse training, Washington provides nurses with instructional aides to help them teach tasks.³⁸ The state also provides an FAQ page for caregivers.³⁹

Distinguishing Teaching or Consultation from Delegation

Nurses are trained that part of their practice involves teaching—particularly to consumers and their families. However, they are also trained to feel responsible for nursing care that consumers receive, whether or not they provide that care directly. This can lead to conflicted feelings for nurses—when they teach, are they responsible for care that may be provided as a result of the teaching? Nurse leaders recognize this conflict, but it may not be reflected in rules. As a Board of Nursing executive stated, “[We need to] try to get clearer on delegation versus teaching, particularly in self-directed care, or even in a number of other settings ... I can teach someone to do something—I am not delegating that to them. ... that’s ... difficult to tease apart.”⁴⁰

Oregon makes a distinction between the two in its rules:

- “‘Delegation’ means that a registered nurse authorizes an unlicensed person to perform tasks of nursing care in selected situations and indicates that authorization in writing. The delegation process includes nursing assessment of a client in a specific situation, evaluation of the ability of the unlicensed persons, teaching the task, ensuring supervision of the unlicensed persons and reevaluating the task at regular intervals. For the purpose of these rules, the unlicensed person, caregiver or certified nursing assistant performs tasks of nursing care under the Registered Nurse’s delegated authority.”⁴¹
- “‘Teaching’ ... means providing instructions for the proper way to administer noninjectable medications and/or perform a task of nursing care. Teaching may include presentation of information in a classroom setting or informally to a group, discussion of written material and/or demonstration of a technique/procedure.”⁴²

In Oregon’s description of “teaching” in the rules, it begins to look like delegation, in that nurses must provide comprehensive written instructions and have responsibility for periodic inspection or reevaluation. However, the intervals are not specified as they are with delegation but are left to the nurse’s discretion.⁴³

³⁵ See <http://www.dhs.state.or.us/spd/tools/cm/crn> (accessed December 5, 2008).

³⁶ See <http://www.aasa.dshs.wa.gov/professional/ND/TOC.htm> (accessed December 5, 2008).

³⁷ See <http://www.adsa.dshs.wa.gov/professional/training/fundamentals/> (accessed December 5, 2008).

³⁸ See http://www.aasa.dshs.wa.gov/Professional/nursedel/documents/NA_Sample_Instr.doc (accessed December 5, 2008).

³⁹ See https://fortress.wa.gov/doh/hpqa1/hps6/Nursing/Caregiver_FAQ.htm (accessed December 5, 2008).

⁴⁰ See Reinhard, S. C., and J. Farnham, *Invitational Forum: Advancing Consumer Choice Through Better Understanding of Nurse Delegation*, Community Living Exchange: Meeting Summary (New Brunswick, NJ: Rutgers Center for State Health Policy, p. 20). Available at <http://www.cshp.rutgers.edu/cle/Products/NDIFPaperWEB.pdf>.

⁴¹ OAR 851-047-0010 (7). Accessed August 4, 2008, at <http://www.oregon.gov/OSBN/adminrules.shtml>.

⁴² OAR 851-047-0010 (23). Accessed August 4, 2008, at <http://www.oregon.gov/OSBN/adminrules.shtml>.

⁴³ See OAR 851-047-0020). Accessed August 4, 2008, at <http://www.oregon.gov/OSBN/adminrules.shtml>.

The Wisconsin Board of Nursing white paper on delegation describes a consultative role for nurses in community settings that is different from delegation and similar to Oregon's description of teaching.⁴⁴

RESEARCH ON DELEGATION

Kane and colleagues focused on nurse delegation as a policy instrument to encourage or discourage home and community-based services.⁴⁵ In the late 1990s, Heather Young and several colleagues evaluated the process of nurse delegation in the state of Washington. They found no evidence of any harm to consumers with the implementation and some benefit with respect to bringing nursing expertise and oversight to what had been unlicensed practice.⁴⁶ In 2001, Reinhard described statutes and regulations on nurse delegation and exemptions from nurse practice regulations in all 50 states.⁴⁷ Reinhard and colleagues also examined nurse delegation of medication administration in assisted living across the country,⁴⁸ published descriptions of how delegation operates in Washington⁴⁹ and Oregon,⁵⁰ and convened a forum on delegation with boards of nursing and staff from agencies that use nursing services to discuss the difficulty of regulating nurse delegation.⁵¹ In 2005, the National Council of State Boards of Nursing published its research and policy prescriptions on delegation in a report entitled *Working with Others*.⁵²

INFLUENCING NURSE PRACTICE DECISIONS

Nurse Practice Policy

The formulation and design of nurse practice policy occurs at the state level; thus, the State Board of Nursing, which licenses and disciplines nurses practicing within its borders, is a critical stakeholder in any effort to make policies influencing nursing practice. Regulations also exist for what nurses may do in specific settings. National bodies are influential, such as

⁴⁴ See <http://drl.wi.gov/dept/papers/pap05.pdf> (accessed December 5, 2008).

⁴⁵ Kane et al., 1995.

⁴⁶ See Young H. M., S. K. Sikma, S. J. Eyres, et al., "Nurse Delegation Study Final Report," University of Washington, Seattle, 1998, p.23. Accessed December 4, 2008, at <http://www.doh.wa.gov/hsqa/uwstudy.doc>. See also Sikma, S., and H. Young, 2001, "Balancing Freedom with Risks: The Experience of Nursing Task Delegation in Community-Based Residential Care Settings," *Nursing Outlook* 49:193–201, p.198.

⁴⁷ Reinhard, S. C., 2001, "Consumer-Directed Care and Nurse Practice Acts," Rutgers Center for State Health Policy, New Brunswick, NJ. Available at <http://www.cshp.rutgers.edu/PDF/consdirnurspract.PDF>.

⁴⁸ Reinhard, S., H. Young, R. Kane, and W. Quinn, 2003, "Nurse Delegation of Medication Administration for Elders in Assisted Living," Rutgers Center for State Health Policy, New Brunswick, NJ. Available at <http://www.cshp.rutgers.edu/Downloads/320.pdf>.

⁴⁹ Reinhard, S., and H. Young, 2006, "Washington's Nurse Practice Policies for Home and Community Living," Rutgers Center for State Health Policy and National Academy for State Health Policy: Community Living Exchange, New Brunswick, NJ. Available at <http://www.cshp.rutgers.edu/cle/Products/WashNursePracPolicyWEB.pdf>.

⁵⁰ Reinhard, S., and W. Quinn, 2004, "Oregon's Nurse Practice Policies for Home and Community Living," Rutgers Center for State Health Policy and National Academy for State Health Policy: Community Living Exchange, New Brunswick, NJ. Available at <http://www.cshp.rutgers.edu/cle/products/QuinnOregon.pdf>.

⁵¹ Reinhard, S., and J. Farnham, 2006, "Invitational Forum: Advancing Consumer Choice Through Better Understanding of Nurse Delegation," Community Living Exchange: Meeting Summary, Rutgers Center for State Health Policy, New Brunswick, NJ. Available at <http://www.cshp.rutgers.edu/cle/Products/NDIFPaperWEB.pdf>.

⁵² Accessed December 5, 2008, at https://www.ncsbn.org/Working_with_Others.pdf.

the National Council of State Boards of Nursing, which developed a Model Nursing Act and Rules on which many State Boards of Nursing have based their own regulations.⁵³

The State Board of Nursing or another state agency may regulate certified unlicensed personnel, and these regulations may limit their scope of practice.⁵⁴

Nurse Practice Decisions

Nurse practice policy creates the boundaries within which practice decisions are made, but there are other influences on practice decisions, particularly when policy is vague or general. In addition to Boards of Nursing, nurses look to employers, educators, peers, and professional organizations to help them determine good practice. Employers are influenced by the requirements of the private or public entities that pay for care, as well as the entities that provide licensing, accreditation, and liability insurance. Employers also look to their peers and trade associations to determine the norms of acceptable practice. These additional stakeholders may need to be involved along with the state board of nursing to change nurse practice norms.⁵⁵

NEW JERSEY DELEGATION PILOT: CASE STUDY

For nearly a decade, officials in several New Jersey state agencies have discussed the possibilities of using nurse delegation to allow people with disabilities to live in community settings. New Jersey nursing practice policy allows delegation, but officials recognized that it would not occur without some additional guidance and encouragement to change existing practice norms. Currently, nurses may delegate tasks, including medication administration in assisted living and AFC settings. However, regulatory language has been a barrier to delegation in individual homes.

Most home care in New Jersey is provided by agencies. Officials found that agencies feared negative consequences with regard to liability insurance and accreditation if they allowed delegation, and nurses in the agencies feared for the status of their licenses if they delegated. Over the years, the state sponsored several stakeholder meetings to discuss the potential parameters of a nurse delegation program. Meetings included state officials, agencies and trade associations, insurers, nurses, nurse educators and nurse associations, aides, and consumer advocates. In 2007, the state Division of Disability Services received a grant to pilot a nurse delegation program in one of its Medicaid programs.⁵⁶ The division worked closely with the board of nursing and other stakeholders to design the program—complete with forms to document assessment and delegation, a comprehensive orientation for nurses in participating agencies, and an evaluation of the pilot. The New Jersey example shows that even where policy permits delegation, much effort is required to change practice.

⁵³ National Council of State Boards of Nursing (2004, revised 2006), “Model Nursing Act and Rules.” Accessed December 3, 2006, at <https://www.ncsbn.org/1455.htm>.

⁵⁴ For example, in New Jersey, certified homemaker home health aides are not permitted to administer medications. There is nothing in nurse practice regulations that prohibits the delegation of medication administration by nurses, but because of this restriction, nurses are unable to delegate medication administration to this type of aide. See NJAC 13:37-14.3 (b), accessed December 3, 2008, at <http://www.nj.gov/lps/ca/laws/hhharegs.pdf>.

⁵⁵ For discussions of policy developments in several states, see Reinhard and Farnham, 2006.

⁵⁶ See announcement at <http://nj.gov/humanservices/dds/projects/njndp/index.html>, accessed August 7, 2009.

APPENDIX B: EXAMPLE OF AN OPERATING BUDGET

This appendix describes a business model for a new single-home adult foster care provider.

1. **Start-up costs.** In this budget scenario, we assume that the new owner/operator has \$20,000 in start-up funds from a home equity loan. Total start-up costs are \$21,850. The home is a ranch-style; the owner is going to convert the garage into an additional bedroom. She needs to purchase furniture for this bedroom and for common areas. The provider also must purchase supplies related to compliance with life safety and public health codes. Finally, she must budget for legal and accounting support, licensing fees, and training fees. In this scenario, the provider relies on the Area Agencies on Aging (AAAs) for referrals, so only a small amount is budgeted for the production of a brochure, which will be shared with AAA staff.

Starting Cash	\$20,000
Start-up Costs	
Construction/rehab.	15,000
Machinery/equipment	-
Furniture/fixtures	1,500
Vehicles	-
Supplies	1,500
Legal, accounting, and professional fees	2,500
Licenses, permits	1,000
Training, certification	200
Deposits	-
Initial advertising, marketing	150
Total start-up costs	21,850
Available cash after start-up	\$ (1,850)

Expenses exceed the home equity line of credit; the provider must cover the overrun (\$1,850) out of pocket.

2. **Operating revenue.** The provider will serve five residents: four enrolled in a Medicaid waiver program that covers AFC and one private pay resident. The Medicaid beneficiaries pay for room and board with their SSI benefit or other income. The Level A residents have the most needs, and the Level C resident has the least intensive needs. The private pay resident, who has lighter needs, pays \$2,100 for services and \$500 for room and board.

Total gross monthly income is \$10,510, minus any revenue lost because of vacancies (see table B-2). Vacancy rates are based on the estimated number of days residents are absent from the home or days a bed stays empty while waiting for a placement.

Because the state agency makes the referrals, all services related income are tax exempt. However, the AFC provider is concerned about her retirement and would prefer to pay the full income tax amounts. She believes that if she does not, her Social Security retirement check will be affected.

**Table B-2
Operating Revenue**

Medicaid Waiver Levels	# of Clients	Revenue/ Client	Revenue					
			Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
Level A # of Residents	2	\$1,687.50	\$3,375.00	\$3,375.00	\$3,375.00	\$3,375.00	\$3,375.00	\$3,375.00
Level B # of Residents	1	\$1,602.90	\$1,602.90	\$1,602.90	\$1,602.90	\$1,602.90	\$1,602.90	\$1,602.90
Level C # of Residents	1	\$1,446.60	\$1,446.60	\$1,446.60	\$1,446.60	\$1,446.60	\$1,446.60	\$1,446.60
Second Occupants								
Room and Board	4	\$600.00	\$2,400.00	\$2,400.00	\$2,400.00	\$2,400.00	\$2,400.00	\$2,400.00
Other Rental Subsidies			-	-	-	-	-	-
VA Services								
VA Service Reimbursements			-	-	-	-	-	-
Room and Board			-	-	-	-	-	-
Private-Pay Services								
Private-Pay Residents - Level A	1	\$2,100.00	\$2,100.00	\$2,100.00	\$2,100.00	\$2,100.00	\$2,100.00	\$2,100.00
Private-Pay Residents- Level B			-	-	-	-	-	-
Private-Pay Residents - Level C			-	-	-	-	-	-
Second Occupants			-	-	-	-	-	-
Rental Subsidies	1	\$500.00	\$500.00	\$500.00	\$500.00	\$500.00	\$500.00	\$500.00
Other Revenue/Subsidy								
			-	-	-	-	-	-
Total Gross Revenue			\$11,424.50	\$11,424.50	\$11,424.50	\$11,424.50	\$11,424.50	\$11,424.50
Less Vacancy Rate			\$913.96	\$913.96	\$913.96	\$913.96	\$913.96	\$913.96
Total Net Revenue			\$10,510.54	\$10,510.54	\$10,510.54	\$10,510.54	\$10,510.54	\$10,510.54

3. **Profit and loss (P&L) statement.** It is important for providers to precalculate specific line items in a profit and loss statement. This enables them to concentrate on differentiating between expenses associated with the AFC business and household expenses. Providers also must enter debt service for any rehabilitation or fixed asset costs associated with the business start-up. Table B-3 lists personnel expenses first, then other operating expenses.

Table B-3 Personnel Expenses		
	Month 1	Month 2
Beginning Cash	\$(1,850.00)	\$(63.46)
Revenue		
Total Net Revenue (Do not enter any amounts in this row of cells)	\$10,510.54	\$10,510.54
EXPENSES:		
Personnel Expenses		
AFC Provider	\$2,500.00	\$2,500.00
Substitute Caregiver	\$1,000.00	\$1,000.00
Activities Director	-	-
RN or LVN/LPN	\$300.00	\$300.00
Nurse On-Call Fee (per month)	-	-
Other Personnel	\$200.00	\$200.00
Subtotal Personnel Costs	\$4,000.00	\$4,000.00
Benefits, Taxes, Etc.		
Overtime, Holiday, Vacation Pay	-	-
Worker's Comp.	-	-
Payroll Taxes	\$850.00	\$850.00
Health Insurance	\$400.00	\$400.00
Other	-	-
Other	-	-
Total Benefits, Taxes, etc.	\$1,250.00	\$1,250.00
Total Personnel Costs	\$5,250.00	\$5,250.00

First, the provider assesses her personal costs. She is planning for \$2,500 in income to support her household, which includes herself and her husband, who is semi-retired. Other owner/operator costs include income taxes and health insurance for herself.

She has budgeted for \$1,000 a month for substitute caregiver time. This will cover one weekend off each month. She has also included \$300 a month for nursing care delivered to the private pay resident; the Medicaid beneficiaries will receive nursing care through another Medicaid benefit. Finally, under "Other personnel," she has budgeted for a housekeeper to deep-clean the kitchen and bathrooms once a month, as well as light housekeeping once a month. The following is an overview of other direct costs related to AFC operations.

Table B-4		
Other Expenses		
ADMINISTRATION		
TOTAL ADMINISTRATION	\$500.00	\$700.00
RESIDENT CARE		
Care Supplies	\$250.00	\$250.00
Pharmacy	-	-
Activity Supplies and Entertainment	\$15.00	\$15.00
Housekeeping Supplies	\$100.00	\$100.00
TOTAL RESIDENT CARE	\$365.00	\$365.00
VEHICLE		
TOTAL VEHICLE	\$100.00	\$100.00
MARKETING		
TOTAL MARKETING	\$35.00	\$35.00
DIETARY		
TOTAL DIETARY	\$1,585.00	\$1,585.00
MAINTENANCE		
TOTAL MAINTENANCE	\$260.00	\$1,360.00
UTILITIES		
TOTAL UTILITIES	\$329.00	\$419.00
PROPERTY		
TOTAL PROPERTY	\$400.00	\$400.00
TOTAL OTHER EXP.	\$3,574.00	\$4,964.00
TOTAL OPERATING EXPENSES	\$8,824.00	\$10,214.00
NET OPERATING INCOME	\$1,686.54	\$296.54
ESTIMATED DEBT SERVICE		
Line of Credit	\$1,133	\$1,133
TOTAL ESTIMATED DEBT SERVICE	\$1,133.00	\$1,133.00
NET CASH FLOW AFTER DEBT	\$(1,296.46)	\$(999.92)

Includes office supplies and a few hours from an accountant to help with billing.

Dietary includes raw food and dietitian hours as required by licensure.

In her second month of operations, the home's HVAC needed significant repair work.

Monthly payment on home equity line of credit at 6.99% interest over a 30-year term.

This model is very liberal. It assumes prompt payment from all sources and only a handful of intermittent expenses, such as the HVAC repairs. It also assumes full occupancy and a vacancy rate within projections. On the basis of this scenario, in the first two months of operation, the single-home AFC operator will operate at a loss and will leverage other lines of credit to cover expenses. Barring unexpected expenses and a higher than projected vacancy rate, she will achieve break-even in month 4. If the vacancy rate remains low and the expenses remain within the

projections, the home operator would be able to shift as much as \$1,500 a month into reserves beginning in month 5 to cover delays in payment or other revenue or expense issues.

Because they are small businesses with limited reserves, AFC providers are especially sensitive to profit and loss changes. For example, the loss of the private pay resident for a two-month Medicare postacute care stay in a nursing facility would cut \$2,600 a month (or \$5,200) from annual revenue. Interviewees provided these other examples of unexpected costs:

- Vehicle maintenance
- Lags in payment, especially in managed care arrangements
- Increases in property taxes
- Prolonged illness of the owner/operator and the need to pay for substitute caregiving
- Helping residents with Medicare Part D drug co-payments

This model does not include personal expenses for the resident owner other than health insurance, only expenses as they relate to the AFC business. In the long term, the provider can expect a total net cash flow after debt of approximately \$2,000 a month to place in reserves or to cover unexpected costs.

APPENDIX C: STATE PROFILES

Information in the state summaries is based on a review of each state's regulations and communication with staff of the agency responsible for adult foster care. In some cases, the regulations were ambiguous. The background information varies with the activity in the program and the responses of staff contacted for the report. Information was not available from all states. Each summary includes information on the following topics:

- Definition of AFC
- Admission/retention criteria
- Assessment and care planning process
- Services available
- Medications
- Resident agreements
- Public Financing
- Staffing
- Training
- Oversight and monitoring

Information for states that cover small facilities under assisted living or other residential categories is based on "Residential Care and Assisted Living Compendium, 2007," available at <http://aspe.hhs.gov/daltcp/reports/2007/07alcom.htm>.

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ALABAMA

BACKGROUND

The Department of Human Resources (DHR) developed adult foster care regulations in 1976 after passage of the Adult Protective Services Act. The number of licensed homes is 95. The program served 72 participants in May 2008. The regulations primarily address the home environment.

Web Site	Content
Not available	

DEFINITION

Foster care for adults is a service provided in private homes for persons who are in need of residential care in a family setting. This service must be provided in the permanent personal residence of the persons approved to provide this level of care. The maximum number of people providers may serve in a home is three.

ADMISSION/RETENTION CRITERIA

Adult foster care serves adults who need protective services, are unable to live in their own homes, and cannot live with their families because of the family's inability or unwillingness to provide adequate care. DHS may arrange care for a person after a protective service investigation reveals that he or she cannot protect himself or herself from abuse, neglect, or exploitation.

ASSESSMENT AND CARE PLANNING PROCESS

Not described.

SERVICES

The foster care provider helps the participant carry out prescribed medical plans; provides personal care as necessary; and provides or arranges for transportation to health care appointments.

MEDICATIONS

Providers may remind residents to take prescribed medications but may not assist with or administer medications.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

A completed information sheet that describes when payment is due, the amount of the fee, and additional services and supplies available to residents.

PUBLIC FINANCING

The resident pays the provider 75 percent of his or her SSI benefit for room and board. For participants with limited income, DHR pays \$135 a month for supervision and services from general revenues and the Social Services Block Grant.

STAFFING

Providers must be over age 19 and able to read and write. Families must have sufficient income to meet their own needs and the room and board payment is used to meet the resident's needs. Substitute caregivers must be available if the provider will be outside the home for an extended period. Providers may seek outside employment if there is no detrimental effect on the health or safety of residents.

TRAINING

Foster families qualify on the basis of their training and experience. Providers receive an orientation during the application process. DHR used to hold quarterly meetings for providers and state staff in two counties, but these meetings have been discontinued.

OVERSIGHT AND MONITORING

On receipt of an application, DHR schedules a home study. The study includes information about the provider's financial status, character and suitability, employment, experience, and training, as well as characteristics of the home and references for the primary provider and substitute care providers. Providers are reexamined and evaluated annually. DHR is responsible for supervising care.

ALASKA

BACKGROUND

Assisted living rules include adult foster homes that serve three or more residents. Adult foster care homes are now licensed as assisted living homes.

The state allows homes that serve one or two unrelated adults to voluntarily apply for a license, which allows the home to participate as a Medicaid waiver service provider. Nothing in the regulations prohibits an assisted living home that is licensed and that serves five or fewer residents from using the term “adult foster home” or “assisted living foster home.”

Web Site	Content
http://www.hss.state.ak.us/dph/cl/PDFs/ALHGuidebook.pdf	Rules
http://www.hss.state.ak.us/dph/CL/PDFs/ALHomes.pdf	List

DEFINITION

An **assisted living home** is a residential facility that serves three or more adults who are not related to the owner by blood or marriage or facility that receives state or federal payment for services, regardless of the number of adults served. A facility is considered to be an assisted living home if it provides housing and food services to its residents; offers to provide or obtain for its residents assistance with activities of daily living; offers personal assistance, or provides or offers any combination of these services.

ADMISSION/RETENTION CRITERIA

To avoid transfer of a resident from the home for medical reasons, the home may provide 24-hour skilled nursing care to the resident for not more than 45 consecutive days. Extensions of the 45-day limit may be approved if the home agrees to retain the resident and either the resident or the resident’s representatives have consulted with the resident’s physician; the home and either the resident or the resident’s representative have discussed the consequences and risks involved in the election to remain in the home; and the portion of the resident’s assisted living plan that relates to health-related services has been revised to provide for the resident’s health-related needs without the use of 24-hour skilled nursing care. The rules allow variances of any provision of the regulations to promote aging in place and to meet the goals of the rules.

ASSESSMENT AND CARE PLANNING PROCESS

The statute specifies that one of the purposes of assisted living homes is to provide a resident of an assisted living home, or the resident’s representative, with the opportunity to participate to the fullest extent possible in the design and implementation of the resident’s assisted living plan and in any decisions involving the resident’s care.

Service plans are prepared within 30 days of move-in for each resident. The resident or his or her representative must approve the plan. The plan identifies the resident’s strengths and weaknesses in performing ADLs, physical disabilities and impairments, preferences for roommates, living environment, food, recreation, religious affiliation, and

other factors. The plan also identifies the ADLs with which the resident needs help, how the home or other agencies will provide help that meet the needs of the resident, and how they will address other health-related services. Health-related services include assistance with self-administration of medication, intermittent nursing services, 24-hour skilled nursing for 45 days, and hospice services.

The plan must promote the resident's participation in the community and increased independence through training and support, in order to provide the resident with an environment suited to the resident's needs and best interests.

SERVICES

Assisted living homes provide housing and food service (three balanced meals and a snack at reasonable times that meet USDA recommendations), assistance with the activities of daily living; and personal assistance. Homes may provide intermittent nursing services to a resident who does not require 24-hour nursing services and supervision. A licensed nurse or a person to whom a nursing task has been delegated may provide intermittent nursing services.

MEDICATIONS

Aides may provide medication reminders, read labels, open containers, observe a resident while taking medication, check self-administered dosage against the label, reassure the resident that the dosage is correct, and direct/guide the hand of a resident at the resident's request. Registered nurses may delegate tasks pursuant to state statute and rules.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

The statute specifies the terms for the residential services contract. The contract describes the services and accommodations; rates charged; rights, duties and obligations of the resident; policies and procedures for termination of the contract; amount and purpose of advance payments; and refund policy.

PUBLIC FINANCING

Alaska covers services in assisted living homes through the Medicaid §1915(c) home and community based services waiver for elders and adults with disabilities. The provider and resident negotiate the room and board payment. In a limited number of cases, the State's "general relief" program may cover room and board and some other services. The payment standard for SSI recipients is \$985 a month and the personal needs allowance is \$100 a month.

Rates vary by area of the state. A multiplier that ranges from 1.0 to 1.38 is applied to the rates, resulting in higher payments in rural and frontier areas (e.g., \$100 service in one region may be reimbursed at \$138 in another region). Providers receive a basic service rate that varies for adult foster care, adult residential I, and adult residential II. An "augmented service rate cost factor" is available for clients whose needs warrant the hiring or designating of additional staff. The augmented care payment recognizes the added staffing needed by homes caring for residents needing incontinent care, skin care, added supervision, and help with medication. Some residents also attend adult day care. The service rate is lower for residents attending day care at least three days a week.

STAFFING

Administrators must be 21 years of age or older and have sufficient experience, training, or education to fulfill the responsibilities of an administrator. Administrators in homes with 10 or fewer units must fulfill at least one of the following requirements: complete an approved management or administrator training course and one year of documented experience relevant to the population to be served, or complete a certified nurse aide training program and have at least one year of documented experience relevant to the population to be served, or two years of documented care experience relevant to the population to be served.

Homes must have the type and number of staff needed to operate the home and must develop a staffing plan that is appropriate to provide services required by resident care plans. Staff must pass a criminal background check.

TRAINING

Regulations require that administrators receive 18 hours of training annually; direct care staff, 12 hours annually. Staff providing direct care without supervision must have sufficient language skills to meet the needs of residents. Staff must receive orientation that covers emergency procedures, fire safety, resident rights, universal precautions, resident interaction, house rules, medication management and security, physical plant layout, and reporting responsibilities.

OVERSIGHT AND MONITORING

Both the Department of Health and Social Services and the Division of Senior and Disabilities Services are responsible for screening applicants, issuing licenses, and investigating complaints. The departments may delegate responsibility for investigating and making recommendations for licensing to a state, municipal, or private agency. Regulations require an annual monitoring visit or a self-monitoring report filed by the facility. The licensing agency may impose a range of sanctions: revoking or suspending the license, denying renewal, issuing a probationary license, restricting the type of care provided, banning or imposing conditions on admissions, or imposing a civil fine.

ARIZONA

BACKGROUND

Arizona’s assisted living regulations cover adult foster care (AFC), assisted living homes (ALHs) and assisted living centers (ALCs). The Department of Health certifies AFC providers, except in three counties, where the county agency certifies the homes.

AFC serves one to four persons, and the owner must live in the home. Assisted living homes serve fewer than 10 residents, and the owner does not live in the home. Assisted living centers serve 11 or more residents. AFC providers follow the same rules as other providers except that there are no licensing fees for AFC providers. Registered nurses may be AFC licensees and may provide services under their license, whereas ALHs and ALCs must contract for nursing services, even if the sponsor/administrator is a registered nurse. AFCs have a sponsor who is responsible for managing the home; ALHs and ALCs must have a manager.

At least one of the residents in adult foster care must enroll in the Arizona Long-Term Care System (ALTCS), which is the state’s managed long-term care program. All adult foster care providers must contract with ALTCS program contractors or managed care organizations as a condition of licensing. When ALTCS began in 1989, adult foster care was the only residential option covered.

Most of the certified AFCs are located in the major population centers of Phoenix, Tucson, and Prescott. The supply declined from 515 in 2001 to 345 in 2006. In October 2008, the department licensed 92 providers with a capacity of 361 beds. The decision by a large contractor to terminate its ALTCS contact is the primary reason for the drop in certified AFCs.

Adult foster care served 23.7 percent of all ALTCS members living in residential settings in 2001 and 8.5 percent in 2006. Over half of the ALTCS members living in residential settings live in larger assisted living centers. Although the department does not track acuity levels, AFC providers serve residents with lower needs than residents in other settings, because providers are not required to have 24-hour awake staff.

Web Site	Content
http://www.azsos.gov/public_services/Title_09/9-10.htm#pgfId-6598	Rules
http://www.azdhs.gov/als/index.htm	List, guide, tools

DEFINITION

Adult foster care is a residential setting that provides room and board and AFC services for at least one and no more than four adults who are participants in the Arizona Long-Term Care System, and in which the sponsor or the manager resides with the residents and integrates the residents who are receiving AFC into his or her family.

ADMISSION/RETENTION REQUIREMENTS

Assisted living facilities (ALFs) with a personal care service license may not accept or retain any resident who is unable to direct self-care; residents who require continuous

nursing services, unless the nursing services are provided by a licensed hospice agency or a private duty nurse; residents with a stage 3 or 4 pressure sore; or those who are bedbound owing to a short illness, unless the primary care physician approves, the resident signs a statement, and the resident is under the care of a nurse, a licensed home health agency, or a licensed hospice agency.

ALFs licensed to provide directed care services may admit residents who are bedbound, need continuous nursing services, or have a stage 3 or 4 pressure sore if the requirements for facilities providing personal care services are met.

ASSESSMENT AND CARE PLANNING PROCESS

Persons who are admitted into an assisted living program or an equivalent alternative are required to receive a preadmission screen (PAS) to ensure that they meet the institutional level of care but can live safely without harming themselves or others in the absence of 24-hour supervision. The PAS tool assesses a person's functional, medical, nursing, and social needs. These factors are weighted and assigned a numerical value. Reassessments for persons over 65 years are done on a case-by-case basis if questions arise about eligibility. Residents on ventilators undergo annual reassessments.

The service provider develops a plan of care and includes measurable goals and objectives for the outcome of services. The resident, manager, nurse, case manager, and any other person requested by the resident develops and reviews the care plan. An ALTCS case manager authorizes the plan and the specific treatment methodologies and services. The facility initiates the care plan upon the resident's arrival. The facility must complete the care plan no later than 14 days after the resident's has been accepted. The facility must update the plan within 14 days of a significant change in the resident's physical, cognitive, or functional condition. For residents who receive supervisory care services, the care plan is reviewed annually; personal care services are reviewed at least every six months; directed care services are reviewed every three months.

SERVICES

Adult foster care has two levels of licensure: personal care and directed care. A third level, supervisory care, may be offered by ALHs and ALCs but not by AFCs, because ALTCS members have higher service needs as a condition of eligibility for the program.

Personal care services include assistance with activities of daily living that can be performed by persons without professional skills or professional training; coordination or provision of intermittent nursing services; and administration of medication and treatments by a licensed nurse, or as otherwise provided by law.

Directed care services are programs and services, including personal care services, provided to residents who are incapable of recognizing danger, summoning assistance, expressing need, or making basic care decisions.

Adult foster care provider services include supervision and assistance with eating, bathing, toileting, dressing, self-medication and other routines of daily living; recreational activities; and assistance arranging transportation or other HCBS services (home health, home health aide, personal care, homemaker, respite, habilitation, transportation, or home-delivered meals). Staff of the AFC home may provide nursing or medical services. If the appropriate staff are onsite, residents may receive services in the

home regardless of the level of physical, emotional, or behavioral health care required, excepting hospitalization.

MEDICATIONS

AFC providers ensure that medication administration is available for residents. Arizona allows only the following persons to provide medication administration: a representative or relative of the resident, a nurse or medical practitioner or other person authorized by law, or an employee authorized by the resident’s physician. A nurse, pharmacist, or primary care provider (PCP) reviews the medication and medication record of each resident every 90 days and after a significant change of the person’s condition.

RESIDENT AGREEMENT/DISCLOSURE/CONTRACT

The resident signs the contract agreement on move-in. The agreement describes the resident’s and the provider’s rights, expectations, and obligations. It includes terms of occupancy; delivery of services; the amount and purpose of any fees; services available at additional charge; policy of refunding charges, or deposits; policy and procedure for termination; grievance policy, and AFC’s responsibility to provide 30 days’ written notice of fee increases. The provider must sign the residency agreement within five days of the resident’s acceptance.

PUBLIC FINANCING

Services in assisted living facilities are covered through the Arizona ALTCS program, which operates under a §1115 waiver. Adult foster care homes serve 276 ALTCS members. Program administrators originally used rates set for adult foster care, nursing facilities, the Oregon assisted living program, and the Arizona HCBS program as guidelines in setting rates. There are three classes of rates based on the level of care: low, intermediate, and high skilled. The rates include room and board paid by the resident. The monthly room and board amount is the resident’s “alternative share of cost” (spend down) or 85 percent of the current SSI payment, whichever is greater. The table below shows rates by program contract. The weighted average reflects participation among program contractors by level.

Arizona allows third party supplementation for room upgrades that are not part of the Medicaid payment. Rates were not available for all program contractors.

Arizona AFC Rates by Program Contractor			
Daily			
Program Contractor	Level I	Level II	Level III
Program A	NA	NA	NA
Program B	NA	NA	NA
Program C	\$51.00	\$51.00	\$51.00
Program D	\$52.61	\$52.61	\$52.61
Program E	\$70.11	\$70.11	\$70.11
Program F	NA	NA	NA
Program G	\$51.89	\$51.89	\$51.89
Program H	\$41.23	\$49.79	\$58.40

STAFFING

Homes are required to have sufficient personnel to provide the services needed by residents.

TRAINING

A licensee is required to complete training within 10 days of the opening date. The initial orientation includes an overview of resident's needs, rights, privacy, choice, and promotion of dignity and respect; the significance of resident service plans and how to read and implement a service plan; internal facility requirements, policies, and procedures; infection control; food preparation and storage; abuse, neglect, and exploitation prevention and reporting requirements; accident, incident, and injury reporting requirements; and fire, safety, and emergency procedures.

Caregivers and managers must complete a minimum of six hours of training every 12 months. The training includes promotion of resident dignity, self-determination, privacy, choice, and rights; safety procedures; infection control; assistance in self-administration of medication; and abuse, neglect, and exploitation prevention and reporting requirements.

OVERSIGHT AND MONITORING

With the exception of AFCs without deficiencies, the department inspects and renews licenses annually. The department licenses AFCs without deficiencies for two years.

ARKANSAS

BACKGROUND

The Division of Aging and Adult Services (DAAS) planned to certify adult family homes for participation in the Elder Choices Medicaid waiver program for home and community-based services in 2008. The division held an orientation meeting for potential providers. Nine providers, who participated in the AFC program operated by the Veterans Administration, attended the meeting.

Web Site	Content
Not available	

DEFINITION

An **adult family home** (AFH) is a service available through the Elder Choices Medicaid waiver program; it offers an alternative to nursing home placement. An adult family home provides a family living environment for no more than three persons who are not related to the principal care provider; who are functionally impaired; and who, owing to the severity of their functional impairments, are considered to be at imminent risk of death or serious bodily harm and, consequently, are not capable of independent living. An unrelated person is anyone who is not the waiver recipient's father, mother, grandparent, sister, brother, spouse, child, grandchild, or in-law.

ADMISSION/RETENTION CRITERIA

Providers must be able to meet the needs of residents who meet the nursing home level of care criteria established in the Elder Choices Medicaid waiver program.

ASSESSMENT AND CARE PLANNING PROCESS

Waiver case managers complete an assessment and establish a plan of care. AFH providers develop a service plan with the resident. The plan, signed by the waiver participant and the AFH provider, describes the resident's needs and capabilities, and the service supports needed.

SERVICES

Services customarily provided include personal care, homemaking, attendant care, supervision, medication oversight, and transportation. Personal care includes assistance with activities of daily living, such as assistance with personal care activities: dressing, grooming, toileting, eating, transferring, ambulating, bathing, getting in and out of bed, laundry, room cleaning, managing money, shopping, using public transportation, writing letters, making telephone calls, scheduling appointments and similar activities. Care includes 24-hour supervision, awareness of a resident's general whereabouts, and monitoring activities on the premises to ensure the resident's health, safety, and welfare. The provision of care helps the resident improve or maintain his or her level of functioning.

MEDICATIONS

AFH providers can remind residents to take their medications and oversee self-administration of medications.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Not described.

PUBLIC FINANCING

The Elder Choices waiver covers services in adult family homes. The daily service rate incorporates the functional level of the resident. Rates were increased in October 2008 to attract providers and participants to the program. The rates are Level A, \$56.25 a day; Level B, \$53.43 a day; and Level C, \$48.22 a day. Residents receive \$637 a month from SSI; they pay \$580 for room and board, and retain \$57 a month for personal needs.

STAFFING

Providers must be at least 21 years old, possess at least a high school degree or GED, and have a minimum of two years experience caring for a person with significant personal care needs, or have a minimum of six months formal work experience in a licensed home health care agency in a direct patient service role, or be a certified nursing assistant (CNA). Providers must live in the home. A qualified substitute caregiver must be present when the provider is absent for more than six consecutive hours.

Substitute caregivers must be at least 21 years old, possess at least a high school degree or GED, and successfully complete all training required by DAAS before assignment and all required continuing education thereafter. Substitute caregivers receive a full orientation from the provider, which includes the scope of their responsibilities, introduction to the resident, resident care plans and needs, location of fire extinguishers, demonstration of evacuation procedures, location of residents' records, emergency telephone numbers, location of medications, and any other procedures to ensure the safety and well-being of the residents.

TRAINING

Providers and substitute caregivers must successfully complete a training course that DAAS determines to enhance the level of care and achieve the desired home atmosphere for the resident. DAAS will authorize, administer, or supervise the successful completion of a comprehensive test. Participants have two opportunities to pass the test.

Providers and substitute caregivers must complete at least 12 hours of continuing education annually. The regulations identify a list of topics that must be covered in the curriculum, including implementation of the care plan; recognition of resident disabilities and the problems of aging; recognition of resident health care and mental health needs; management of behavioral problems; nutritional, basic hygiene and dental care; first aid; home management, administration, and recording keeping, including budgeting, shopping, organizing, and sanitizing; resident rights, including awareness of federal and state laws prohibiting discrimination; identification and use of community resources; fire safety; activity and exercise for persons with disabilities, including those developed through aging; mobility and transfer; special skin care needs; reality orientation; death

and dying; medications and reactions; cardiopulmonary resuscitation; the aging process; mental illness and mental retardation; behavior management; listening skills and communication; working with difficult clients; stress management; diseases/illnesses of the elderly; and forming and maintaining a community support network.

OVERSIGHT AND MONITORING

DAAS conducts annual inspections to assess compliance with the regulations.

CALIFORNIA

BACKGROUND

California licenses all facilities that care for older adults as Residential Care Facilities for the Elderly (RCFE), the state’s term for assisted living. Additional requirements in some areas are specified for facilities that serve more than 16 residents.

Web Site	Content
http://www.dss.cahwnet.gov/ord/PG295.htm	Rules
http://www.cclld.ca.gov/docs/cclld_search/cclld_search.aspx	List
http://www.cclld.ca.gov/PG832.htm	Provider

DEFINITION

A **residential care facility for the elderly** is a housing arrangement chosen voluntarily by the resident or the resident’s guardian, conservator, or other responsible person in which 75 percent of the residents are 60 years of age or older and varying levels of care and supervision are provided, as agreed to at the time of admission or as determined necessary at subsequent times of reappraisal. Younger residents must have needs compatible with those of other residents.

ADMISSION/RETENTION CRITERIA

Facilities may admit or retain residents who are capable of administering their own medications; persons who receive medical care and treatment outside the facility or from a visiting nurse; persons who because of forgetfulness or physical limitations need only to be reminded or helped to take medication usually prescribed for self-administration; persons with problems including, but not limited to, forgetfulness, wandering, confusion, irritability, and inability to manage money; and people with mild dementia or mild temporary emotional disturbance resulting from personal loss or change in living arrangement.

Facilities may not admit or retain anyone with a communicable disease; anyone who requires 24-hour skilled nursing or intermediate care; or anyone whose primary need for care and supervision results from either an ongoing behavior caused by a mental disorder that would upset the general resident group or dementia, unless certain requirements are met or the resident is bedridden. The regulations allow residents with health conditions that require incidental medical services that are specified in the rules (e.g., administration of oxygen, catheter care, colostomy/ileostomy care, contractures, diabetes, enemas, suppositories, fecal impaction removal, incontinence of bowel or bladder, injections, intermittent positive pressure breathing machine, and stage 1 and 2 dermal ulcers) to be admitted and retained if the resident can perform the care or a licensed professional provides care. Facilities may not serve people who require care for stage 3 and 4 dermal ulcers, gastrostomy care, naso-gastric tubes, tracheostomies, staph infection or other serious infection, or those who depend on others to perform all activities of daily living.

Facilities may retain residents who will be bedridden more than 14 days if the facility notifies the Department of Social Services that the condition is temporary.

ASSESSMENT AND CARE PLANNING PROCESS

Before admission, a determination of the prospective resident's suitability for admission is completed, including an appraisal of his or her service needs in comparison with the admission criteria. The appraisal shall include, at a minimum, an evaluation of the prospective resident's functional capabilities, mental condition, and social factors. The assessment includes bathing, dressing, toileting, transferring, continence, eating, vision, hearing and speech, walking, dietary limitations, and need for prescription medications. Before a person is accepted as a resident, the licensee shall obtain and keep on file documentation of a medical assessment, signed by a physician, conducted within one year before admission.

SERVICES

Facilities provide basic services, care, and supervision. Basic services include safe and healthful living accommodations, personal assistance and care, observation and supervision, planned activities, food service, and arrangements for obtaining incidental medical and dental care. Care and supervision covers assistance with activities of daily living and assumption of varying degrees of responsibility for the safety and well-being of residents. Tasks include assistance with dressing, grooming, bathing, and other personal hygiene; assistance with self-administered medications; and central storing and distribution of medications.

Legislation enacted a few years ago requires that RCFEs inform residents that they have the right to have an advance directive. The department developed a brochure explaining advance directives that care providers can give residents.

Legislation enacted in 1994 allows hospice care, provided the resident contracts individually with a hospice agency. Facilities must request a waiver to allow hospice care and must be able to meet the resident's needs when the hospice agency is not present. If the resident shares a room, the other party must agree to allow hospice care in the shared living space.

MEDICATIONS

Facility staff may assist with self-administration of medications and, if authorized by law, administer injections. Licensed home health agency personnel may also administer medications. Direct care staff in RCFEs, excluding licensed medical professionals, must meet specified training requirements, including passing an examination, to be permitted to assist residents with the self-administration of medications. Unlicensed personnel may not administer medications. Staff working in facilities with 15 or fewer residents must complete six hours of initial training on specified topics relating to medications, including two hours of hands-on shadowing and four hours of other training or instruction. A licensed nurse, pharmacist or physician must be involved in the development of the training and examination for all RCFEs. Employees who receive the initial training and pass the required exam, and who continue to assist with the self-administration of medications, must complete four hours of in-service training on medication-related issues in each 12-month period.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Admission agreements include provisions for the basic services available; optional services; payment provisions (basic rate, optional service rate, payer, due date, funding source); process for changing the requirements; refund policies; department or licensing agency authority to examine residents' records as a part of evaluation of the facility; general facility policies that make it possible for residents to live together; actions, circumstances, or conditions that may result in the resident's eviction from the facility; the facility's policy concerning family visits and other communication with residents; and other conditions under which the agreement may be terminated.

PUBLIC FINANCING

The California Department of Health Services developed an Assisted Living Waiver Pilot Project (ALWPP) in three counties to serve 1,000 people over three years in two settings: licensed RCFEs and conventional elderly housing sites. In the summer of 2007, 20 licensed assisted living facilities were participating in a pilot program serving 205 participants. Units have a kitchen area equipped with a refrigerator, a cooking appliance (microwave is acceptable), and storage space for utensils and supplies. Since the pilot requires private occupancy, with shared occupancy only by residents' choice, it is not comparable with adult foster care.

STAFFING

Providers must employ sufficient staff to deliver services required by residents. Facilities with 16 or fewer residents must have a qualified person on call. Requirements for awake staff vary by the size of the facility. Facilities serving 16 or fewer residents must have staff available onsite.

TRAINING

RCFE staff must undergo 10 hours of initial training on the aging process and physical limitations; techniques for providing personal care services; resident rights; medications; psychosocial needs; and recognizing signs and symptoms of dementia. On-the-job training or experience is required in the principles of nutrition, food storage and preparation, housekeeping, and sanitation standards; skill and knowledge to provide necessary care and supervision; assistance with medications; knowledge to recognize early signs of illness; and knowledge of community resources.

Administrators must complete an approved certification program before they are employed. The program must include 40 hours of classroom training that covers laws, rights, regulations, and policies (8 hours); business operations (3 hours); management and supervision (3 hours); psycho-social needs of the elderly (5 hours); physical needs of the elderly (5 hours); community and support services (2 hours); use, misuse, and interactions of drugs (5 hours); admission, retention, and assessment procedures (5 hours), and 4 hours in the care of residents with Alzheimer's disease and other dementias. All administrators are required to complete at least 20 hours of continuing education each year in areas related to aging or administration.

All staff members must be given on-the-job training or have related experience in the principles of good nutrition, food preparation and storage, and menu planning, as well as housekeeping and sanitation procedures. They must have the skill and knowledge to

provide necessary resident care and supervision, including the ability to communicate with residents; the knowledge required to safely assist with self-administered medications; the knowledge necessary to recognize early signs of illness and the need for professional help; and knowledge of community services and resources. All RCFE staff who assist residents with personal activities of daily living must receive at least 10 hours of initial training within the first four weeks of employment and at least 4 hours annually. The training shall include, but not be limited to, the following: the aging process and physical limitations and special needs of the elderly; techniques of personal care services, including, but not limited to, bathing, grooming, dressing, feeding, toileting, and universal precautions (at least 3 of the required 10 hours shall cover this subject); residents' rights; policies and procedures regarding medications (at least 2 of the required 10 hours shall cover this subject); psychosocial needs of the elderly, such as recreation, companionship, and independence; and recognizing signs and symptoms of dementia.

OVERSIGHT AND MONITORING

The agency inspects facilities on a rotating basis. Facilities are inspected on a random sample basis, but at least once every five years. The agency conducts annual inspections for facilities that require "targeted visits." These are facilities that need closer attention because of their compliance histories. There are three levels of penalties for violations with an (A) immediate, (B) potential, and (C) technical impact. Fifty dollars a day in civil penalties are allowed for A and B violations, increasing to \$100 a day if the facility repeats the same violation three times in a 12-month period. The agency provides consultation for Type C violations. California mandates that the licensing agency conducts an investigation within 10 days on any complaints received against a facility.

COLORADO

BACKGROUND

Colorado passed legislation in 2008 to license all adult foster homes as assisted living residences. The law replaced certification by single entry point agencies. As a result of this legislation, all adult foster home providers became assisted living residences and must comply with the regulations summarized below.

Web Site	Content
http://www.cdphe.state.co.us/hf/alr/index.html	Rules, list, consumer

DEFINITION

Previous policy considered **adult foster care** (AFC) as care provided on a 24-hour basis for no more than 16 residents in a nonmedical facility certified by the agency designated by the state for frail elderly, physically disabled, or emotionally disabled adults 18 years of age and older who do not require 24-hour medical care.

An **assisted living residence** is a residential facility that makes available to three or more adults not related to the owner of such facility (either directly or indirectly), through a resident agreement, room and board and at least the following services: personal services; protective oversight; social care needed because of impaired capacity to live independently; and regular supervision on a 24-hour basis (24-hour medical or nursing care is not required).

ADMISSION/RETENTION CRITERIA

Assisted living residences may not admit or retain residents who—

- Are consistently, uncontrollably incontinent, unless the resident or staff are able to prevent it from becoming a health hazard.
- Are totally bedridden with limited potential for improvement.
- Are in need of 24-hour nursing or medical service.
- Are in need of restraints.
- Have a communicable disease.
- Have a substance abuse problem, unless it is no longer acute.

A facility may keep a resident who becomes bedridden if a physician describes the services needed to meet the person’s health needs; ongoing assessment and monitoring by a licensed home health agency or hospice service can ensure that the resident’s physical, mental, and psychological needs are met; and adequate staff are available who are trained to care for bedridden persons.

ASSESSMENT AND CARE PLANNING PROCESS

A written care plan—reviewed at least annually—is required for each resident. It includes a comprehensive assessment of physical, health, behavioral, and social needs; capacity

for self-care; a list of prescribed medications (dosage, time and route of administration, whether self-administered or assisted); dietary restrictions; allergies; and any physical or mental limitations or activity restrictions. Residents may receive nursing and other therapies provided by a home health agency. The resident shall be reassessed annually—or more frequently, if necessary—to address significant changes in his or her physical, behavioral, cognitive, and functional condition, and to identify services the facility should provide to address the resident’s changing needs.

SERVICES

Facilities must provide a physically safe and sanitary environment, room and board, personal services (transportation, assistance with activities of daily living and instrumental activities of daily living, individualized social supervision), social and recreational services, protective oversight, and social care.

MEDICATIONS

The state created a medication administration course to teach unlicensed staff how to safely administer medications in settings authorized by law. Staff who complete the course are not certified or licensed in any way and are not trained or authorized to make any type of judgment, assessment, or evaluation of a client. They are considered to be qualified medication administration persons.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

The provider must provide a copy of the resident agreement upon move-in. The agreement must include charges; refunds and deposit policies; services included in the rates and charges, including optional services for which there will be additional, specified charges; a list of the types of services provided by the facility, services not provided, and those that the facility will help the resident obtain; bed hold fees; transportation services; therapeutic diets; and whether the facility will be responsible for providing bed and linens, furnishings, and supplies. There must be written evidence that the facility has disclosed its policies and procedures regarding admissions; discharges; emergency plan and fire escape procedures; illness, injury, or death; resident rights; smoking; management of residents’ funds; internal grievance process; investigation of abuse and neglect allegations; and restrictive egress devices. The facility must also disclose its method of determining staffing levels and the extent to which certified or licensed health professionals are available onsite; whether it has an automatic sprinkler system; and whether it uses restrictive egress alert devices, and the types of behavior exhibited by persons needing such devices. An addendum to the agreement includes the care plan and house rules.

PUBLIC FINANCING

An adult foster home program was in existence before home and community-based services waiver programs; it served persons who needed room, board and limited services. Participants did not meet the waiver level-of-care criteria. The payment rate was \$1,200 a month, less a \$50 personal needs allowance. At its peak, the program served 175–200 persons; currently, only two people receive services in adult foster homes.

Providers licensed as assisted living residences can participate in the Medicaid HCBS waiver as alternative care providers. Medicaid rules limit room and board charges for

Medicaid recipients to \$571 a month, and the Medicaid rate for services is \$47.58 a day. The rate covers oversight, personal care, homemaker, chore, and laundry services.

STAFFING

Facilities must employ sufficient staff to ensure the provision of services necessary to meet resident needs, including services provided under the care plan and services provided under the resident agreement. Facilities participating in the Medicaid HCBS waiver program must meet staffing ratios: 1:10 during the day; 1:16 at night; and 1:6 in secure units.

TRAINING

Administrators must meet the minimum education, training, and experience requirements by successfully completing a program approved by the Department of Public Health and Environment. Acceptable programs may be conducted by an accredited college; university, or vocational school; or a program, seminar, or in-service training program sponsored by an organization, association, corporation, group, or agency with specific expertise in that area. The curriculum must include at least 30 hours, of which at least 15 are devoted to discussions of each of the following topics: resident rights; environment and fire safety, including emergency procedures and first aid; assessment skills; identifying and dealing with difficult behaviors; and nutrition. The remaining 15 hours should emphasize meeting the personal, social, and emotional care needs of the resident population.

Administrators of facilities contracting with Medicaid must complete training on rules and regulations for ACFs.

All staff, including volunteers, must be given on-the-job training or have related experience in the job assigned to them; they must be supervised until they have completed on-the-job training appropriate to their duties and responsibilities or until the administrator has evaluated their previous related experience. Staff members and volunteers must receive training and orientation in emergency procedures within three days of their employment.

Staff members who are not an operator of the facility and who have direct responsibility for the provision of personal care to residents or the supervision or training of residents in their own personal care shall provide documentation of successful completion of course work in the provision of personal care or previous related experience in providing personal care to residents.

Before providing direct care, staff must receive training specific to the needs of the population served, resident rights, environment and fire safety, first aid and injury response, and the facility's medication administration program.

The facility shall provide adequate training and supervision for staff, including a discussion of each of the following topics: resident rights, environment and fire safety, including emergency procedures and first aid; assessment skills; and identifying and dealing with difficult situations and behaviors.

OVERSIGHT AND MONITORING

Residences are inspected annually and licenses are issued or renewed for one year if the applicant or licensee has satisfied authorities that he or she is in compliance with the regulations.

CONNECTICUT

BACKGROUND

The Department of Social Services (DSS) regulates adult family living. The Adult Family Living program no longer accepts applicants but continues to support two residents. The program began in 1993, attracted very few participants despite outreach efforts, and suffered from lack of funding, inadequate staff, and high staff turnover. After a 2001 study concluded that the program was not cost-effective, DSS decided to end its efforts to find new applicants.

In 1993, the legislature required the DSS commissioner establish an adult foster care program to serve elders who were inappropriately institutionalized or who might otherwise be placed in nursing homes. Persons who were over age 18 years and had physical disabilities were also eligible. In return for a monthly stipend, the home was expected to provide room, board, and personal care services. However, owing to liability concerns, DSS later interpreted the law as not allowing foster family members to directly provide personal care. Consequently, DSS, often under the Connecticut Home Care Program for Elders, arranged for home health care aides for participants who needed hands-on personal care. Participants could also attend an adult day care center during the day and return to the foster home at night. The host family's duties included 24-hour supervision, daily nutritious meals and snacks, laundry services, housekeeping, supervision of health-related activities, transportation, and shopping assistance.

Participating seniors paid \$1,400 a month to the program; the contractor paid \$1,000 to the foster families and retained \$400 for administrative services. Although the program screened as many as 15 potential participants and nine potential host families in its most active year (FY 2000), it never had more than six matches in any year.

Web Site	Content
Not available	

DEFINITION

Adult family living is an adult foster care program that matches one or two adults who require room, board, and personal care services with approved host families or individuals.

ADMISSION/RETENTION CRITERIA

Not available

ASSESSMENT AND CARE PLANNING PROCESS

Not available

SERVICES

The host family provides 24-hour supervision when needed and assistance with activities of daily living, housekeeping, shopping, and meals.

MEDICATIONS

Not available.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Not available.

PUBLIC FINANCING

Not available.

STAFFING

Not available.

TRAINING

Not available.

OVERSIGHT AND MONITORING

Not available.

DELAWARE

BACKGROUND

The Department of Health and Social Services, Division of Long-Term Care Residents Protection licenses family care homes. In April 2008, 120 licensed homes were in operation, with a capacity to serve 360 persons. The homes serve older adults; 80 percent to 90 percent of the residents have a developmental disability.

Web Site	Content
http://www.state.de.us/research/AdminCode/title16/3000/3315.shtml	Rules

DEFINITION

Family care homes provide resident beds and personal care services for two or three residents who can no longer live independently, or who need a family living situation. The home should provide friendly understanding to residents, as well as appropriate care to reinforce the residents' self-esteem, self-image and role as contributing members of the community.

“Resident beds” means accommodations with supportive services such as meals, laundry, and housekeeping for persons who generally stay longer than 24 hours

ADMISSION/RETENTION CRITERIA

At the time of admission, residents should be able to perform all activities of daily living: washing, bathing, feeding, dressing, ambulating, and providing for personal activities such as hygiene, comfort, and toilet needs. However, care needs may increase over time. Delaware prohibits the admission of individuals with an indwelling catheter unless the person can handle all his or her own catheter care.

ASSESSMENT AND CARE PLANNING PROCESS

Each resident shall be given a physical/medical examination within 90 days before placement and at least every three years thereafter—more frequently if required by the affiliated social agency or program, or the Division of Public Health.

A nursing representative of the Division of Public Health completes a statement of level of care for the resident before placement and at least annually thereafter.

SERVICES

A care provider administers services. The state defines a care provider as “a person who is responsible for giving and providing direct supervision and care for residents. The care provider is to offer the residents who need and desire the support, protection, and security of family living an opportunity to continue or resume living within a family unit, where they can function as an individual with both rights and obligations.” Care providers offer general supervision of and direct assistance to persons in their activities of daily living to ensure their safety, comfort, nutritional needs, and well-being.

MEDICATIONS

Medications must be self-administered or distributed directly to the resident from the prescription container, in strict accordance with directions.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Before or upon admission, residents and their families shall receive a written statement of the services that will be provided by the facility, including those required to be offered on an as-needed basis. AFC operators must also provide residents with a statement of charges, including any charges for services not covered under Medicare, Medicaid, or the facility's basic per diem rate. After admission, the facility must provide the resident or legal representative with an itemized statement each month of the charges and expenses incurred during the previous month.

PUBLIC FINANCING

Title XX Social Services Block Grant and state revenues cover AFC for older adults, but the program is small and serves only five clients. The state contracts with an organization that is responsible for finding homes, providing case management, conducting an annual level-of-care assessment, and monitoring publicly funded clients.

STAFFING

All family care homes must be under the supervision of a full-time care provider. The care provider may not leave the premises for a sustained period (longer than 12 hours) without delegating his or her duties to a responsible adult whose name is on file.

TRAINING

Not specified by regulation. Contracting agencies may provide training.

OVERSIGHT AND MONITORING

The Division of Long-Term Care Resident Protection conducts annual surveys. Remedies and sanctions for deficiencies are the same as for nursing facilities and assisted living facilities.

DISTRICT OF COLUMBIA

BACKGROUND

The District of Columbia licenses small facilities as assisted living residences (ALRs) or community residence facilities. The assisted living law includes a philosophy of care that emphasizes personal dignity, autonomy, independence, privacy, and freedom of choice. The services and physical environment should enhance a person’s ability to age in place in a homelike setting by increasing or decreasing services as needed. The HCBS Medicaid waiver includes ALRs.

Web Site	Content
http://hrla.doh.dc.gov/hrla/cwp/view,A,1384,Q,572323.asp	List, application

DEFINITION

An **assisted living residence** is an entity—whether public or private, for profit or not for profit—that combines housing, health services, and personal assistance (in accordance with individually developed service plans) for the support of persons who are unrelated to the owner or operator of the entity. The philosophy of assisted living emphasizes personal dignity, autonomy, independence, privacy, and freedom of choice. The services and physical environment of an assisted living residence should enhance a person’s ability to age in place in a homelike setting by increasing or decreasing the amount of assistance in accordance with his or her changing needs.

A **community residence facility** is one that provides safe, hygienic sheltered living arrangements for one or more persons 18 years or older (except in the case of group homes for mentally retarded persons, where no minimum age limit shall apply) who are not related by blood or marriage to the residence director; who are ambulatory; and who are able to perform activities of daily living with minimal assistance. This category includes facilities—including halfway houses and group homes for mentally retarded persons—that provide a sheltered living arrangement for persons who desire or require supervision or assistance in a protective environment because of physical, mental, familial, or social circumstances, or mental retardation.

ADMISSION/RETENTION

Assisted living residences. ALRs may not accept persons who are dangerous to themselves or others; who exhibit behavior that negatively affects the lives of others; who are at risk for health or safety complications that cannot be addressed by the home; who require more than 35 hours a week of skilled nursing or home health aide services provided on less than a daily basis; or who require more than intermittent skilled nursing care, treatment of stage 3 or 4 skin ulcers, ventilator services, or treatment for an active, infectious, and reportable disease.

Residents have the right to remain in the facility despite a recommendation to transfer if they obtain additional services that are acceptable to the ALR.

Community residence facilities. A prospective resident, his or her physician, and the residence director must agree that the person does not need professional care and can be

assisted safely and adequately in a community residence facility. Residents must be able to perform ADLs with minimal assistance, must be generally oriented as to person and place, and must be capable of exercising proper judgment in taking action for self-preservation under emergency conditions. By special permission of the mayor, persons who are not generally oriented or who are substantially ambulatory but need minimal ADL assistance may be admitted if sufficient staff resources are available.

ASSESSMENT AND CARE PLANNING PROCESS

Not described.

SERVICES

Assisted living residences. Services include 24-hour supervision and oversight, three nutritious meals and snacks modified to meet individual dietary needs, some assistance with ADLs and IADLs to meet scheduled and unscheduled needs, and laundry/housekeeping services. ALRs facilitate access to appropriate health and social services, and provide or coordinate transportation to community-based services.

ALRs must complete an assessment of the resident within 30 days of admission. An individual service plan is required that is signed by the resident and identifies the services provided, when they are provided, and by whom. The plan is based on a medical, rehabilitation, and psychosocial assessment; a functional assessment; and reasonable accommodation of resident and surrogate preferences. A shared responsibility agreement is also required. Whenever disagreements arise as to lifestyle, personal behavior, safety, or service plans, the ALR staff, resident or surrogate, and other relevant service providers shall attempt to develop a shared responsibility agreement.

Community residence facilities. Community residence facilities provide meals, housekeeping, laundry, and dietary services. The facility may provide or arrange for up to 72 hours of short-term nursing care.

MEDICATIONS

Assisted living residences. Trained aides may administer medications. A medication aide training program approved by the board of nursing will be developed. ALRs must arrange for an onsite review by a registered nurse every 45 days. The review covers supervision of medication administration by trained medication aides, resident responses to medications, and resident ability to self-administer medications.

Community residence facilities. Facilities must provide each resident with a place to store medications. Facilities list assisting with self-administration as an activity of daily living.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Assisted living residences. Written contracts cover the ALR's organizational affiliation, the nature of any special services offered, services included or excluded, residents' rights and grievance process, unit assignment procedures, admission and discharge policies, responsibilities for coordinating health care, arrangements for notification in the event of the resident's death, obligations for handling finances, renting of equipment, coordinating and contracting for services not provided by the ALR, purchase of medications and

durable medical equipment, rate structure and payment provisions, 45-day notice for changes in rates, procedures to be followed in the event the resident can no longer pay for services, and terms governing refunds.

Community residence facilities. Not described.

PUBLIC FINANCING

Assisted living residences. Medicaid HCBS waiver coverage was implemented in 2007. The assisted living services include personal care aide services, homemaker, chore aide, attendant care, medication administration, therapeutic social and recreational services, transportation, and intermittent skilled nursing. Participating facilities will receive \$60 a day for services.

Community residence facilities. The SSI payment standard is \$637 a month, and the personal needs allowance is \$70.

STAFFING

Assisted living residences. Administrators must have a high school diploma or GED and at least one year's experience as a direct care provider/administrator. They must have satisfactory knowledge of the philosophy of assisted living, the health and psychosocial needs of residents, the assessment process, the development and use of an individual service plan (ISP) medication administration, provision of ADL/IADL assistance, residents' rights, fire and life safety codes, infection control, food safety and sanitation, first aid and CPR, emergency disaster plans, human resource management, and financial management.

ALRs must have a staffing plan to ensure the safety and proper care of residents based on their needs, the size and layout of the facility, and the capabilities and training of staff.

Community residence facilities. Not described.

TRAINING

Assisted living residences. Forty hours of initial training is required on delivering care to bedbound residents, use of first aid kits, procedures for detecting and reporting abuse, managing difficult behaviors, advanced body mechanics, communicating with adults with communication deficits, recognizing the signs and symptoms of dementia, caring for people with cognitive impairments, techniques for assisting in overcoming trauma, awareness of changes in conditions, as well as basic competence in housekeeping, laundry, food handling, meal preparation, and any specialized training for special needs not covered by the basic training.

Staff must complete 12 hours of in-service training annually on emergency procedures and disaster drills, and the rights of residents. Staff must complete another 12 hours of annual training on managing residents with dementia conducted by a nationally recognized organization with experience in Alzheimer's care.

Community residence facilities. Not described.

OVERSIGHT AND MONITORING

Assisted living residences. The oversight and monitoring process measures the ability of the ALR to fulfill customers' expectations and provide for the health and safety of the residents. Surveyors gather information from a variety of sources, including: interviews with the residents, family, and staff, and a review of the medical records. Oversight also includes an inspection of life safety support, fire safety systems, emergency and disaster planning, physical plant, environmental services, food services, sanitation, medical administration, and other systems.

Community residence facilities. Not described.

FLORIDA

BACKGROUND

Adult foster homes began in the 1970s as a resource for older adults discharged from state mental health facilities. Adult foster homes were licensed to serve up to three residents until 1994, when the name was changed to adult family care homes (AFCHs). AFCHs may serve up to five residents; at least one resident must be a participant in the SSI/optional state supplement program. In May 2008, the state licensed 491 AFCHs with a capacity of 2,172 persons. The supply of homes has been stable over the past several years.

The Department of Elder Affairs, in collaboration with the Agency for Health Care Administration (AHCA), the Department of Health, the state fire marshal, the Office of Community Affairs, and the ombudsman publish regulations for AFCHs. AHCA issues licenses for AFCHs and is responsible for inspections and compliance.

There is some overlap between AFCHs and assisted living facilities. AFCH operators must live in the home. Operators who do not live in the home must be licensed as an assisted living facility. AFCHs can serve one to five residents, while assisted living facilities may serve one or more residents. Forty-two percent of the assisted living facilities are licensed for 10 or fewer beds. Assisted living facilities may obtain specialty licenses that allow them to serve residents with greater needs compared with AFCH residents.

Web Site	Content
http://ahca.myflorida.com/MCHQ/Long_Term_Care/Assisted_living/afc.shtml	Rules, provider tools

DEFINITION

Florida statute §429.65 defines an **adult family care home** as a full-time, family-type living arrangement in a private home, under which a person who owns or rents the home provides room, board, and personal care on a 24-hour basis for no more than five disabled adults or frail elders who are not relatives. Family-type living arrangements are not required to be licensed if the person who owns or rents the home provides room, board, and personal services for only one or two adults who do not receive optional state supplementation; the person who owns or rents the home provides room, board, and personal services only to his or her relatives; or the establishment is licensed as an assisted living facility.

ADMISSION/RETENTION CRITERIA

Residents must be capable of self-preservation in an emergency situation involving the immediate evacuation of the AFCH, with assistance with ambulation if needed; be able to perform, with supervision or assistance, activities of daily living; not be a danger to self or others as determined by a health care provider or licensed mental health professional; not require licensed professional mental health treatment on a 24-hour basis; not have special dietary needs that cannot be met by the provider; not be bedridden; not have stage 3 or 4 pressure sores (a person with a stage 2 pressure sore may be admitted if he or she is under the care of a nurse); not require the use of chemical or physical restraints; not

require 24-hour nursing supervision; and not have personal care and nursing needs that exceed the capability of the provider to meet or arrange for such needs. The provider is responsible for determining the appropriate placement of the person in the AFCH.

ASSESSMENT AND CARE PLANNING PROCESS

Not described.

SERVICES

AFCH providers offer assistance with or supervision of the activities of daily living as required by the resident; health monitoring; and arrangement for or provision of nursing services. Providers must provide general supervision, which includes being aware of the resident's general whereabouts and well-being on the premises to ensure his or her safety and security, and reminding the resident of any important tasks or activities, including appointments, as needed.

The AFCH provider is responsible for observing, recording, and reporting any significant changes in the resident's appearance, behavior, or state of health to the resident's health care provider and representative or case manager. Significant changes include a sudden or major shift in behavior or mood; deterioration in health status, such as unplanned weight gain or loss, stroke, heart condition, or a stage 2 pressure sore.

The regulations allow residents to contract with a licensed home health agency or nurse to provide nursing services, provided that the resident does not exceed the admission and continued residency standards; if provided or arranged by the AFCH, the nursing service must be authorized by a health care provider's order, be medically necessary and reasonable for treating the resident's condition, and meet other conditions.

To the extent needed by the resident, the AFCH arranges for transportation and for someone to accompany the resident to medical, dental, nursing, or mental health appointments.

MEDICATIONS

Medication administration is a nursing service. Nurses may manage weekly pill organizers for residents who self-administer, or who require supervision or assistance with self-administration.

Residents who are capable of self-administering their medications are encouraged to do so. For residents who require supervision or assistance with self-administration, the provider or staff may remind residents when to take medications; prepare and make available such items as water, juice, cups, spoons, or other items necessary for administering the medication; get the medication and give it to the resident; watch the resident take the medication and verify that he or she is taking the prescribed dosage; and provide any other assistance at the express direction of the resident or the resident's representative.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Before or at the time of admission to an AFCH, the provider and the resident or the resident's representative must sign a residency agreement that includes the following:

- A specific list of services and accommodations provided by the adult family care home.
- The daily, weekly, or monthly rates and charges, and a statement that the provider will give at least 30 days' notice before implementing a rate increase.
- A bed hold policy for residents who request that the provider reserve a bed for them if their health requires them to transfer to a nursing home or hospital.
- The AFCH's discharge policy.
- A refund policy that states that the resident or resident's representative is entitled to a prorated refund for any unused portion of payment beyond a discharge or termination date. The refund will be less the cost of documented damages to the AFCH (beyond normal use) caused by the resident. The refund must occur within 45 days of receipt of a written notice of discharge, or within 15 days of the resident's departure or death, whichever occurs later.
- An addendum describing any additional services and charges not covered by the basic agreement.

PUBLIC FINANCING

The elderly HCBS waiver does not cover AFCHs. Eligible participants may receive \$715 a month from SSI (\$637 in 2008) and an optional state supplement (\$78). The personal needs allowance is \$54 a month. The Medicaid state plan also covers participants who receive assistive care services (ACS). The state implemented ACS in all assisted living facilities in September 2001 and in all AFCHs in January 2002. ACS includes health support, assistance with activities of daily living, assistance with instrumental activities of daily living, and assistance with self-administration of medication. Providers receive \$9.28 a day.

STAFFING

An adult family care home provider must be at least 21 years old, live in the home, and be able to read, write and complete written materials involved in applying for an AFCH license and maintaining an AFCH.

The provider, all staff and substitute care providers, and all adult household members must meet or be exempt from level 1 background screening requirements. The provider must submit a form that documents compliance.

TRAINING

All AFCH providers must attend a 12-hour basic adult family care home training. Training and education programs must include information relating to the following:

- State law and rules governing adult family care homes, with emphasis on appropriateness of placement of residents in an AFCH.
- Identifying and reporting abuse, neglect, or exploitation.
- Identifying and meeting the special needs of disabled adults and frail elders.

- Monitoring the health of residents, including following guidelines for the prevention and care of pressure ulcers.

AFCH providers must receive three hours of continuing education in topics related to the care and treatment of frail elders or disabled adults, or the management and administration of an adult family care home. The AFCH provider, each relief person, and any person left in sole charge of residents must hold a currently valid card documenting completion of courses in first aid and CPR. Nurses are deemed to have met the first aid training requirement.

OVERSIGHT AND MONITORING

The state conducts inspections of AFCHs before issuing or renewing the one-year license. Correction plans are required to remedy deficiencies. AHCA may deny, revoke, or suspend a license for failure to correct deficiencies or may impose fines that vary according to the severity of the violation.

Admission Requirements for Florida Facilities		
Adult Family Care Homes	Basic Assisted Living, Limited Nursing Service, Limited Mental Health Service	Extended Congregate Care
<p>18 years of age</p> <p>Able to perform, with supervision or assistance, activities of daily living</p> <p>Free of signs and symptoms of communicable diseases</p> <p>Not a danger to self or others as determined by a health care provider or licensed mental health professional</p> <p>Capable of self-preservation in an emergency situation involving the immediate evacuation of the AFCH, with assistance with ambulation if needed;</p> <p>Does not require licensed professional mental health treatment 24 hours a day</p> <p>Does not have special dietary needs that cannot be met by the provider</p> <p>Not bedridden</p> <p>Does not have stage 3 or 4 pressure sores (persons with a stage 2 pressure sore may be admitted only if they are under the care of a nurse)</p> <p>Does not require the use of chemical or physical restraints</p> <p>Does not require 24-hour nursing supervision</p> <p>Does not have personal care or nursing needs that exceed the capability of the provider to meet or arrange for.</p>	<p>18 years of age</p> <p>Able to perform ADLs with supervision or assistance (but not total assistance)</p> <p>Free of signs and symptoms of communicable diseases</p> <p>Able to transfer, with assistance if necessary</p> <p>Able to take medications, with assistance from staff if needed</p> <p>Not a danger to self or others</p> <p>Does not require licensed professional mental health services 24 hours a day</p> <p>Does not have special dietary needs that cannot be met by the provider</p> <p>Not bedridden;</p> <p>Does not require oral or nasopharyngeal suctioning, assistance with tube feeding, monitoring of blood gases, intermittent positive pressure breathing therapy, skilled rehabilitation services, or treatment of unstable surgical incisions</p> <p>Does not require 24-hour nursing supervision</p> <p>Does not have stage 3 or 4 pressure sores (residents with stage 2 pressure sores may be served if the facility has an LNS license or resident contracts for care with a home health agency or nurse)</p>	<p>18 years of age</p> <p>Free of signs and symptoms of communicable disease</p> <p>Able to transfer, with assistance if necessary</p> <p>Not a danger to self or others</p> <p>Not bedridden</p> <p>Does not require oral or nasopharyngeal suctioning, nasogastric tube feeding, monitoring of blood gases, intermittent positive breathing pressure, skilled rehabilitative services, or treatment of unstable surgical incisions</p> <p>Does not require 24-hour nursing supervision</p> <p>Does not have stage 3 or 4 pressure sores.</p>

GEORGIA

BACKGROUND

Adult foster care providers are licensed as a category of personal care homes for facilities that serve two or more adults. Georgia revised the regulations in 2008. Fire safety requirements for facilities with two to six residents differ from those that apply to larger facilities. Larger facilities must also obtain a food service permit. There were 553 personal care homes in 2008.

Web Site	Content
http://ors.dhr.georgia.gov	Regulations, laws, provider tools, list search, training, forms and applications. Inspection reports. See also recently passed rules.

DEFINITION

A **personal care home** is any dwelling, whether operated for profit or not, that undertakes through its owners or managers to provide or arrange for the provision of housing, food services, and one or more personal services for two or more adults who are not related to the owner or administrator by blood or marriage.

ADMISSION/RETENTION CRITERIA

Personal care homes serve people “18 and older who are ambulatory and have the ability to move from place to place by walking (either unaided or aided by prosthesis, brace, cane, crutches, walker, or hand rails) or by propelling a wheelchair; who can respond to an emergency condition . . . and escape with minimal human assistance. . . .” Personal care homes may not admit or retain persons who need physical or chemical restraints, isolation, or confinement for behavioral control. Residents may not be bedbound or require continuous medical or nursing care and treatment.

If short-term medical, nursing, health, or supportive services are necessary, the resident (or representative) is responsible for purchasing them from licensed providers. The home may assist in the arrangement for such services but not their provision. Facilities may not admit or retain applicants who require continuous medical or nursing services. Facilities may receive waivers of the admission/retention requirements.

ASSESSMENT AND CARE PLANNING PROCESS

The administrator or onsite manager of a home conducts an interview with the applicant, representative, or legal surrogate to determine whether the home can meet the applicant’s needs.

SERVICES

Homes provide room, meals, and personal services, which include but are not limited to individual assistance with or supervision of self-administered medication, assistance with ambulation and transfer, and essential activities of daily living. Homes are responsible 24 hours a day for the well-being of residents.

MEDICATIONS

Staff may assist with self-administration by reminding, reading labels, checking dosage, and pouring medications. Generally, a licensed registered nurse from an outside agency may administer medications. An appropriately licensed person may administer injectable medications to residents. Physicians may designate a staff person to inject insulin under an established medical protocol.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Resident agreements must be made available before and upon move-in. They must cover all fees and daily, weekly, or monthly charges; services available for an additional fee; 60-day notice of changes; authorization to release medical records; provisions for ongoing assessment of resident needs; provisions for transportation services; refund policy; and a copy of the house rules.

PUBLIC FINANCING

A Medicaid §1915(c) waiver reimburses personal care homes that serve two to six people in the Community Care Services program. In October 2008, the program served 422 Medicaid beneficiaries. Homes receive \$35.04 a day for Medicaid services. SSI beneficiaries receive \$637 a month; \$542 is paid for room and board, and the beneficiary retains a personal needs allowance of \$95 a month. Family members or other parties may supplement room and board payments. Facilities may charge higher amounts for room and board to residents who do not receive SSI.

STAFFING

At least one administrator, onsite manager, or responsible staff person must be on the premises 24 hours a day. The minimum onsite staff-to-resident ratio is one staff person per 15 residents during waking hours and one staff person per 25 residents during nonwaking hours.

TRAINING

All employees must receive work-related training acceptable to the Department of Human Resources within the first 60 days of employment. This training must include current certification in emergency first aid, except where the staff person is a currently licensed health care professional; current certification in CPR; emergency evacuation procedures; medical and social needs and characteristics of the resident population; residents' rights; and a copy of the Long Term Care Resident Abuse Reporting Act.

Direct care staff are required to complete 16 hours of continuing education a year in courses approved by the department, covering but not limited to working with the elderly; working with residents with Alzheimer's disease; working with the mentally retarded, mentally ill, and developmentally disabled; social and recreational activities; legal issues;

physical maintenance and fire safety; housekeeping; and other topics as needed or determined by the department.

OVERSIGHT AND MONITORING

The Office of Regulatory Services (ORS) conducts initial, annual, and follow-up inspections and complaint investigations. ORS generally conducts inspections on an unannounced basis. The agency has the authority to impose fines, revoke a license, limit or restrict a license, prohibit certain persons from serving in management or control roles, suspend any license for a definite or indefinite period, or administer a public reprimand.

HAWAII

BACKGROUND

Hawaii licenses adult foster care homes as adult residential care homes (ARCHs) or expanded adult residential care homes (E-ARCHs). Regulations license Type I and Type II homes. Type I homes serve five or fewer residents. E-ARCHs offer a higher level of care and must operate as an ARCH for six months before applying for the expanded license. In November 2008, there were 420 Type I and II ARCH and E-ARCHs, with a capacity to serve 2,105 residents.

The Department of Human Services certifies community care foster family homes (CCFFHs) that must serve one Medicaid beneficiary, or two Medicaid beneficiaries if the department approved the home to serve up to three clients. Homes may accept one private pay client who meets the criteria for admission to the Residential Alternative Community Care Program. There are 869 certified homes.

Web Site	Content
www.hawaii.gov/dhs/main/har/har_current/17-1418.pdf	Medicaid rules
http://gen.doh.hawaii.gov/sites/har/AdmRules1/11-100-1.pdf	Licensing rules
http://hawaii.gov/health/elder-care/health-assurance/licensing/vacancies.pdf	List
http://hawaii.gov/dhs/main/har/har_current/AdminRules/document_view	Certification standards, chapter 17-1454

DEFINITION

An **adult residential care home** is a facility that provides 24-hour accommodations for a fee to adults unrelated to the family who require at least minimal assistance with ADLs, personal care, or protection and health care services, but who do not need the professional health services of an intermediate, skilled nursing, or acute care facility. The state allows expanded ARCHs to serve no more than two residents who meet the nursing facility level-of-care criteria.

The definition of an **expanded ARCH** allows these facilities to serve residents who may need the professional health services provided in a nursing home.

A **community care foster family home** receives a certificate of approval from the Department of Human Services (DHS) to provide for a fee 24-hour accommodations, including personal care and homemaker services, for not more than two adults (three at the discretion of DHS) at any one time. At least one of these persons must be a Medicaid recipient, and all must be at the nursing facility level of care, unrelated to the foster family, and served in the home by a licensed home and community based case-management agency. This category does not include expanded adult residential care homes or assisted living facilities, which must be licensed by the Department of Health.

ADMISSION/RETENTION CRITERIA

Before licensing, each **ARCH** or **E-ARCH** submits its general operational policies, which include admission policies, types of services to be offered (ADL assistance at a minimum), transfer and discharge policies, and other items.

ARCH residents require minimal ADL assistance and do not need assistance from skilled, professional personnel on a regular long-term basis. The level of care needed by each new resident must be determined and documented by a physician or advanced practice registered nurse (APRN) before admission. Residents who need a higher level of care may be served if the Department of Health determines that the primary caregiver is capable of providing care on an interim basis while a transfer is pending.

Community care foster family homes. A physician must certify that a resident needs a nursing facility level of care. Residents must be Medicaid beneficiaries and receive ongoing case management. Homes may care for no more than two residents (three at the discretion of DHS).

ASSESSMENT AND CARE PLANNING PROCESS

A comprehensive assessment is required for all **E-ARCH** residents before placement. The assessment covers physical, mental, psychological, and spiritual areas. An interim care plan is prepared within 48 hours of admission and a final care plan is required within seven days of admission that addresses the medical, nursing, social, mental, behavioral, recreational, dental, emergency care, nutritional, spiritual, rehabilitation, and other needs of the resident. Case managers must have monthly face-to-face contact with residents and must conduct comprehensive reassessments every six months, or sooner if needed.

Community care foster family homes. The case management agency must have written policies and procedures that describe the services available to clients, including the standards and requirements for application, eligibility, admission, wait-listing, suspension, discharge, transfer, and readmission. Case managers are responsible for completing an assessment, developing and authorizing a service plan, coordinating services, monitoring, reassessment, and other functions. The case management agency uses a standardized assessment tool to assess the applicant's needs before he or she becomes a client of the agency. The agency also uses a standardized intake tool to ensure that all eligibility requirements for the placement of a person with nursing facility level-of-care needs in a residential care facility are met before admission.

On completion of the comprehensive assessment, a case manager prepares the service plan, which must be authorized before the person is admitted to a residential care facility. In the expanded ARCH process, case managers must have monthly face-to-face contact with residents and must conduct comprehensive reassessments every six months, or sooner if needed.

SERVICES

ARCHs may provide personal care, shelter, protection, supervision, assistance, guidance or training, planned activities, food service, and laundry services. They also provide for services in response to changes in health status and arrange transportation for medical and dental appointments.

Ongoing recreational and social activities are provided to support the interests and the physical, mental, and psychosocial well-being of the resident according to his or her comprehensive assessment and care plan. Registered nurses provide case management services to residents to plan, coordinate, and monitor services in response to the comprehensive care plan.

Community care foster family homes. Services are provided according to a service plan. They include personal care, homemaker and respite services where appropriate, recreation, and social activities. Care and services should be appropriate to the person's age and condition and should be provided in a homelike environment. They should be based on care directions from the client to the maximum extent possible, with monitoring by the case management agency if the client is not capable of providing directions, and should follow the service plan for addressing the client's needs. The RN case manager may delegate client care and services as permitted by regulations. Services include personal care, homemaker, and respite services, as appropriate.

MEDICATIONS

Trained **ARCH** staff may make prescribed medications available to residents. Residents may manage their own medications if that is determined to be a safe practice by the resident, family guardian, case manager, and primary caregiver and authorized by the physician or APRN.

A licensed nurse in an E-ARCH may administer injectable medications. The RN case manager may delegate this task.

Community care foster family homes. RNs and LPNs may administer injectable medications. An RN may delegate the administration of medications.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Written agreements are completed at the time of admission. They include the resident's rights, the primary care provider's responsibilities, the services that will be provided according to a schedule of activities or a care plan, and the resident's responsibilities to the licensee/care provider.

Community care foster family home. Provisions often found in resident agreement requirements are included in the client rights section of the regulations; they include being fully informed at all times of services available in or through the home and of related charges, and being given a minimum of three weeks' advance notice of transfers or discharges, except in emergencies.

PUBLIC FINANCING

The DHS Adult Foster Care Program provides placement and case management services to eligible clients in licensed adult residential care homes, expanded adult residential care homes, and community care foster family homes. Clients must be eligible for Supplemental Security Income, Medicaid, or financial assistance from the department.

DHS payments incorporate the individual's level of care, which means the amount of supervision and assistance required to carry out the activities of daily living, socializing, and meeting health care needs.

In April 2008, there were about 1,200 Medicaid waiver participants in ARCH, E-ARCH, and CCFFHs, and about 930 people living CCFFHs. Monthly rates were \$2003.38 for Level I clients (including \$1,278.90 for room and board) and \$2501.82 for Level II clients.

STAFFING

The primary caregiver or the licensee acting as primary caregiver must be present at the ARCH at all times unless he or she arranges for a substitute caregiver.

Expanded ARHCs must submit a plan describing how they will contract for a registered nurse, case manager, and caregivers; and how they will obtain training for the primary and substitute caregiver. An RN trains the personal and monitors the specialized care provided to residents to implement their care plans.

Community care foster family homes. The primary caregiver must reside in the home and be a nurse aide, licensed practical nurse, or registered nurse. Substitute caregivers must have the same qualifications and must be available when the primary caregiver will not be onsite.

TRAINING

ARCH Type I caregivers must be at least 21 years old and must complete training modules approved by the Department of Health. A minimum of six hours of training is required each year, covering topics such as personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, and community services and resources. Licensees who operate multiple ARCHs must demonstrate that they have the skills and abilities to operate multiple facilities.

Substitute caregivers who provide coverage for more than four hours must have a CPR certification, be able to provide personal care, have knowledge of and experience with nursing techniques, be able to provide recreational programs, and know how to follow planned menus and prepare and serve meals.

Expanded ARCH caregivers must be nurse aides or licensed nurses.

Community care foster family homes. The primary caregiver must have 12 hours of training annually, and substitute caregivers must have 8 hours of annual training related to the needs of the residents served in the home. The Department of Human Services assesses primary and substitute caregivers to determine their competency.

OVERSIGHT AND MONITORING

ARCH. The department licenses homes on an annual basis. The Department of Health conducts unannounced annual visits or visits as needed to ensure the health, safety, and welfare of residents. The department also conducts follow-up inspections and visits to confirm correction of deficiencies or to investigate complaints or suspicion of abuse or neglect. Remedies include correction plans or issuance of a provisional license.

Community care foster family homes. Certificates are issued for one year. If the CCFFH has operated for a year, made no structural changes, and received no complaints that were confirmed and resulted in a corrective action plan, it may apply for a two-year certificate.

Homes with a one-year certificate are monitored annually; those with a two-year certificate are monitored biennially. Any home may be monitored in response to a

complaint that it is in violation of applicable requirements. Monitoring may include unannounced visits to review service delivery sites, records, and files, as well as interviews with clients. Homes that do not comply with the requirements must establish a specific time frame for the correction of each area of noncompliance and must submit a written corrective action plan that addresses each area of noncompliance. The department may suspend the admission of new clients. The department may transfer clients, issue fines, or revoke certification for homes that do not take corrective action.

IDAHO

BACKGROUND

The state licenses 2,111 family care homes with a capacity to serve 2,551 residents.

Web Site	Content
http://adm.idaho.gov/adminrules/rules/idapa16/0319.pdf	Rules

DEFINITION

The Department of Health and Welfare (DHW) certifies **adult family care homes** to provide care to one or two adults who are unable to live on their own and require help with activities of daily living, as well as protection and security, and encouragement toward independence. A home may apply to DHW for an exception to the two-resident limit and receive approval to care for three or four residents.

Certified family home care providers are the adult member of the certified family home living in the home who are responsible for providing care to the resident.

ADMISSION/RETENTION CRITERIA

A home may care for one resident who requires nursing facility level of care without obtaining a waiver. A home that seeks to provide care to two residents who require nursing facility level of care must request a DHW waiver. The waiver will be granted if both residents provides a written statement requesting the arrangement; both are competent and informed, and have not been coerced; and the department considers the arrangement to be safe and effective.

ASSESSMENT AND CARE PLANNING PROCESS

The provider develops, identifies, assesses, or directs a uniform needs assessment of private pay residents. Providers can use the department’s uniform needs assessment tool to evaluate their ability to meet a resident’s needs. The assessment can be used to determine the special training, licenses, or certificates that providers must obtain to care for certain residents. The assessment tool used by the home for private pay residents must cover identification and background information, medical diagnosis, health problems, prescription and over-the-counter medications, behavior patterns, cognitive function, psychosocial and physical needs, functional status, and required level of care.

The assessment must be completed no later than 14 calendar days after admission. It must be reviewed when the resident’s needs change or every 12 months, whichever comes first.

A resident’s plan of service will be based on the assessment; service needs for activities of daily living; need for limited nursing services; need for medication assistance; frequency of needed services; level of assistance; habilitation and training needs; behavioral management needs, including identification of situations that trigger inappropriate behavior; a physician’s dated history and physical; admission records; community support systems; the resident’s desires; transfer and discharge requirement; and other identified needs.

SERVICES

Homes provide appropriate, adequate supervision for 24 hours each day (unless the resident's plan of service provides for alone time), daily activities, recreational activities, maintenance of self-help skills, assistance with activities of daily living, provisions for trips to social functions, special diets, arrangements for medical and dental services, and monitoring of medications. Homes must also provide linens, towels, washcloths; a reasonable supply of soap, shampoo, toilet paper, sanitary napkins or tampons, first aid supplies, and shaving supplies; laundering of linens; housekeeping service; maintenance; and basic television in common areas. The home must provide activity supplies in reasonable amounts that reflect the interests of the residents and must arrange a reasonable amount of transportation to community, recreational, and religious activities within 25 miles of the home. The home must also arrange for emergency transportation.

MEDICATIONS

The certified family home provider must develop written medication policies and procedures that outline how the home will ensure appropriate handling and safeguarding of medications. If the resident is capable of self-administration, his or her primary physician or other practitioner must supply a written statement to that effect. The record must show that a licensed nurse or other qualified professional has evaluated the resident's ability to self-administer medication and has found that the resident understands the purpose of the medication; knows the appropriate dosage and times to take the medication; understands the expected effects, adverse reactions or side effects, and action to take in an emergency; and is able to take the medication without assistance.

The certified family home must provide assistance with medications to residents who need such assistance; however, only a licensed nurse or other licensed health professional may administer medications. Staff who have successfully completed the "Assistance with Medications" course available through the Idaho Professional Technical Education Program or other department-approved training may assist residents with their medications. The resident's health condition must be stable and the resident must not require nursing assessment before receiving the medication or assessment of the therapeutic or side effects after the medication is taken.

Only a licensed nurse or other health professionals working within the scope of their licenses may administer medications. Administration of medications must comply with the Administrative Rules of the Board of Nursing, IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." Some services are of such a technical nature that they must be performed by, or under the supervision of, a licensed nurse or other licensed health professional.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

At the time of admission to a certified family home, the provider and the resident must enter into a written admission agreement. The agreement must, in itself or by reference to the resident's plan of care, include at least the following:

- Whether or not the resident will assume responsibility for his or her own medication, including reporting missed medication or medication taken on an as-needed (PRN) basis.

- Whether or not the resident has the ongoing ability to safeguard him- or herself against personal harm, injury, or accident. The certified family home must have a plan in place for steps it will take if the resident is not able to ensure self-preservation.
- Whether or not the provider will accept responsibility for the resident's funds.
- How a partial month's refund will be managed.
- Responsibility for valuables belonging to the resident and provision for the return of a resident's valuables if he or she leaves the home; amount of liability coverage provided by the homeowner's or renter's insurance policy.
- Fifteen to 30 calendar days' written notice on the part of either party prior to transfer or discharge.
- Conditions under which emergency transfers will be made.
- Signed permission to transfer pertinent information from the resident's record to a hospital, nursing home, residential and assisted living facility, or other certified family home.
- Responsibility to obtain consent for medical procedures, including the name, address, and telephone number of the guardian or a power of attorney for health care for any resident who is unable to make his or her own medical decisions.
- Resident responsibilities.
- Charges for room, utilities, and three meals each day.

PUBLIC FINANCING

The state's Aged and Disabled HCBS §1915(c) waiver and the state Medicaid plan for personal care services cover services in certified family homes. From July 2006 through September 2008, the supply of homes serving Medicaid waiver participants rose 16 percent, from 1,464 to 2,111, and the number of Medicaid waiver participants increased 15 percent, from 1,699 to 1,830.

HCBS waiver payments are capped at the average per capita nursing home cost, and payments for individual participants are based on a care plan developed in response to the assessment. Homes provide personal care; arrange for supportive services; monitor the activities of residents to ensure their health, safety, and well-being; and assist with self-administration of medication.

For Medicaid personal care services, providers receive payment based on four levels of need, which include the number of hours of assistance needed. Payment rates range from \$135.15 to \$245.07 a week.

- Reimbursement for Level I: 1.25 hours of personal care a day or 8.75 hours a week.
- Reimbursement Level II : 1.5 hours of personal care a day or 10.5 hours a week.
- Reimbursement Level III: 2.25 hours of personal care a day or 15.75 hours a week.

- Reimbursement Level IV: 1.79 hours of personal care a day or 12.5 hours a week. (This level is based on a documented diagnosis of mental illness, mental retardation, or Alzheimer’s disease.)

An SSI state supplement is available in family care homes. It varies by level of care: Level I, \$956; Level II, \$1,023; and Level III, \$1,090. State officials reported that the supplement is only available to persons with developmental disabilities who receive waiver services.

STAFFING

The provider and all adults who live in the home must complete a criminal history and background check. Substitute caregivers complete a self-declaration form, are fingerprinted, and must not have disclosed any crimes before they have unsupervised contact with residents.

TRAINING

All providers must receive training in the following areas: resident rights; certification in first aid and CPR, which must be kept current; emergency procedures; fire safety, fire extinguishers, and smoke alarms; completion of an approved “Assistance with Medications” course; and complaint investigations and inspection procedures.

Each provider must document a minimum of eight hours a year of relevant training in the provision of supervision, services, and care. The training must include at least four hours of classroom work; the other four hours may be independent study. Up to two hours of first aid or CPR training will count toward the eight-hour requirement. The initial training counts toward the first year’s eight-hour training requirement.

Providers of three- or four-bed homes must obtain additional training to meet the needs of the residents as determined by the department.

OVERSIGHT AND MONITORING

The department inspects certified family homes at least every 24 months, beginning with the first month of the most recent certification, and may visit more frequently if necessary, depending on the results of previous inspections, history of compliance with rules, and complaints.

ILLINOIS

BACKGROUND

The state regulates three types of residential settings that serve older persons. *Assisted living establishments* serve three or more unrelated adults; *shared housing establishments* serve 16 or fewer residents; *supported living facilities* serve Medicaid beneficiaries in apartment settings with onsite services.

Web Site	Content
http://www.ilga.gov/commission/jcar/admincode/077/07700295sections.html	Assisted living rules
http://www.ilga.gov/commission/jcar/admincode/077/077003300A01100R.html	Shelter care rules
http://www.idph.state.il.us/healthca/assisted_living_list.htm	Assisted living list
http://www.idph.state.il.us/healthca/sheltered_care_list.htm	Shelter care list
http://www.idph.state.il.us/pdf/assistedlivingapp.pdf	Application
http://www.slfillinois.com/	SLF home page

DEFINITION

An **assisted living establishment** is a building or residence where sleeping accommodations are provided for at least three unrelated adults, where at least 80 percent of the residents are 55 years of age or older, and where the following are provided:

- Services consistent with a social model based on the premise that a resident’s unit in assisted living and shared housing is his or her own home.
- Community-based residential care for persons who need assistance with ADLs, including personal, supportive, and intermittent health-related services available 24 hours a day if necessary to meet the scheduled and unscheduled needs of a resident.
- Mandatory services, whether provided directly by the establishment or by another entity arranged for by the establishment with the consent of the resident.
- A homelike setting that includes such elements as established by the Department of Public Health in conjunction with the assisted living and shared housing advisory board: individual living units, each of which accommodates small kitchen appliances and contains private bathing, washing, and toilet facilities, or private washing and toilet facilities with a common bathing room that is readily accessible to each resident. Units shall be maintained for single occupancy unless shared by consent.

A **shared housing establishment** is a publicly or privately operated free-standing residence for 16 or fewer persons and one manager. At least 80 percent of the residents must be 55 years of age or older, and none may be related to the owner(s) or manager. The following are provided:

- Services consistent with a social model based on the premise that the resident’s unit is his or her own home.

- Community-based residential care for persons who need assistance with ADLs, including housing and personal, supportive, and intermittent health-related services available 24 hours a day if needed to meet the scheduled and unscheduled needs of a resident.
- Mandatory services, whether provided directly by the establishment or by another entity arranged for by the establishment with the consent of the resident.

A **supportive living facility (SLF)** is a residential setting that provides or coordinates personal care services, 24-hour supervision and assistance (scheduled and unscheduled), activities, and health-related services with a service program in a physical environment designed to minimize the need for residents to move within or from the setting to accommodate changing needs and preferences; has an organized mission, service programs, and a physical environment designed to maximize residents' dignity, autonomy, privacy, and independence; and encourages family and community involvement.

ADMISSION/RETENTION CRITERIA

Assisted living establishments. Facilities may not accept residents who are a danger to themselves or others; are not able to communicate their needs and do not have a representative residing in the facility; require total assistance with two or more ADLs; require the assistance of more than one paid caregiver with any ADL; or require more than minimal assistance in moving to a safe area in an emergency. They may not accept residents who need the following health services *unless* self-administered or administered by a qualified, licensed health care professional who is not employed by or affiliated with the owner or operator:

- Intravenous therapy or feedings
- Gastronomy feedings
- Insertion, sterile irrigation, or replacement of a catheter, except for routine maintenance of urinary catheters
- Sterile wound care
- Sliding scale insulin
- Routine insulin injections
- Stage 3 or 4 decubitus ulcers

Supportive living facilities may serve elderly (age 65 years or older) or disabled residents (22 years or older) who have been screened and meet the nursing facility level-of-care criteria. SLFs may discharge residents if they are a danger to themselves or others, or if the SLF cannot meet the needs of the resident. For each resident, the SLF must develop a service plan and execute a written contract that specifies the services the resident will receive and other terms of the agreement.

ASSESSMENT AND CARE PLANNING PROCESS

Assisted living establishments. No more than 180 days before admission, a physician must complete a comprehensive assessment that includes an evaluation of the prospective resident's physical, cognitive, and psychosocial condition. A physician must update the assessment annually or upon significant change in condition. Establishments may also use their own evaluation/assessment tools but not in place of the physician assessment.

Supportive living facilities. Facilities are expected to involve family members in service planning. Residents must receive an initial assessment within 24 hours of admission and a comprehensive assessment within 14 days. The facility must update assessments at least annually.

SERVICES

Assisted living establishments. Mandatory services include three meals a day, housekeeping, laundry, security, emergency response system, and assistance with ADLs. Optional services include medication reminders, supervision of self-administered medications and medication administration, and nonmedical services defined by the regulations.

Assisted living promotes resident choice, autonomy, and decision making. A negotiated agreement between the resident or the resident's representative and the provider should clearly identify the services that will be provided by the facility. This model assumes that residents are able to direct services provided for them or will designate a representative to direct these services for them. The model supports the principles that there is an acceptable balance between consumer protection and resident willingness to accept risk, and that most consumers are competent to make their own judgments about the services they receive. Establishments must function in a manner that provides the least restrictive and most homelike environment and that promotes independence, autonomy, individuality, privacy, dignity, and the right to negotiated risk in residential surroundings.

Supportive living facilities must provide a combination of housing, personal, and health-related services that promote autonomy, dignity, and quality of life, and respond to the individual needs of residents. Room and board includes three meals a day. Services include nursing services, personal care, medication oversight and assistance in self-administration, housekeeping services, laundry service, social and recreational programs, 24-hour response/security staff, emergency call systems, health promotion and referral, exercise, transportation, daily checks, and maintenance services. Nursing services include completion of a resident assessment and service plan, a quarterly health status evaluation, administration of medication if a resident is temporarily unable to self-administer, medication set-up, health counseling, episodic and intermittent health promotion or disease prevention counseling, and teaching self-care in meeting routine and special health care needs that can be met by staff under supervision of a registered nurse.

MEDICATIONS

Assisted living and shared housing establishments may assist with self-administered medications, supervise, or administer medications. A physician, pharmacist, or registered nurse must approve policies related to administration. Only a licensed health care professional employed by the establishment may administer medications, including

injections, oral medications, topical treatments, eye and ear drops, nitroglycerin patches, and sliding scale insulin injections.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Assisted living and shared housing. Contracts with residents include the duration of the contract; base rate and description of services; additional services available and fees; description of the process for terminating or modifying the contract; complaint resolution process; resident obligations; billing and payment procedures; admission, risk management, and termination procedures; resident rights; the department’s annual onsite review process; terms of occupancy; charges during absences; refund policy; notice for changes in fees; and policy concerning notification of relatives of changes in the resident’s condition.

Supportive living facilities. Agreements cover services provided under Medicaid; arrangements for payment; grievance procedure; termination provisions; rules for staff, management, and resident conduct; and resident rights. The agreement includes services available for an additional fee and arrangements to share a unit.

PUBLIC FINANCING

The state has implemented a program to serve elders and adults with disabilities who are Medicaid waiver beneficiaries in supportive living facilities (SLFs). The service payment is 60 percent of the average nursing facility rate in the region. The statute does not allow assisted living establishment to serve Medicaid beneficiaries.

Medicaid Payment Rates by Geographic Area (2007)				
Region	Daily	Room and Board	Medicaid	Total
Chicago	\$66.92	\$533	\$1,883	\$2,540
South Suburban	\$62.57	\$533	\$1,797	\$2,410
Northwest	\$58.48	\$533	\$1,639	\$2,287
Central	\$56.13	\$533	\$1,552	\$2,216
West Central	\$52.34	\$533	\$1,552	\$2,103
St. Louis	\$55.87	\$533	\$1,445	\$2,209
South	\$50.76	\$533	\$1,384	\$2,056

STAFFING

Assisted living and shared housing. Establishments must have sufficient trained staff to meet the 24-hour scheduled and unscheduled needs of residents. Assisted living establishments must have at least one awake staff person on duty who has CPR training.

Supportive living facilities must provide licensed and certified staff sufficient to meet the needs of residents in conjunction with contractual agreements. Certified nurse assistants must provide personal care services and assistance with self-administration of medications.

TRAINING

Assisted living and shared housing. Staff must complete an orientation that addresses philosophy and goals; promotion of dignity, independence, self-determination, privacy,

choice, and resident rights; confidentiality; hygiene and infection control; abuse and neglect prevention and reporting; and disaster procedures. Additional orientation covers needs of residents; service plans; internal policies; job responsibilities and limitations; and ADLs. Eight hours of annual training on these topics is required for staff and managers.

Direct care staff must receive 16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation. Training must cover encouraging independence in and providing assistance with activities of daily; living emergency and evacuation procedures specific to the dementia population; techniques for creating an environment that minimizes challenging behaviors; resident rights and choices for persons with dementia; working with families; caregiver stress; and techniques for successful communication.

Direct care staff must complete 12 hours of in-service education annually on Alzheimer's disease and related dementia disorders. Topics may include assessing resident capabilities and developing and implementing service plans; promoting resident dignity, independence, individuality, privacy, and choice; planning and facilitating activities appropriate for the dementia resident; communicating with families and other persons interested in the resident; resident rights and principles of self-determination; care of elderly persons with physical, cognitive, behavioral, and social disabilities; medical and social needs of the resident; common psychotropic medications and their side effects; and local community resources.

Supportive living facilities. Staff receive documented training by qualified individuals in their areas of responsibility and on infection control, crisis intervention, prevention and notification of abuse and neglect, behavior intervention, negotiated risk, and encouraging independence; training that includes techniques for working with persons with disabilities and the elderly; and, in the case of an SLF serving persons with disabilities, disability-specific sensitivity training conducted by an outside entity as part of staff orientation and at least annually thereafter. Nurse assistants must be certified or enrolled in and pursuing certification. A trained staff person must be responsible for planning and directing social and recreational activities.

OVERSIGHT AND MONITORING

The state makes annual, unannounced visits to inspect assisted living and shared housing establishments. The inspection focuses on compliance with rules, solving resident issues and concerns, and the establishment's quality improvement (QI) process. Each establishment must have a QI program that covers oversight and monitoring; the process must have benchmarks, be data driven, and focus on resident satisfaction. The system detects and resolves problems. Individuals may not use the existence, results, or process of the QI system as evidence in any civil or criminal proceeding.

INDIANA

BACKGROUND

The Family and Social Services Administration (FSSA), Division of Aging certifies adult foster homes. The state included adult foster care as a service in the assisted living waiver in 2000 but did not implement the program until it developed and issued provider standards. The state added AFC as a service to the aged and disabled waiver in 2006.

In April 2008, the Division of Aging announced the creation of the Adult Foster Care Advisory Board, made up of providers. The board’s goal is to find ways to enhance services, provide technical assistance for providers, and increase participant enrollment.

According to a news release from the director of the Division of Aging, the state created the board as a means to engage stakeholders in partnering with providers on a statewide basis, and to solicit ideas and suggestions on how to improve programs and services,.

The board is open to all adult foster care providers and Area Agencies on Aging that provide case management. The program is just one service offered under the Division of Aging’s Options initiative. Adult foster care is a comprehensive residential service provided under the aged and disabled Medicaid waiver. Homes provide services in a homelike environment with an unrelated primary caregiver and family. Services may include personal care, homemaker, attendant care, medication oversight, transportation, and companionship.

The Division of Aging assigned a staff member to market AFC as an option under the waiver and to recruit providers.

Web Site	Content
http://www.in.gov/fssa/files/AFCProposedRule.pdf	Rule
http://www.in.gov/fssa/files/AdultFosterCareProviderAppPacket.pdf	Provider information

DEFINITION

An **adult foster care home** is a family home in which resident care is provided to three or fewer elderly individuals or adults with either physical or cognitive disabilities, or both, who are not members of the provider’s or primary caregiver’s family. Care is provided in a homelike environment for compensation. For the purpose of these certification standards, the adult foster care home does not include any house, institution, hotel, or other similar living situation that supplies only room or board or both, if no resident thereof requires any element of care.

Adult foster care is a comprehensive service provided under the aging and disabled Medicaid waiver in which a person lives with an unrelated caregiver and up to two other residents in a home owned, rented, or managed by the AFC provider, in order to receive personal assistance designed to provide options for alternative long-term care to persons who have nursing facility level-of-care requirements but whose needs can be met in an AFC setting.

ADMISSION/RETENTION CRITERIA

AFC providers offer in-home services to residents at three care levels. Providers may serve one level or any combination of levels as long as the provider can meet the person's needs. Safeguards must be in place to ensure that the provider can handle any additional medical issues. The provider must have the ability to supply the highest level of care that the person requires through professional licensure, previous experience working with individuals with a similar level of care, or other appropriate means.

Providers may admit or continue to care for only those persons whose impairment levels are within the classification level of the home. If a physician determines that it is unsafe for the person or the provider determines that the person will not be a good match for the home, AFC is not a viable option.

Level of care is determined through an assessment. Level 1 potential residents score 36 or fewer points; Level 2 score 37–60 points; and Level 3 score 61–75 points.

ASSESSMENT AND CARE PLANNING PROCESS

The case manager prepares the care plan and conducts the comprehensive adult foster care assessment to establish supports and strategies that will accomplish the person's short- and long-term goals. The care plan accommodates the available financial and human resources, as well as assistance through paid provider services or volunteer services, or both, as designed and agreed upon. The plan describes the medical and other services (regardless of funding source) to be furnished, their frequency, and the types of providers that will furnish them.

The care plan must support the principles of dignity, privacy, and choice in decision making, individuality, and independence. It describes the person's capabilities, needs, and preferences, and defines the division of responsibility in the implementation of services. The plan must address, at minimum, assessed health care needs; social needs, and preferences; personal care tasks; and, if applicable, limited nursing and medication services, including frequency of service and level of assistance.

SERVICES

The provider must have the ability to provide services in a manner and environment that encourages maintenance or enhancement of each resident's quality of life and promotes his or her privacy, dignity, choice, independence, individuality, and decision-making ability. Providers offer the following services: personal care; homemaker, chore, attendant, and companion services; and medication oversight, to the extent permitted under state law. Providers may offer homemaker activities essential to the resident's health care needs to prevent or postpone institutionalization when provided during the provision of other attendant care services and assistance, which may include the following:

- Personal care (bathing, partial bathing, oral hygiene, hair care, shaving, hand and foot care, dressing, clipping hair, and application of cosmetics).
- Mobility (proper body mechanics, transfer between bed and chair, and ambulation that does not include assistive devices).

- Elimination (assists with bedpan, bedside commode, toilet; incontinent or involuntary care; and emptying urine collection and colostomy bags).
- Nutrition (meal planning in accordance with special diets, preparation, clean-up).
- Safety (use of principles of health and safety in relation to self and the resident; identify and eliminate safety hazards; practice health protection and cleanliness by appropriate techniques of hand washing; and waste disposal and household tasks).
- Assistance with correspondence and bill paying.
- Escorting people to doctor appointments and community activities that are therapeutic in nature or that assist with developing or maintaining natural supports.

MEDICATIONS

AFC homes provide medication management: reminders or cues, the opening of preset commercial medication containers, or providing assistance in the handling or ingesting of medication. Both prescription and over-the-counter medications are included in this category. Self-administration of medication means the act of a person placing a medication in or on his or her own body. It means that the resident manages and takes his or her own medications (i.e., identifies the medication and the times and methods of administration, and placing the medication internally or externally on his or her own body without assistance. This may include reminders, cues, or opening medication containers when requested to do so. This does not include assistance with prescription eye drops, which must be self-administered.

Provision of medication management services must be at the direction of a resident who is competent but not able to accomplish the task him- or herself because of an impairment or physical infirmity. If the person not competent—or competence is in question—a competent person who is responsible for the health and care of the resident may direct the appropriate assistance for the resident.

Prescription medications ordered to be given “as needed” must have additional directions that explain what the medication is for and specifically when, how much, and how often it should be administered. A physician, nurse practitioner, registered nurse, or pharmacist may provide these written directions.

Residents must have a physician’s or nurse practitioner’s written order of approval to self-medicate. Those who are able to handle their own medical regimen will keep their medications in their room in a locked storage area. The provider will notify the physician or nurse practitioner if the resident can no longer self-medicate safely. Each resident’s medication container will be clearly labeled with the pharmacist’s label or be in the original labeled container or bubble pack, and must be held by the resident or the primary caregiver, depending on the individual’s person’s and abilities. If residents manage their own medicine regimen, caregivers must be well informed of medication management to ensure that assistance is provided when needed.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Before admission, the AFC services provider must complete a resident contract with each potential resident or his or her designated representative. The contract must cover the

following: name of the provider; address; mailing address of the AFC home; term of the contract; description of the services to be provided; description of services provided outside the waiver program but for which the provider may assist by arrangement of appointments or provision of transportation; description of the process through which the contract can be modified, amended, or terminated; description of the complaint resolution process available to residents; name of the resident’s designated representative, if applicable; and any specific information related to any house rules, which must not be in conflict with the resident rights as defined in this article or the family atmosphere of the home. House rules are subject to review and approval by FSSA waiver services before enrollment in the HCBS Medicaid waiver program.

PUBLIC FINANCING

The state’s Medicaid aging and disabled HCBS waiver program covers AFC. The Medicaid service rate includes personal care and services; homemaker, chore, attendant care, and companion services; medication oversight to the extent permitted under state law; and transportation. The waiver reimburses providers on the basis of scores from an assessment. Rates are based on three levels of care (see table below) and do not include room and board. Pursuant to legislation passed in 2008, the state is reviewing rates for all waiver services. SSI beneficiaries pay \$585 for room and board, and retain a personal needs allowance of \$52 a month. The state has certified approximately 39 AFCs, and about 50 waiver participants live in AFC settings.

Indiana AFC payment levels, 2008		
Level	Points	Rate
Level 1	Fewer than 36 points	\$57.48/day
Level 2	37–60 points	\$67.93/day
Level 3	61–75 points	\$78.38/day

STAFFING

The provider must be at least 21 years of age, and must live in a setting that is suitable for the provider and the resident(s). AFC home providers must live in the home unless they contract a primary caregiver to live in the home. If the primary caregiver is not the provider, the same qualifications are required for that caregiver as those required for the provider, and the provider is still responsible for liability insurance and safety provisions.

Caregivers other than the provider must be subcontractors or employees of the provider. Providers must keep a file showing that subcontractors or employees meet the minimum provider requirements. The provider and other caregivers must pass a state criminal background check obtained through the Indiana State Police central repository before opening the home to residents or working in the home; they must notify the division if they are convicted of a crime after they are certified.

TRAINING

Provider and staff must have training that is appropriate to the age, care needs, and condition of the residents served. If a resident has a medical regimen or personal care plan prescribed by a licensed health care professional, the provider must cooperate with the plan and ensure its implementation.

OVERSIGHT AND MONITORING

FSSA waiver services staff conduct an inspection of each home before issuing an HCBS Medicaid waiver provider agreement. They make announced or unannounced inspection visits annually, and whenever they receive a complaint about a violation that could threaten the health, safety, or welfare of residents. FSSA waiver services staff may conduct an inspection anytime they believe a home has violated a condition of the Medicaid waiver provider agreement or a provision of this article; or is operating without an HCBS Medicaid waiver provider agreement. Inspections can take place for the purpose of routine monitoring of the resident's care. Case managers conduct mini-inspections during their visits.

IOWA

BACKGROUND

The state enacted legislation in 1997 establishing assisted living residences and elder group homes. The Department of Inspections and Appeals (DIA) certifies elder group homes. The department has nine certified homes with a capacity to serve 30–45 residents. Participants are private pay. The regulations require that all residents must be able to evacuate independently in an emergency, and older adults who are eligible for the Medicaid home and community-based services waiver program do not meet that criteria. All homes are owner-occupied, and many providers knew the residents before they moved in.

Web Site	Content
http://www.legis.state.ia.us/ACO/IAhtml/321.htm#agency_321	Rules
http://www.state.ia.us/elderaffairs/services/ElderGroupHomes.html	Consumer Q&A

DEFINITION

An **elder group home (EGH)** is a single-family residence operated by a person who is providing room, board, and personal care, and may provide health-related services, to three to five elders. The provider and elders receiving services are not related within the third degree of consanguinity or affinity, and the home has an onsite manager 24 hours a day, seven days a week.

ADMISSION/RETENTION CRITERIA

Operators may admit or continue to care for only those tenants whose service needs include personal care; they may not admit tenants who—

- Are bedbound.
- Require routine one-person assistance with standing, transfer, or evacuation.
- Are dangerous to themselves, other tenants, or staff, including but not limited to a tenant who, despite intervention, chronically wanders into danger, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression; or a tenant who displays behavior that places another tenant at risk.
- Are in an acute stage of alcoholism, drug addiction, or uncontrolled mental illness.
- Are under the age of 18 years.
- Require more than part-time or intermittent health-related care.
- On a routine basis, has unmanageable incontinence.

Providers can apply for a waiver to serve tenants who need licensed nursing activities or hospice care if the tenant or tenant’s legal representative does not want or approve of a transfer from the EGH. The tenant, tenant’s legal representative, homeowner, operator, or onsite manager must submit a request for a waiver of the level of care.

ASSESSMENT AND CARE PLANNING PROCESS

At the time of admission and based on an assessment of the tenant's functional abilities, in cooperation with the tenant or the tenant's legal representative, the provider develops a service plan. This is an individualized plan that, at a minimum—

- Indicates the tenant's identified needs and requests for assistance, and the expected outcomes.
- Indicates any services and care to be provided pursuant to the agreement with the tenant.
- Identifies care provider(s) if other than the EGH.
- Is updated within 30 days of admission, as needed, and, at a minimum, annually.

SERVICES

Elder group homes offer personal care and assistance with self-administration of medications.

MEDICATIONS

An Iowa-licensed registered nurse, an advanced registered nurse practitioner registered in Iowa, or an agent delegated in accordance with state Nurse Practice Act rules may administer medications. A registered nurse may teach a provider how to administer a medication, demonstrate the procedures to follow, observe the provider administering the medication, and document that it was administered appropriately. Medications may be administered or stored by the EGH if they are administered by an Iowa-licensed registered nurse or advanced registered nurse practitioner registered in Iowa or a delegated agent.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

The written occupancy agreement includes but is not limited to the following:

- A description of all fees, charges, and rates describing the tenant's accommodations and basic services, as well as any additional and optional services with their related costs.
- A statement regarding the impact of the fee structure on third party payments and whether EGH accepts third party payments and resources.
- The procedure for nonpayment of fees.
- Identification of the party responsible for payment of fees and of the tenant's legal representative, if any.
- The term of the occupancy agreement.
- A statement that the EGH must notify the tenant or the tenant's legal representative in writing at least 30 days before any change in the occupancy agreement. Changes may be made immediately when the tenant's health status or behavior constitutes a

substantial threat to the health or safety to the tenant, other tenants, or others, including when the tenant refuses to consent to relocation.

- Changes may be made immediately in an emergency or if a significant change in the tenant's condition results in the need for services that exceed the level specified in the occupancy agreement and the EGH cannot safely provide these services.
- A statement that all tenant information is confidential to the extent required under state and federal law.
- Occupancy, involuntary transfer, and transfer criteria and procedures to ensure a safe and orderly transfer from the EGH. The internal appeals process for an involuntary transfer.
- The EGH policies and procedures for addressing grievances between the EGH and the tenant, including grievances related to transfer and occupancy.
- Policy regarding discrimination or retaliation against a tenant, a tenant's family, or an employee of the EGH who initiates or participates in any proceeding authorized by the regulations.
- The emergency response policy.
- The staffing policy, which specifies that staff are available 24 hours a day, whether nurse delegation will be used, and how staffing will be adapted to meet changing tenant needs.
- The refund policy.
- A statement regarding billing and payment procedures.
- The telephone number for filing a complaint with DIA.
- The telephone number for the office of the state ombudsman.
- The telephone number for the elder abuse hotline.
- A copy of the EGH statement on tenant rights.
- A statement that the tenant-landlord law applies to the EGH.

PUBLIC FINANCING

The state's elderly waiver does not cover services in elder group homes.

STAFFING

The EGH must have an on-site manager 24 hours a day, seven days a week. Sufficient trained staff must be available at all times to meet tenants' identified needs. All personnel must be able to implement accident, fire safety, and emergency procedures.

TRAINING

Personal care providers shall have completed, at minimum, a home care aide training program. Home care aide rules set requirements for five levels of service: chore, home helper, homemaker; personal care, and protective worker. Homemaker and personal care aides must complete a 60-hour training curriculum, a 75-hour certified nurse aide course, or home care aide training approved by the Public Health Department. Workers must complete 12 hours of training annually.

OVERSIGHT AND MONITORING

The state certifies and inspects homes every two years.

KANSAS

BACKGROUND

The state licenses adult foster care providers as home-plus facilities that may serve no more than eight persons. As of June 2008, the state had 74 licensed facilities with a capacity to serve 480 residents. Homes licensed to serve eight residents accounted for over 60 percent of the total capacity.

The state also licenses boarding care homes, which are private residences or facilities for up to 10 people. A person may share a bedroom or have his or her own room. Noncertified or nonlicensed staff provide supervision 24 hours a day, seven days a week. The only assistance and services that participants may receive are meals, laundry, housekeeping, and supervision for self-administration of medication. Boarding care homes do not provide personal, medical, or skilled nursing care, and residents must be able to walk and manage their own affairs.

Web Site	Content
http://www.aging.state.ks.us/PolicyInfo_and_Regs/ACH_Current_Regs/ACH_Reg_Index.html	Rules
http://www.agingkansas.org/CultureChange/FacReports/home_plus.pdf	List

DEFINITION

A **home-plus facility** is any residence or facility that cares for not more than eight persons not related within the third degree to the operator or owner by blood or marriage unless the resident in need of care is approved for placement by the secretary of the Department of Social and Rehabilitation Services and, because of functional impairment, needs personal care and may need supervised nursing care to compensate for ADL limitations. The Department on Aging determines, through rules and regulations, the level of care provided to residents. An adult care home may convert a portion of one wing of the facility to a not-less-than-five-bed and not-more-than-eight-bed home-plus facility if the home-plus facility remains separate from the adult care home, and each facility must remain contiguous.

ADMISSION/RETENTION CRITERIA

Each home-plus facility must develop and implement written admission, transfer, and discharge policies that protect the rights of residents. If the operator of the facility is not a licensed nurse, the facility shall not admit or retain residents who have one or more of the following conditions:

- Incontinence, if the resident cannot or will not participate in management of the problem.
- Immobility, if the resident requires total assistance to exit the building.
- Any ongoing condition that requires a two-person transfer.
- Any ongoing skilled nursing intervention that is needed 24 hours a day for an extended period of time.
- Any unmanageable behavioral symptom.

ASSESSMENT AND CARE PLANNING PROCESS

On or before admission to a home-plus facility, a licensed nurse, licensed social worker, or the administrator or operator shall conduct a screening to determine the person's functional capacity and shall record all findings on a screening form specified by DIA. A facility administrator or operator may integrate the department's screening form into a form developed by the facility, as long as it includes each element and Definition specified by the department.

Designated staff at each facility conduct a screening at least once a year to determine each resident's functional capacity; residents are screened at least quarterly if they receives assistance with eating from a paid nutrition assistant. A resident is screened whenever there is a significant change in his or her condition. The screening is used to determine which services will be included in a negotiated service agreement.

Each facility develops a written negotiated service agreement based on the service needs identified by the functional capacity screen or the preferences of the resident. The agreement includes a description of the services to be provided, identification of the provider, and identification of the party or parties responsible for payment when services are provided by an outside resource. The negotiated service agreement supports the dignity, privacy, choice, individuality, and autonomy of the resident.

The home-plus facility provides or coordinates the provision of health care services to each resident as specified in the negotiated service agreement. If the functional capacity screen indicates that a resident is in need of health care services, a licensed nurse—in collaboration with the resident, the resident's legal representative, the family (if agreed to by the resident), or a case manager—develop a health care service plan to be included in the negotiated service agreement.

If the resident or the resident's legal representative refuses a service that the staff, the resident's physician, or the case manager believes is necessary for the resident's health and safety, the negotiated service agreement shall include the following information:

- The service or services refused.
- Potential negative outcomes for the resident if the service or services are not provided.
- An indication of the acceptance of the potential risk by the resident or the resident's legal representative.

SERVICES

Services include daily meal service; health care services based on an assessment by a licensed nurse; housekeeping services essential for the health, comfort, and safety of residents; medical, dental, and social transportation; group and individual activities based on the needs and interests of the resident; and other services necessary to support the health and safety of the resident.

Health care services provided by or coordinated by the facility may include the following: personal care provided by the facility's direct care staff, a home health agency,

or gratuitously by friends or family members; or supervised nursing care provided by a licensed nurse employed by the facility, a home health agency, a hospice, or the resident.

A licensed nurse may delegate to unlicensed direct care staff under the Kansas Nurse Practice Act if nursing procedures are not included in the nurse aide or medication aide curriculums.

MEDICATIONS

In assisted living, residential health care, home-plus, and adult day care facilities, a resident may self-administer drugs unless a registered professional nurse or a physician has determined that this practice is unsafe.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

The negotiated service agreement is similar to and contains provisions normally found in a resident agreement. Each home-plus facility develops—in collaboration with the resident, the resident's legal representative, family (if agreed to by the resident), or case manager—a written negotiated service agreement based on the service needs identified by the functional capacity screen and the preferences of the resident. The negotiated service agreement includes the following information:

- Services to be provided.
- Provider of the services.
- Party or parties responsible for payment when services are provided by an outside resource.

PUBLIC FINANCING

The frail elderly Medicaid HCBS waiver, based on the plan of care, covers services in home-plus facilities. However, no information was available on the number of participants reported.

STAFFING

The administrator or operator must be at least 21 years old; have a high school diploma or the equivalent; hold a Kansas license as an adult home care administrator or have successfully completed an operator training program designated by the secretary; and have authority and responsibility for the operation of the facility and compliance with licensing requirements.

Each home-plus facility shall provide sufficient qualified personnel to ensure that residents receive the services and care specified in the negotiated service agreement.

TRAINING

Unlicensed staff members who provide direct care must successfully complete a 90-hour nurse aide course approved by the licensing agency and must pass a test. Staff who administer medications must complete a medication aide course and pass the state test.

OVERSIGHT AND MONITORING

Not described.

KENTUCKY

BACKGROUND

The Cabinet for Health and Family Services, Office of Inspector General certifies family care homes (FCHs). As of June 2008, the state had licensed 93 homes with a capacity of 272 beds.

Web Site	Content
http://www.lrc.ky.gov/kar/902/020/041.htm	Rules
http://chfs.ky.gov/os/oig/directories.htm	List

DEFINITION

A **family care home** provide 24-hour supervision and personal care services in residential accommodations for up to three residents who (because of impaired capacity for self-care) elect to have or require a protective environment but do not have an illness, injury, or disability for which constant medical care or skilled nursing services are required.

ADMISSION/RETENTION CRITERIA

Residents must be ambulatory or mobile nonambulatory and able to manage most of the activities of daily living. A resident admitted or retained for care shall not require—because of illness, injury, or disease—a degree of care that exceeds the skill of the operator to provide.

ASSESSMENT AND CARE PLANNING PROCESS

Not specified. However, the resident’s physician may be responsible for ensuring that no skilled nursing is required and that the person’s basic needs can be meet in an FCH.

SERVICES

A family care home shall, through continuous supervision and monitoring, ensure that it meets the health care needs of a resident by—

- Supervising self-administration of medication.
- Monitoring storage and control of medication.
- Arranging for necessary therapeutic or physician services.

Family care homes assist with the following:

- Bathing to maintain clean skin and freedom from offensive odors, with the following items provided for each resident and not used by others: soap, clean towels and washcloths, brushes and combs, and other appropriate toilet articles.
- Shaving.

- Cleaning the mouth and teeth to maintain good oral hygiene, and care of the lips to prevent dryness and cracking.
- Washing, grooming, and cutting hair.

MEDICATIONS

The state allows the self-administration of a prescription medication only upon the written instruction of the attending physician or other practitioner acting within the limits of his or her statutory scope of practice. A prescription medication administered to a resident shall be noted in writing (date, time, and dosage) and signed by the person who administered it. Medication shall not be administered to a resident except on the written order of a physician or other practitioner acting within the limits of his or her statutory scope of practice. If medication requires administration by a licensed person, an arrangement shall be made to procure the services of a person licensed to administer medication.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

A statement signed by the resident and the provider describes the terms of the stay.

PUBLIC FINANCING

The state provides a state SSI supplement of \$172 a month, for a total payment of \$809 in 2008.

STAFFING

Not described.

TRAINING

The Cabinet for Health and Family Services requires that family care home operators approved by the department, attend at least one training program a year.

OVERSIGHT AND MONITORING

Not described.

LOUISIANA

BACKGROUND

Louisiana regulates personal care homes in its regulations for adult residential care facilities. The homes may serve two to eight residents. Currently, there are 32 licensed homes with a capacity of 213.

Web Site	Content
http://www.dss.state.la.us/assets/docs/searchable/OS/licensing/Adult_Residential.pdf	Rules

DEFINITION

A **personal care home** is an adult residential care home/facility that provides room and board and personal services for compensation to two to eight residents in a congregate living and dining setting. The home looks like any other private dwelling in the neighborhood. Personal care homes comply with the core standards and those in the personal care home module.

ADMISSION/RETENTION CRITERIA

Residents include persons who need or wish to have room, board, personal care, and supervision owing to age, infirmity, physical disability, or social dependency. A resident with advanced or higher care needs may be accepted or retained if he or she can provide or arrange for care through appropriate private duty personnel, and does not need continuous nursing care for more than 90 days; and if the provider can meet the resident's needs. Facilities may not enter into contracts with outside providers to deliver health-related services. The resident, family members, or the resident's representative must arrange these services. The provider must discharge a resident if a physician certifies that he or she needs more than 90 days of continuous care or is a danger to him- or herself or others.

ASSESSMENT AND CARE PLANNING PROCESS

Providers complete and maintain a preadmission appraisal on each applicant. The initial screening assesses the applicant's needs and his or her appropriateness for admission. It includes the following: the resident's physical and mental status; need for personal services and assistance with instrumental activities of daily living; and ability to evacuate the facility in the event of an emergency. Providers complete and date the preadmission appraisal before signing the contract/admissions agreement.

SERVICES

Basic services include assistance with ADLs and IADLs, three meals a day, personal and other laundry, opportunities for individual and group socialization, housekeeping, services for residents who have behavior problems, recreation services, and assistance with self-administration of medications. Providers must plan or arrange for health assessments, health care monitoring, and assistance with health tasks as needed or requested. Facilities must have the capacity to provide transportation for medical

services, personal services (barber/beauty shop), personal errands, and social/recreational activities.

MEDICATIONS

Facilities may provide assistance with self-administration of medications only if they know what the medication is and understand why it is needed. Residents may contract with an outside source for medication administration. Staff assisting with medications must have training on the policies and procedures for assistance.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

The admission agreement must include clear and specific occupancy criteria and procedures (admission, transfer, and discharge); basic services available; optional services available; payment provisions (covered and noncovered services, service packages and à la carte services, extra fees, funding source); modification provisions including at least a 30-day notice of rate changes; refund policy; authority of the licensing agency to examine records; general facility policies/house rules; responsibilities of the facility, resident, and family for overseeing medical care, purchasing supplies/equipment, and handling emergencies and finances; and the availability of a service plan.

PUBLIC FINANCING

Medicaid funding is not available in personal care homes.

STAFFING

Homes must have sufficient qualified staff to meet the needs of residents.

TRAINING

Directors of personal care homes must have at least two years of college training and one year of experience in the fields of health, social services, geriatrics, management, or administration; or three years' experience or a bachelor's degree in geriatrics, social services, nursing, health care administration, or a related field.

Orientation for staff includes the facility's policies and procedures, emergency and evacuation procedures, residents' rights, reporting abuse and critical incidents, and instruction in the specific responsibilities of each employee's job. Direct care staff orientation must cover training in resident care services (personal care), infection control, and any specialized training to meet resident needs. All direct care staff must receive certification in first aid. An annual training plan for direct care staff must include the topics covered by the orientation.

OVERSIGHT AND MONITORING

The Department of Health makes at least annual inspections. The appropriate state agency reviews and investigates complaints.

MAINE

BACKGROUND

Maine licenses adult foster care providers on the basis of size and number of employees as residential care facilities (RCFs). Maine has four categories of RCFs, three of which fit the definition of adult foster care used in this study. Licensing is voluntary for RCFs that serve one or two residents, and most choose not to be licensed. RCF Level II and Level III providers serve three to six residents. Level III providers have three or more staff who are neither owners of the facility nor related to the owner. Only Level III providers receive Medicaid reimbursement.

In the 1970s and 1980s, Maine licensed AFC homes of four or fewer beds. These facilities phased out because of quality of care issues. They were generally “mom and pop” homes, and payments were limited to state supplements to SSI for low-income residents. In the mid 1990s, the state undertook a major initiative to rebalance long-term care, and interest grew once again in small, homelike options for older people that would provide a high quality of care.

Maine modeled a new adult family care home (AFCH) program on lessons learned from Oregon. Oregon paid for AFCHs using home and community-based waiver funding. To be successful, providers needed adequate income to pay staff and, if they lived in the home, to take time away from the facility to avoid burnout.

Currently, Maine has 27 AFCHs. This model is well-suited to rural areas, where population density will not support larger facilities. It is also a popular model for some urban areas, where elders prefer a more homelike setting. AFCHs that participate in the Medicaid program are licensed as Residential Care Facilities III.

Web Site	Content
http://www.maine.gov/sos/cec/rules/10/ch113.htm	Rules
http://www.maine.gov/sos/cec/rules/10/ch101.htm	Medicaid rules

DEFINITION

A **residential care facility (RCF)** is a house or other building that, for consideration, is maintained wholly or partly for the purpose of providing residents with assisted living services. RCFs provide housing and services to residents in private or semiprivate bedrooms in buildings with common living areas and dining areas. The following are the types of residential care facilities:

Level I: A facility with a licensed capacity of one to two residents. Licensure is voluntary for this group.

Level II: A facility with a licensed capacity of three to six residents.

Level III: A facility with a licensed capacity of three to six residents and that employs three or more persons who are not owners and are not related to the owner.

An **adult family care home (AFCH)** is a residential-style home for up to six residents that is licensed by the Department of Health and Human Services pursuant to the Regulations Governing the Licensing and Functioning of Assisted Housing Programs: Level III Residential Care Facilities or Assisted Housing Programs: Level IV Residential Care Facilities, and is primarily engaged in providing services to the elderly.

ADMISSION/RETENTION CRITERIA

Facilities are required to provide the department with a written admission policy when they apply for a license. The policy describes the admission criteria and scope of services provided, including nursing services, consistent with applicable state and federal law.

ASSESSMENT AND CARE PLANNING PROCESS

Facilities must assess residents within 30 calendar days of admission. Facilities are also required to reassess residents annually or more frequently if there is a significant change in the resident's condition. The assessments/reassessments determine each resident's abilities and need for services. Residents receive individualized services that help them function in the facility and in the community, and that help restore them to an optimal state of health or for constructive activity, as needed. Facilities ensure, to the extent practicable, that they accommodate the resident's choices and preferences.

A service plan, based on an assessment, is developed and implemented within 30 calendar days of admission. The plan addresses areas in which the resident needs encouragement, assistance, or an intervention strategy. The resident, his or her legal representative (if applicable), and others chosen by the resident shall be actively involved in the development of the service plan, unless he or she is unable or unwilling to participate. The resident's record will include documentation identifying the participants in the development of the service plan. The plan shall include strategies and approaches to meet the resident's needs, names of persons who will arrange or deliver services, when and how often services will be provided, and goals to improve or maintain the resident's level of functioning. Residents shall be encouraged to be as independent as possible in their functioning, including ADLs and normal household tasks if they choose, unless contraindicated by the resident's authorized licensed practitioner. The service plan shall be modified, as necessary, on the basis of identified changes in the resident's status. Residents shall never be required to perform activities specified in the residential service plan or any other activities, and may not be used to replace paid staff.

SERVICES

Facilities provide assistance with ADLs, IADLs, personal supervision, protection from environmental hazards, meals, care management, and diversional or motivational activities. Personal supervision means awareness of a resident's general whereabouts, even though the resident may travel independently in the community, and observation and assessment of each resident's functioning and behavior to enhance his or her health or safety, or the health or safety of others. Protection from environmental hazards means mitigation of risk in the physical environment to prevent unnecessary injury or accident. Diversional, motivational, and recreational activities are those that respond to residents' interests or stimulate social interaction.

Professional nurses may provide nursing services, and unlicensed health care assistive personnel may help with coordination and oversight of resident care services.

MEDICATIONS

At admission, the facility determines the person’s ability to self-administer medications or need for assistance. In Level II facilities, a registered nurse may train unlicensed persons to manage care for persons with diabetes and to administer insulin injections. The RN must provide in-service training and documentation.

In Level III facilities, unlicensed assistive personnel administering medications or treatments must complete training approved by the department. A person who is qualified to administer medications must be onsite if a resident has a medication prescribed “as needed” (PRN) and this medication is not self-administered.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

The state requires adoption of a standard contract for all types of assisted living and residential care facilities. These contracts contain standard provisions regarding services and accommodations, and the rates and charges for such services. They may not contain provisions for the discharge of a resident that are inconsistent with state law or rule, or provisions that require or imply a lesser standard of care or responsibility than required by law or rule. The contract must provide for at least 30 calendar days’ notice before any changes in rates, responsibilities, services, or any other items included in the contract; may not require a deposit or other prepayment, except one month’s rent in an assisted living program, which may be used as a security deposit provided if the return policy is spelled out; and may not contain a provision that provides for the payment of attorney fees or any other cost of collecting payments from the resident. Additional information is appended to the contract: grievance procedure, tenancy obligations, resident rights, and a copy of the admissions policy.

PUBLIC FINANCING

Maine contracts with Level III RCFs as private nonmedical institutions and covers payment under the rehabilitation state plan option. Twenty-seven facilities with a capacity to serve 486 residents participate in Medicaid. The SSI standard payment is \$871 a month. The reimbursement for each member is based on the resource group to which the member is assigned under the MDS-ALS (Assisted Living Services) assessment.

Maine Rate Structure		
Resource group	Medicaid (MaineCare) weight	Resource-adjusted price (\$42 unadjusted price times MaineCare weight)
1	1.657	\$69.59
2	1.210	\$50.82
3	1.360	\$57.12
4	1.027	\$43.13
5	.924	\$38.80
6	.804	\$33.76
7	.551	\$23.14
8	.551	\$23.14

There are eight resource-adjusted (case mix) groups, including one group for members who cannot be classified into one of the other seven groups. Each group has a specific resource-adjusted weight.

Resource Classification Group and Weight			
Resident group	Resource classification group	Short description	MaineCare Weight
ALS 7-9	1	ADL=7-28	1.657
	2	ADL=0-6	1.210
ALS 5-6	3	ADL=3-28	1.360
	4	ADL=0-1	1.027
ALS 2-4	5	IADLB=12-18*	.924
	6	IADLB=10-11*	.804
ALS 0-1 or ALS 2-4 and IADL 0-9	7	ALS 0-1 or ALS 2-4 and IADL 0-9	.551
ALS 0-1	8	Unclassified	.551

* IADLB = instrumental activities of daily living with bathing

STAFFING

The provider must be at least 21 years of age and must submit evidence of education, experience, and training that meets the needs of the residents. The provider must demonstrate to the department’s satisfaction the capacity to operate and manage the facility in the best interests of residents and consistently with regulations.

Staffing shall be sufficient to implement service plans and provide a safe setting. If the department determines at any time that supervision and services are not adequate to meet resident needs, additional staffing may be required.

TRAINING

Unlicensed assistive personnel who will administer medications or treatments must complete training approved by the department. An exception may be made for persons who only administer dietary supplements or minor medicated treatments, shampoos, lotions, and creams that could be obtained over the counter without a physician’s order.

A person who is qualified to administer medications must be onsite if residents have medications prescribed “as needed” (PRN) and these medications are not self-administered.

All unlicensed assistive personnel who administer medications or treatments must complete a department-approved eight-hour refresher course for recertification every two years after their original certification.

OVERSIGHT AND MONITORING

The Department of Health and Human Services makes regular and unannounced inspections of all facilities. The regulations specify grounds for imposition of intermediate sanctions and the method of calculating penalties. The state ombudsman program has the authority to visit facilities and to receive and investigate complaints.

MARYLAND

BACKGROUND

The state’s assisted living regulations also apply to adult foster care homes. Of the 331 licensed facilities, 191 have 25 or fewer beds.

The Certified Adult Residential Environment (CARE), also called Project Home, is a program administered by the Department of Human Resources, Office of Adult Services. Providers are individuals and families willing to open their home to an adult with disabilities. Providers must meet assisted living licensing and Project Home regulation requirements. They must be willing to work with a Department of Social Services case manager and the individual resident to implement the treatment plan. Providers must participate in training provided by the local department of social services and demonstrate an attitude of acceptance toward others.

Web Site	Content
http://dhr.maryland.gov/oas/pdf/projhome.pdf	Brochure
http://www.dhnh.state.md.us/ohcq/regulated_programs/assisted_living.htm	Tools, guide, consumer
www.dsd.state.md.us/comar/subtitle_chapters/10_Chapters.aspx#Subtitle10	AL rules (10.07.14)

DEFINITION

An **assisted living program** is “a residential or facility-based program that provides housing and supportive services, supervision, personalized assistance, health-related services, or a combination thereof to meet the needs of residents who are unable to perform, or who need assistance in performing, ADLs or IADLs in a way that promotes optimum dignity and independence for the residents.” The state mandates that facilities do not use the term “assisted living program” in advertising unless it is a licensed facility.

ADMISSION/RETENTION CRITERIA

The level of impairment of residents in a facility determines the license classification. Residents are assigned to a level on the basis of an assessment score. The assessment includes 12 questions that cover medical illnesses/conditions, as well as questions about cognitive and psychiatric conditions, treatment requirements, medication management, ADL assistance, risk factor management, and management of problematic behaviors.

In general, programs may not serve anyone who, at the time of admission, requires more than intermittent nursing care; treatment of stage 3 or 4 skin ulcers; ventilator services; skilled monitoring or testing; aggressive adjustment of medications and treatments in the presence of, or risk for, a fluctuating acute condition; monitoring of a chronic medical condition that is not controllable through readily available medications and treatments; treatment for an active reportable communicable disease; or treatment for a disease or condition that requires more than contact isolation. Facilities may deny admission to residents that are a danger to themselves or others.

A program may request a waiver to care for residents with needs that exceed the licensure level. It must demonstrate that it can meet the resident’s needs and the safety of others.

Waivers for Level I and Level II programs may not be granted for more than 50 percent of the licensed bed capacity. Level III programs may not receive waivers for more than 20 percent of capacity or 20 beds, whichever is less. Eighty-nine percent of the licensed facilities provide Level III services.

ASSESSMENT AND CARE PLANNING PROCESS

Before move-in, the assisted living manager determines whether the resident may be admitted and whether the resident's needs can be met by the program on the basis of an assessment and an examination by a health care professional. A functional assessment is completed within 30 days of admission that includes level of functioning in activities of daily living; level of support and intervention needed, including any special equipment or supplies required to compensate for the individual's deficits in ADLs; current physical or psychological symptoms that require monitoring, support, or other intervention by the assisted living program; capacity for making personal and health care-related decisions; presence of disruptive behaviors, or behaviors that present a risk to the health and safety of the resident or others; and specified social factors.

The assisted living manager or designee shall ensure that all services are provided in a manner that respects and enhances the dignity, privacy, and independence of each resident. The service plan for each resident should reflect the principles of dignity, privacy, resident choice, resident capabilities, individuality, and independence without compromising the health or reasonable safety of other residents.

A written service plan or other documentation sufficiently recorded in the resident's record is developed by staff. At a minimum, it addresses the services to be provided; when and how often these services will be provided; and how and by whom. The service plan must be developed within 30 days of a person's admission to an assisted living program; it must be reviewed and updated as necessary—at least every six months

SERVICES

Assisted living facility services include three meals in a common dining area, special diets, personal care, laundry, housekeeping, social and spiritual activities, and medication management. The program must facilitate access to health care and social services (e.g., social work, rehabilitation, home health, skilled nursing, physician services, oral health, counseling, and psychiatric care).

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Agreements must include a clear and complete reflection of commitments and actual practices, and a recommendation for review by an attorney. The agreement includes the level of care for which the facility is licensed; the level of care needed by the resident; a statement that describes that a resident may be discharged if the level of care increases and a waiver is not approved; a list of services provided and not provided; complaint/grievance procedure; occupancy provisions (room assignment, relocation, change in roommate, transfer policy, availability of locks for storage); the staff's right to enter a room (if any); resident rights; bed hold policy; admission and discharge policy; obligations of all parties for arranging for and overseeing medical care and monitoring health status.

The agreement must also include financial information, such as obligations for payment; methods for handling finances; purchase of rental equipment; arranging and contracting for services not provided by the facility; durable medical equipment; and disposition of resident property upon discharge or death. Also included are the rate structure for the service package, fee-for-service rates; notification of changes; third party payments; person responsible for payment; procedures if the resident is no longer able to pay; and terms governing refunds. If the resident's needs change significantly, the facility is to amend the agreement with the consent of the resident or the resident's representative.

MEDICATIONS

Aides who have completed required training may administer medications. Untrained aides may assist with self-administration. Management must arrange for quarterly onsite reviews of medications by a registered nurse, authorized prescriber, or licensed pharmacist for each resident who self-administers medications.

PUBLIC FINANCING

The state administers an HCBS waiver and a state-funded program that serves beneficiaries age 50 years and older in residential settings. Room and board, paid by the resident, is capped at \$420 a month. Medicaid pays the lesser of the provider's usual and customary charge or \$55.74 a day for assisted living Level II services (\$41.81 if the resident receives medical day care services) and \$70.31 a day for Level III services (\$52.73 if the resident receives medical day care services).

Additional payments are available for assistive equipment. Medicaid will pay the actual costs, with payments capped at \$1,000 per participant for 12 months. Medicaid will pay 67 percent of the costs of environmental modifications (the provider pays 33 percent) up to a maximum of \$3,000 per participant. The Department on Aging can allow exceptions to the maximum.

For low- and moderate-income seniors, the Senior Assisted Living Group Home Subsidy program provides access to assisted living in small group homes. The Department of Health and Mental Hygiene licenses this program for 4–16 residents. The subsidy supports the cost of services provided in assisted living, including meals, personal care, and 24-hour supervision for elderly residents who are frail and unable to live independently. In accordance with an interagency agreement with the Department of Health and Mental Hygiene, the Department of Aging—through partnerships with Area Agencies on Aging (AAAs) around the state—monitors the homes.

Residents of a participating assisted living program or applicants for residency who require financial assistance may apply to their AAA for a subsidy. The person must be at least 62 years old, a resident in a facility or approved for entrance into a facility that has entered into a service agreement with the AAA, physically or mentally impaired, in need of assistance with the activities of daily living provided by the assisted living program, and financially eligible for a subsidy.

To be financially eligible, an applicant's net monthly income may not be higher than 60 percent of the state median income and he or she cannot have assets over \$11,000 if single (\$14,000 for a couple). The subsidy generally covers the difference between the person's net monthly income (after a \$60/month personal allowance deduction) and the

monthly assisted living fee. The maximum subsidy, paid directly to the provider, is \$550 a month

STAFFING

The facility develops a staffing plan based on the number of residents and their needs that identifies the type and number of staff required to provide the necessary services. The staffing plan includes sufficient qualified onsite staff to meet the 24-hour scheduled and unscheduled needs of the residents. A staff member must be present whenever a resident is in the facility.

Programs must have staff capacity to deliver the care for which they are licensed. Facilities that contract with Medicaid must have one staff member for every eight residents during daytime hours.

TRAINING

The assisted living manager's training includes the following courses: philosophy of assisted living (2 hours); aging process and its impact (4 hours); assessment and level-of-care waiver (6 hours); service planning (6 hours); clinical management (20 hours); admission and discharge criteria (4 hours); nutrition and food safety (8 hours); dementia, mental health, and behavior management (12 hours); end-of-life care (4 hours); management and operation (4 hours); emergency planning (4 hours); and quality assistance (4 hours).

Staff must receive initial and ongoing training to ensure that residents receive services that are consistent with their needs and with generally accepted standards of care. Staff must also receive initial and ongoing training in fire and life safety; infection control, including standard precautions; basic food safety; basic first aid; emergency disaster plans; and the job requirements specific to their jobs.

Staff must have knowledge consistent with their job responsibilities about health and psychosocial needs of the population served; the resident assessment process; the use of service plans; and resident rights.

If job duties involve the provision of personal care services, staff must have training in cueing, coaching, and providing assistance with ADLs. Staff who will work with people with cognitive impairments or mental illness must have training in various areas related to the population served.

For facilities that participate in the Medicaid waiver, staff must complete eight hours of training on medication administration and must pass a performance test.

OVERSIGHT AND MONITORING

The Department of Health and Mental Hygiene may delegate monitoring and inspection of programs to the Office on Aging and the Department of Human Resources, or to local health departments through an interagency agreement. The department requires that facilities post survey findings and plans of correction in a public area in the facility.

MASSACHUSETTS

BACKGROUND

The Massachusetts General Hospital developed adult foster care in the mid-1970s, and the MassHealth (Medicaid) program later approved it as a Medicaid state plan service. Thirty-six program sponsors operate the program and are responsible for recruiting, reimbursing, and monitoring caregivers. The program sponsors do not report the number of caregivers and their capacity to the Medicaid agency.

Web Site	Content
http://www.mass.gov/Eeohhs2/docs/masshealth/regs_provider/regs_adultfostercare.txt	Rules

DEFINITION

Adult foster care is the provision of services ordered by a physician delivered to a MassHealth member in a qualified setting by a multidisciplinary team and qualified AFC caregiver. It includes assistance with ADLs, IADLs, other personal care as needed, nursing services and oversight, and AFC care management. Providers may serve up to three residents; no more than two residents may have Level II needs.

ADMISSION/RETENTION CRITERIA

Beneficiaries qualify for Medicaid payments if a physician authorizes the service and the resident has a medical or mental condition that requires daily physical assistance or cueing and supervision during the task for the resident to successfully complete at least one of the following activities:

- Bathing (full-body bath or shower).
- Dressing, including street clothes and undergarments, but not just help with shoes, socks, buttons, snaps, or zippers.
- Toileting, if the resident is incontinent (bladder or bowel) or requires scheduled assistance or routine catheter or colostomy care.
- Transferring, if the resident must be assisted or lifted to another position.
- Ambulating, if the resident must be physically steadied, assisted, or guided one-on-one in ambulation or is unable to self-propel a wheelchair appropriately without the assistance of another person.
- Eating, if the resident requires constant supervision and cueing during the entire meal, or physical assistance with part or all of the meal.

ASSESSMENT AND CARE PLANNING PROCESS

An AFC plan of care is an individualized, written description of activities developed to furnish care that meets the individual’s medical, physical, emotional, and social needs. It is based on a clinical and psychosocial assessment and prepared by the AFC provider’s registered nurse, with input from the AFC care manager, the caregiver, and the resident.

The AFC provider is responsible for planning, coordinating, and monitoring the resident's care. Care management includes—

- Conducting an initial psychosocial assessment and evaluation of a person's appropriateness for AFC, with ongoing monitoring as needed.
- Evaluating, supporting, and training the AFC caregiver.
- Ensuring implementation of the AFC plan of care.
 - Conducting onsite visits with each resident at the facility:
 - For Level I, bimonthly (alternating with the bimonthly visit by the registered nurse).
 - For Level II, monthly.
- Completing a care management progress note for each onsite visit or encounter and when there is significant change.
- Conducting regular, periodic evaluations and assessments (at least annually) of each setting.

The plan of care must contain measurable goals and objectives, and must reflect the clinical assessment of needs, current care and treatment, problem identification with appropriate follow-up, and implementation with interventions and evaluation. A multidisciplinary professional team develops the plan of care within 30 days of admission. The registered nurse must sign the plan, which includes the following:

- A treatment plan that describes how the resident's service needs will be met 24 hours a day, seven days a week, and is based on the resident's physician's summary, physical examination, nursing assessments, and all other applicable clinical assessments.
- An assessment, completed by the multidisciplinary team, of the resident's ability to manage safely in the facility for a maximum of three hours a day without the presence of a qualified caregiver.
- Documentation of any other health services or supportive services the resident is receiving from MassHealth or other agencies or organizations.

SERVICES

AFC includes 24-hour supervision, assistance with ADLs and IADLs, and other personal care as needed. The AFC sponsor/provider must offer nursing coverage by a registered nurse, including individualized nursing services to meet the needs of each resident and to handle all of the following activities:

- Complete a nursing assessment.
- Coordinate all other applicable clinical assessments.
- Develop the resident's AFC plan of care.
- Conduct onsite visits with each resident at the facility:

- For Level I, bimonthly (alternating with the bimonthly visit by the care manager).
- For Level II, monthly, or more often if the resident's condition warrants; completing a nursing progress note for each visit and when there is significant change.
- Monitor each resident's health status and document those findings in the person's medical record for each onsite visit or encounter, or more often if the person's condition warrants.
- Educate the resident about hygiene and health concerns.
- Report changes in condition to the resident's physician.
- Coordinate the implementation of physicians' orders with the resident, the AFC caregiver, and AFC provider personnel.
- Evaluate, support, and train the AFC caregiver.

MEDICATIONS

Caregivers may assist with but not administer medications.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Not described.

PUBLIC FINANCING

Medicaid pays for AFC services at Level I for residents who have a medical or mental condition that requires daily physical assistance or cueing and supervision during the task for the person to successfully complete one or more of the following activities: bathing, dressing, toileting, eating, transferring, and ambulation.

Level II residents require physical assistance with three ADLs, or physical assistance with two ADLs and management of behaviors that require caregiver intervention: wandering (moving with no rational purpose, seemingly oblivious to needs or safety); verbally abusive behavioral symptoms (threatening, screaming, or cursing at others); physically abusive behavioral symptoms (hitting, shoving, or scratching); socially inappropriate or disruptive behavioral symptoms (disruptive sounds, noisiness, screaming, self-abusive acts, disrobing in public, smearing or throwing food or feces, rummaging, repetitive behavior, or causing general disruption); or resisting care.

Thirty-six program sponsors serve 1,500 Medicaid beneficiaries. The table below shows the rates. The caregiver and the beneficiary negotiate the room and board payment. To cover administrative and case management costs, the sponsor organization retains about 20 percent of the payment for Level I and II participants.

Massachusetts AFC Rates 7/1/08	
Service description	Rate
Level I	\$47.13 per day
Level II	\$83.09 per day
Intake and assessment services	\$242.38 per admission
Alternative placement I (respite)	\$37.47 per day
Alternative placement II	\$74.93 per day

STAFFING

Each AFC provider/sponsor must have a multidisciplinary professional team to meet the nursing, oversight, and care management needs of residents. The team must include a registered nurse and an AFC care manager, either of whom may assume the role of program director. Team staff must provide a minimum of 3.5 hours of service per resident per week.

The AFC provider must employ a program director who is a health care professional with a bachelor's degree and a minimum of five years of professional health care experience working with elderly or disabled adults. If the person has a master's degree, only three years of work experience are required. The program director is responsible for the development and implementation of the AFC provider's policies and procedures; the direction and supervision of all aspects of the AFC program; oversight of the hiring, training, supervision, firing, and evaluation of all AFC employees and independent contractors; payment of all AFC caregivers; fiscal administration of the AFC program, including billing, budget preparation, and required statistical and financial reports; and ensuring that the AFC provider meets all regulatory requirements.

TRAINING

Sponsors/providers must offer AFC caregivers a minimum of eight hours of in-service training a year. The initial orientation includes care for ADLs, IADLs, and any other personal care; delivery of AFC by the provider; written policies and procedures; requirements of the regulations; the roles and responsibilities of staff and caregivers; behavioral interventions, behavior acceptance, and accommodations; CPR and first aid; infection control and safety practices; privacy and confidentiality; communication skills; advance directive policies; elder and disabled persons abuse identification and reporting; body mechanics; cultural sensitivity; universal precautions; and emergency procedures, including the provider's fire, safety, and disaster plans. The ongoing annual training curriculum must include at least eight hours of training that complements or reinforces these topics.

OVERSIGHT AND MONITORING

Each AFC provider must conduct a biennial survey of residents, caregivers, and staff, and must develop a quality improvement plan that addresses issues and concerns raised by the survey.

MICHIGAN

BACKGROUND

Michigan began licensing family homes in the 1970s. The state licenses four types of adult foster care: family homes serve six or fewer residents; small group homes serve 1–12 residents and the owner does not have to but may live in the home; large group homes serve 13–20 residents; and congregate homes serve 21 or more residents.

In October 2008, Michigan had 1,199 homes with 5,561 beds. The supply has been stable over the past six years.

Web Site	Content
http://www.michigan.gov/dhs/0,1607,7-124-5455_27716_27717---,00.html	Rules, provider information
http://www.dleg.state.mi.us/brs_afc/sr_afc.asp	Database, survey findings

DEFINITION

An **adult foster care family home** is a private residence with the approved capacity to provide up to six adults with foster care for five or more days a week for two or more consecutive weeks. The AFC family home licensee must be a member of the household and an occupant of the residence. The state also licenses adult foster care small and large group homes, and congregate care facilities—for these, the licensee is not required to reside on site.

ADMISSION/RETENTION CRITERIA

AFCs may not accept, retain, or care for a resident who requires continuous nursing care but may accommodate a resident who becomes temporarily ill while in the home. A licensee may not accept a resident until a written assessment is made and it is determined that the person is a suitable candidate for AFC according to these factors: the amount of personal care, supervision, and protection required by the resident is available in the home; the services and skills required to meet the resident’s needs are available in the home; and the resident appears to be compatible with other residents and members of the household. Residents must receive a 30-day written notice before discharge from the home, stating the reasons for discharge. AFC providers must send a copy of this notice to the resident’s designated representative and responsible agency.

AFC providers may discharge a resident without 30-day notice if any of the following exists: substantial risk of or occurrence of self-destructive behavior, serious physical assault, or destruction of property.

ASSESSMENT AND CARE PLANNING PROCESS

A licensee may not accept or retain a resident for care until a written assessment is made and it is determined that the resident is suitable. When a resident is referred for admission, the assessment is conducted in conjunction with the resident or the resident’s designated representative, the responsible agency, and the licensee. The facility retains a

copy of the assessment on file. In the case of an emergency admission, the responsible agency and licensee must complete the assessment within 15 calendar days.

SERVICES

A licensee must provide basic self-care and habilitation training in accordance with the resident's written assessment plan and must ensure the availability of transportation services. A licensee shall provide the following if specified in the resident's written assessment plan: direction and opportunity for growth and development achieved through activities that foster independent functioning, such as dressing, grooming, manners, shopping, cooking, money management, and use of public transportation; and opportunity for involvement in educational, employment, and day program activities. A licensee shall provide the following opportunities for residents: development of social skills and contact with relatives and friends; participation in community-based recreational activities; privacy and leisure time; and religious education and attendance at religious services of the resident's choice.

MEDICATIONS

Prescription medications—including tranquilizers, sedatives, dietary supplements, and special medical procedures—are given or applied only as prescribed by a licensed physician or dentist. Prescription medication is kept in the original pharmacy container, which is labeled. Medication is given pursuant to label instructions and administration is supervised by the licensee or other responsible person, who must comply with the following: maintain a record of the time and the amount of medication given or applied; maintain records of prescription medication on file in the home for not less than two years; and do not adjust or modify a resident's prescription medication without agreement and instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. The licensee shall record in writing any adjustments or modifications of a resident's prescription medication.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

When a resident is admitted, the licensee completes a written care agreement that is signed by the resident or designated representative, the responsible agency, and the licensee. A department form is used unless the department has granted prior authorization to use a substitute form. The resident will receive all the care and services listed in this agreement.

Residents or their designated representatives must receive a statement of the fee policy at the time of admission. The fee statement includes a description of services and the fee; a description of additional costs above the basic fee; and a description of the transportation costs in the basic fee structure and transportation provided at extra cost.

PUBLIC FINANCING

The SSI adult foster care payment and the Medicaid personal care supplement under the state plan cover AFC services. In 2008, the SSI payment was \$794.50, which included a \$44 personal needs allowance. The Medicaid personal care rate was \$192.38 per month. The number of AFC residents served by public funding was not reported.

STAFFING

The ratio of responsible persons to residents shall not be less than one responsible person to six residents or to two children under the age of 12 years.

TRAINING

The licensee must be a responsible member of the household who is at least 18 years old and able to meet the physical, emotional, social, and intellectual needs of each resident. Other criteria related to the character of the licensee must be met. In an emergency, the licensee must have an arrangement with a responsible person who is available to provide care up to 72 hours. The rules did not list the training requirements.

OVERSIGHT AND MONITORING

Before issuing a license, the Department of Human Services conducts an onsite inspection to ensure the compliance of the AFC family home with fire safety requirements. Local health authorities also complete an environmental health inspection of the septic system and well if these are in use and issue a temporary license for six months. At the end of that period, the department conducts another onsite inspection to determine compliance with all rules before it issues a regular two-year license. A renewal application submitted by the licensee and a renewal inspection by the licensing consultant are required to renew a regular license. The licensing consultant also investigates complaints and may coordinate a special investigation with adult protective services, the community mental health office of recipient rights, or local law enforcement, if necessary. The consultant recommends disciplinary action if the provider fails to demonstrate substantial and willful compliance.

MINNESOTA

BACKGROUND

Adult foster care homes may obtain several types of licenses from the state of Minnesota. The Department of Human Services (DHS) and the Department of Health (DH) license homes that participate in the Medicaid program.

The state began covering adult foster care in the mid 1980s as an HCBS waiver service and a service covered under the state-funded Alternative Care Program. DHS issues a family adult foster home license if the home is the primary residence of the license holder and the license holder is the primary caregiver. DHS issues a corporate adult foster home license if the license holder does not live in the home.

In addition to holding a DHS license as an adult foster care provider, a provider may be licensed as a Class A home care provider, which allows it to offer a higher level of service. The state licenses all corporate model homes as Class A providers.

An AFC home may also be registered as a housing with services establishment and offer services with a Class F license. A Class F home care licensee may provide nursing services, delegated nursing services, other services performed by unlicensed personnel, and central storage of medications for residents of one or more other registered housing with services establishments.

The local county human service/social service agency is responsible for implementing an annual adult foster home recruitment plan specifying a method and timetable for recruiting operators to meet the county’s adult foster care needs if adult foster care services to residents or prospective residents of adult foster homes are specified by the county board in the community social services plan.

In March 2008, 928 AFC facilities had the capacity to serve 3,374 older adults.

Web Site	Content
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_028245 https://www.revisor.leg.state.mn.us/rules/?id=4668	AFC rules Home care rules

DEFINITION

Adult foster care is the provision of food, lodging, protection, supervision, and household services to a functionally impaired adult in a residence; it may include the provision of personal care, household and living skills assistance or training, medication assistance, and assistance safeguarding cash resources.

An **adult foster home** is a residence operated by an operator who, for financial gain or otherwise, provides 24-hour foster care to no more than four functionally impaired residents.

A **Class A home care provider** is a person, organization, association, corporation, unit of government, or other entity that is regularly engaged in the delivery, directly or by contractual arrangement, of home care services for a fee. At least one home care service

must be provided directly, although additional home care services may be provided by contractual arrangements.

A **housing with services establishment** is an establishment that provides sleeping accommodations to one or more adult residents, at least 80 percent of whom are 55 years of age or older, and that offers, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services, whether provided directly by the establishment or by another entity arranged for by the establishment.

ADMISSION/RETENTION CRITERIA

DHS rules do not contain specific admission or retention criteria. Operators submit a plan that describes the type of functionally impaired adults providers will serve in their homes. A resident is appropriate for adult foster home placement if he or she is an adult; is functionally impaired; has requested, or his or her legal representative has requested, foster care placement; has demonstrated a need for foster care based on the assessment; and does not require continuous medical care or treatment in a facility licensed for acute care.

ASSESSMENT AND CARE PLANNING PROCESS

A social worker from the local agency or the county service agency ensures that persons seeking adult foster home placement are assessed to determine their need for adult foster care.

An assessment coordinated by a social worker measures the ability to manage activities of daily living; physical health, including impairments of mobility, sight, hearing, and speech; intellectual functioning and mental health, including impairments of judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life; need for supervision; need for protection; need for assistance in safeguarding cash resources; need for medication assistance; employability and vocational skills; need for family and community involvement; and need for community, social, or health services.

SERVICES

Adult foster home operators develop and implement a written plan approved by the commissioner of human services that allows residents to share in the privileges and responsibilities of the adult foster home and includes the type of functionally impaired adults to be served; the foster care that will be available to residents in the home, including lodging, food, and protection; personal care; household and living skills assistance or training; opportunities to participate in community, recreation, and religious activities, and events of the resident's choosing; opportunities for the resident to have contact with family and friends; assistance safeguarding cash resources, such as banking, reporting the resident's earnings to appropriate agencies, keeping records of financial information (checks issued and received), and accounting for the resident's funds controlled by the operator; supervision; transportation; assistance with the provision of other community, social, or health services as specified in the resident's individual service plan, if any; and medication assistance.

Corporate homes with a Class A home care provider license may provide all home care services, at least one of which is nursing, physical therapy, speech therapy, respiratory therapy, occupational therapy, nutritional services, medical social services, home health aide tasks, home care aide tasks (personal care, modified diet, household chores), or the

provision of medical supplies and equipment when accompanied by the provision of a home care service.

Home health aide tasks are defined as administration of medications; performing routine delegated medical, nursing, or assigned therapy procedures; assisting with body positioning or transfers of clients who are not ambulatory; feeding of clients who, because of their condition, are at risk of choking; assistance with bowel and bladder control, devices, and training programs; assistance with therapeutic or passive range-of-motion exercises; providing skin care, including full or partial bathing and foot soaks; and, during episodes of serious disease or acute illness, providing services to help a client maintain hygiene of the body and immediate environment, satisfy nutritional needs, and assist with the client's mobility, including movement, change of location, and positioning, and bathing, oral hygiene, dressing, hair care, toileting, bedding changes, basic housekeeping, and meal preparation.

A Class F home care provider may provide nursing services, delegated nursing services, other services performed by unlicensed personnel, or central storage of medications only for residents of one or more registered housing with services establishments. A Class F home care licensee must provide at least one of the following assisted living home care services directly: professional nursing services; delegated nursing services; non-nursing services performed by unlicensed personnel; or central storage of medications.

MEDICATIONS

Providers with a Class A license may administer medications as a home health aide task—whether oral, suppository, eye drops, ear drops, inhalant, topical, or administered through a gastrostomy tube—if the medications are regularly scheduled. In the case of as-needed (PRN) medications, the administration of the medication must be reported to a registered nurse either within 24 hours of its administration or within a period that is specified by a registered nurse before the administration; the person must be instructed by a registered nurse in the procedures to administer the medications to each client; a registered nurse must document in the clients' records the procedures to administer the medications; and the person must demonstrate to a registered nurse the ability to competently follow the procedure.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

A resident placement agreement specifies the terms for provision of foster care to an adult. The individual resident placement agreement must describe the reason for placement; describe what the operator must provide in the areas of lodging, food, protection, household or living skills training or assistance, personal care assistance, assistance safeguarding cash resources, transportation, residence accessibility modifications, and medication assistance and supervision. The operator must also describe who is financially responsible for payment for the foster care; and any community, health, and social services the operator will assist in providing. Services must be coordinated with the individual program plan.

Class A licensed providers enter into a written service agreement with the client or the client's representative. Any modifications of the agreement must be in writing and agreed to by the client or his or her representative. The agreement must include a description of the services to be provided and their frequency; identification of the persons or categories of persons who are to provide the services; the schedule or frequency of sessions of

supervision or monitoring required, if any; fees for services; a plan for contingency action that includes the action to be taken by the licensee, client, and responsible persons if scheduled services cannot be provided; the method for a client or responsible person to contact a representative of the licensee whenever staff are providing services; whom to contact in case of an emergency or significant adverse change in the client’s condition; the method for the licensee to contact the client’s representative, if any; and circumstances in which emergency medical services are not to be summoned.

PUBLIC FINANCING

The state’s HCBS waiver program covers AFC services. The waiver covers three types of services in these settings: adult foster care, customized living, and 24-hour customized living.

In March 2008, the elderly/disabled waiver served about 800 Medicaid beneficiaries in AFC settings. Rates are negotiated with providers on the basis of each resident’s case mix classification and the average monthly limits for services to all waiver participants.

The rate limit for 24-hour customized living services and adult foster care is the person’s monthly service cap less the cost of additional services needed and authorized for payment. However, costs of all authorized services, including case management, must be included in the person’s monthly service cap. Negotiated rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale.

The state funds a group residential housing (GRH) program that provides an income supplement for rent and food. Counties administer the SSI state supplement payment. The payment standard is \$776 a month, which includes the federal SSI payment. The personal needs allowance is \$116 a month.

Minnesota Case-Mix Categories and Maximum Statewide Rate Limits for Assisted Living and All Other Waiver Services—Effective 10/01/08–6/30/09			
Case Mix	Average Monthly Limits^a	Total Rate Limits for All Services^b	Description
A	\$1,149	\$2,298	Up to 3 ADL dependencies ^c
B	\$1,307	\$2,615	3 ADLs + behavior
C	\$1,534	\$3,067	3 ADLs + special nursing care
D	\$1,682	\$3,169	4–6 ADLs
E	\$1,747	\$3,495	4–6 ADLs + behavior
F	\$1,800	\$3,601	4–6 ADLs + special nursing care
G	\$1,858	\$3,716	7–8 ADLs
H	\$2,095	\$4,193	7–8 ADLs + behavior
I	\$2,161	\$4,303	7–8 ADLs + needs total or partial help eating (observation for choking, tube, or IV feeding and inappropriate behavior)
J	\$2,292	\$4,587	7–8 ADLs + total help eating (as above) or severe neuromuscular diagnosis or behavior problems
K	\$2,673	\$5,346	7–8 ADLs + special nursing

^a Statewide average customized living monthly payment by case-mix classification.
^b The monthly payment for 24-hour customized living, residential care, or foster care services plus all other authorized individualized elderly waiver services may not exceed the monthly budget limit to which the person is assigned.
^c ADLs include bathing, dressing, grooming, eating, bed mobility, transferring, walking, and toileting.

STAFFING

Corporate homes with a Class A license must have sufficient staff qualified to adequately provide the services agreed to in the service agreement.

TRAINING

The local county or multicounty social service agency must provide three hours of orientation to a foster home operator and caregivers before placement of the first resident following initial licensure. The orientation must include training on requirements of the Vulnerable Adults Act.

Caregivers with five or fewer years of licensure or experience as an adult foster home caregiver must complete 12 hours of training a year. Caregivers with six or more years of licensure or experience as an adult foster home caregiver must complete six hours of training a year.

Training subjects shall be selected from the following areas: communication skills; roles and relationships in foster care; community services for adults; constructive problem solving; cultural differences; basic first aid and CPR; home safety; self-esteem; medication assistance; human sexuality; death, dying, separation, and grieving; aging process; recreation and leisure time; nutrition; mental health; developmental disability; physical disabilities; chemical dependency; abuse and neglect; stress management; assertiveness; eating disorders; behavior problem solving; money management; data privacy; living skills training; and other areas that the local agency considers relevant to adult foster care.

OVERSIGHT AND MONITORING

A fire marshal must inspect the residence within 12 months before initial licensure to verify that the residence is a dwelling unit that complies with the fire safety standards for that residential occupancy zone in the Minnesota Uniform Fire Code. Before license renewal, the operator must complete a home safety checklist approved by the DHS commissioner. The fire marshal shall inspect the residence according to the licensed capacity specified on the initial application form. If the commissioner has cause to believe that a potentially hazardous condition may be present or that the number of residents has increased to four, the commissioner shall request another inspection and written report by a fire marshal. Before the issuance of a license or renewal, the operator must correct any condition cited by a fire marshal, building official, or health authority as hazardous or creating an immediate danger of fire or threat to the health and safety of residents.

DHS issues two-year licenses. DHS conducts a study of the operator and an inspection of the residence at least once every 24 months to determine whether the provider is complying with regulations and is eligible for license renewal.

Class A licensees are inspected at least every three to four years, depending on Department of Health staffing capacity. The department receives information from inspections under the DHS program that are relevant to the Class A license.

MISSISSIPPI

BACKGROUND

The Department of Health issued regulations in October 2007 to implement a law passed in 2007 that created an adult foster care category. The legislature authorized coverage under a pilot program to provide “social and protective services on a pilot program basis in an approved foster care facility for vulnerable adults who would otherwise need care in a long-term care facility, to be implemented in an area of the state with the greatest need for such program, under the Medicaid Waivers for the Elderly and Disabled program or an assisted living waiver. The division may use grants, waivers, demonstrations or other projects as necessary in the development and implementation of this adult foster care services pilot program.” However, the legislature has not funded the pilot.

Web Site	Content
http://www.msdh.state.ms.us/msdhsite/_static/resources/2347.pdf	Rules

DEFINITION

An **adult foster care facility** is a home setting for vulnerable adults in the community who are unable to live independently owing to physical, emotional, developmental, or mental impairments, or are in need of emergency and continuing protective social services for purposes of preventing further abuse or neglect and for safeguarding and enhancing their welfare. Adult foster care programs shall be designed to meet the needs of vulnerable adults with impairments through individual plans of care, which provide a variety of health, social, and related support services in a protective setting, enabling participants to live in the community. Adult foster care programs may be traditional (the foster care provider lives in the residence and is the primary caregiver); corporate (the foster care home is operated by a corporation with staff delivery of services to residents); or shelter (the foster care home accepts residents on an emergency short-term basis for up to 30 days). The definition does not specify the maximum number of beds.

ADMISSION/RETENTION CRITERIA

AFC homes may not admit or retain a person who is not ambulatory; requires physical restraints; poses a serious threat to himself or herself or others; requires nasopharyngeal or tracheotomy suctioning; requires gastric feedings; requires intravenous fluids, medications, or feedings; requires an indwelling urinary catheter; requires sterile wound care; or requires treatment of decubitus ulcer or exfoliative dermatitis.

ASSESSMENT AND CARE PLANNING PROCESS

Upon admission or within 24 hours of admission, the adult foster care facility develops and documents an individualized plan of care for the resident. The plan must include a comprehensive assessment of the person’s needs and identification of services required to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being.

SERVICES

Adult foster care is defined as the provision of services to persons who require personal care through individualized plans of care, including a variety of health, social, and related support services in a protective setting that enables people to live in the community. Personal care means the assistance rendered by personnel of the licensed facility to residents in performing one or more of the activities of daily living, including but not limited to bathing, walking, excretory functions, feeding, personal grooming, and dressing. The regulations require three meals a day. The licensed facility shall make provisions for referring residents with social and emotional needs to an appropriate social services agency. AFC providers must offer an activities program appropriate to the needs and interests of each resident. Activities must include adequate and appropriate space, and be provided on daily basis. They must use available community resources and provide supplies for activities. A nonresident employee must be responsible for the program.

MEDICATIONS

No Schedule I drugs are allowed in an AFC facility, but a facility may admit residents who require administration of Schedule II narcotics. These drugs must be under the direct supervision of a licensed physician or nurse. Facilities may keep on hand a limited amount of nonprescription, over-the-counter medications; however, they may not store intramuscular, subcutaneous, intravenous injectables, except for insulin and vitamin B-12, which may be administered only by the resident him- or herself or by a licensed nurse.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Before or at admission, the operator and the resident or responsible party shall execute in writing a financial agreement. As a minimum, this agreement must contain the following:

- Basic charges agreed upon (room, board, laundry, and personal care).
- Period to be covered in the charges.
- Services for which special charges apply.
- Agreement regarding refunds for any payments made in advance.
- A statement that the operator shall make the resident's responsible party aware, in a timely manner, of any changes in the resident's status, including those that require transfer and discharge. If the operator has been designated as a resident's responsible party, the operator shall ensure prompt and efficient action to meet the resident's needs.

PUBLIC FINANCING

Not available.

STAFFING

A full-time employee must be designated as the operator of the licensed facility; this person is responsible for the management of the facility. The operator must be at least

21 years old; must be a high school graduate or have a GED; and must not be a resident of the facility. The operator must document that he or she is not listed on the Mississippi Nurses Aide Abuse Registry.

Staffing patterns must meet the following ratios: one resident attendant per 15 or fewer residents between of 7:00 a.m. and 7:00 p.m., and one resident attendant per 25 or fewer residents between 7:00 p.m. and 7:00 a.m.

All direct care employees must be at least 18 years of age and not listed on the Mississippi Nurses Aide Abuse Registry. Employees shall be on duty, awake, and fully dressed to provide personal care to the residents.

TRAINING

Personnel shall receive training on a quarterly basis on topics and issues related to the population served in the licensed facility. Training shall be documented by a narrative of the content and signatures of those attending.

OVERSIGHT AND MONITORING

Not described.

MISSOURI

BACKGROUND

Assisted living and residential care facility regulations apply to facilities serving three or more persons.

Web Site	Content
http://www.sos.mo.gov/adrules/csr/current/19csr/19csr.asp	General rules

DEFINITION

An **assisted living facility** is any premises—other than a residential care facility II, intermediate care facility, or skilled nursing facility—that is used by its owner, operator, or manager to provide 24-hour care and services and protective oversight to three or more residents who are provided with shelter and board, and who need and are provided with the following: assistance with any activities of daily living and any instrumental activities of daily living; storage, distribution, or administration of medications; and supervision of health care under the direction of a licensed physician, provided that such services are consistent with a social model of care. The term “assisted living facility” does not include a facility in which all the residents are related within the fourth degree of consanguinity or affinity to the owner, operator, or manager.

ADMISSION/RETENTION CRITERIA

Assisted living facilities (ALFs) may admit and retain persons who do not require hospitalization or skilled nursing placement only if the facility provides for or coordinates oversight and services to meet the needs of the resident; has 24-hour staff appropriate in numbers and with appropriate skills to provide such services; has a written plan for the protection of all residents in the event of a disaster, including keeping residents in place, evacuating residents to areas of refuge, evacuating residents from the building, or other methods of protection depending on the disaster and the building design; completes a pre-move-in screening with participation of the prospective resident; completes for each resident a community-based assessment conducted by appropriately trained and qualified persons; and develops an individualized service plan in partnership with the resident or his or her legal representative that outlines the person’s needs and preferences. ALFs must prepare a plan to protect the rights, privacy, and safety of all residents and to protect against financial exploitation. Facilities may not accept or retain a resident who has exhibited behaviors that present a reasonable likelihood of serious harm to himself or herself or others; requires physical or chemical restraint; requires skilled nursing services for which the facility is not licensed; requires more than one person to simultaneously physically assist the resident with any activity of daily living, with the exception of bathing and transferring; is bedbound or similarly immobilized owing to a debilitating or chronic condition.

ASSESSMENT AND CARE PLANNING PROCESS

Facilities must provide coordination, oversight and services to meet the resident's needs and social and recreational preferences in accordance with the individualized service plan as documented in a written contract signed by the resident or legal representative. Staff must complete a pre-move-in screening that documents basic information and analysis provided by appropriately trained and qualified persons of the prospective resident's abilities and needs in activities of daily living, instrumental activities of daily living, vision/hearing, nutrition, social participation and support, and cognitive functioning. The screening is designed to determine whether the person is eligible for admission to the assisted living facility.

The facility must complete a community-based assessment within five days of admission, at least twice a year, and whenever there is a change in the resident's condition. Staff develop an individualized service plan in response to the assessment that outlines the resident's needs and preferences, services provided, and goals expected by the resident or the resident's legal representative in partnership with the facility.

SERVICES

Assisted living facilities provide self-care and leisure activity programs and person-centered activities appropriate to individual needs, preferences, background, and culture. The state requires use of a standard preadmission screening and assessment tool. The assisted living facility must complete the individualized service plan (ISP) and the resident or legal representative of the resident must review the plan at least annually. An authorized representative of the facility and the resident or resident's legal representative must sign the ISP.

MEDICATIONS

Certified medication technicians (CMTs) may administer medications in all licensed facilities. Level I medication aides may administer medications in residential care facilities and assisted living facilities. Injections shall be administered only by a physician or a licensed nurse, except for insulin injections, which may be administered by a CMT (all levels of care) or a Level I medication aide who has successfully completed the state-approved course for insulin administration taught by an approved instructor.

A pharmacist or registered nurse must review medications every other month in Level II facilities and every three months in Level I facilities.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

The assisted living facility must disclose to a prospective resident or legal representative information regarding the services the facility can provide or coordinate, the cost of these services, and conditions that will require discharge or transfer, including the following: exhibits behaviors that present a reasonable likelihood of serious harm to himself or herself or others; requires physical restraint or chemical restraint; requires skilled nursing services that the facility is not licensed or able to provide; requires more than one person to simultaneously physically assist with any activity of daily living, with the exception of bathing and transferring; or is bedbound or similarly immobilized owing to a debilitating or chronic condition.

Regulations require that residents be fully informed in writing before or at admission of the services available and related charges; charges for services not covered in the basic rate; procedures in a medical emergency; services that may be available outside the facility; the resident's right to make treatment decisions; and state laws concerning advance directives.

PUBLIC FINANCING

Personal care and advanced personal care services are reimbursed as a Medicaid state plan service in residential care facilities. The program serves elders, people with disabilities, people with mental retardation and developmental disabilities, and people with mental illness.

STAFFING

Facilities must have adequate staffing. Assisted living facilities must have staff 24 hours a day sufficient in numbers and skills to provide the services specified in the individualized service plan for each resident. Staffing patterns are higher for ALFs that serve residents with physical, cognitive, or other impairments that would prevent them from safely evacuating the facility with minimal assistance. Residential care facilities (those formerly licensed as RCF I and those formerly licensed as RCF II that will continue to meet those standards) must have an adequate number and type of personnel for the proper care of residents and upkeep of the facility.

ALFs serving 3–30 residents who would need more than minimal assistance with evacuation must have one staff person per 15 residents during the day and evening shifts and one staff person per 20 residents at night.

TRAINING

New employees receive at least one hour of orientation to their job functions. The minimum orientation includes job responsibilities, how to handle emergency situations, the importance of infection control and hand washing, confidentiality of resident information, preservation of resident dignity, how to report abuse/neglect to the department, information regarding the Employee Disqualification List, instruction regarding the rights of residents and protection of property, and instructions for working with residents with mental illness. New ALF employees must receive instruction regarding person-centered care and the concept of a social model of care, as well as techniques that are effective to enhance resident's choice and control over his or her environment. Training is also required regarding safely transferring residents.

OVERSIGHT AND MONITORING

Not described.

MONTANA

BACKGROUND

The Department of Public Health and Human Services licenses adult foster homes (AFHs). AFHs are small, owner-occupied homes. In 2008, there were 95 licensed homes with 246 beds; the supply has been stable in recent years.

Adult foster family care homes offer light personal care, custodial care, and supervision to aged or disabled adults who require assistance in meeting their basic needs. An adult foster family care home does not provide skilled nursing care. The licensing requirements for operating an adult foster home do not apply to persons in a mutual or shared living arrangement.

Among the provider tools on the Department of Public Health and Human Services Web site are the licensing application, sample forms, and policies, including a placement agreement, grievance policy, accident or sudden illness report, emergency preparedness statement, resident money policy, and a medication record form.

Web Site	Content
http://www.dphhs.mt.gov/qad/adultfostercare/index.shtml	Rules, provider tools
http://www.dphhs.mt.gov/qad/healthcarefacilitieslist/adultfostercarefacilities.pdf	List

DEFINITION

The statute defines an **adult foster home** as a private home or other facility that offers (except as provided in §50-5-216, which allows persons who have a developmental disability or adults who were served before age 18 years and who may need skilled nursing care or restraints, are nonambulatory or bedridden, are incontinent, or who are unable to self-administer medications) only light personal care or custodial care to four or fewer disabled adults or aged persons who are not related to the owner or manager of the home by blood, marriage, or adoption, and who are not under the full guardianship of the owner or manager.

ADMISSION/RETENTION CRITERIA

The statute states that the types of care offered by adult foster care homes are limited to light personal care or custodial care and may not include skilled nursing care. Exceptions are listed for an adult who receives state-funded services through the developmental disabilities program of the department or an adult who resided in the home before age 18 who needs skilled nursing care; needs medical, physical, or chemical restraint; is nonambulatory or bedridden; is incontinent to the extent that bowel or bladder control is absent; or is unable to self-administer medications. Homes licensed for these exceptions must have a signed statement—renewed annually—from a physician, physician assistant, nurse practitioner, or registered nurse whose work is unrelated to the operation of the home and who has visited the home within the year covered by the statement. The statement certifies that the services available to the resident in the home or in the community, or services that may be brought into the home from the community, including nursing services or therapies, are appropriate to meet the health care or other

needs of the resident; and that the health care status of the resident does not necessitate placing the resident in a more intensive residential service setting.

ASSESSMENT AND CARE PLANNING PROCESS

Not described.

SERVICES

Homes provide light personal care, custodial care, and supervision for residents, and a minimum of three regular, nutritious, attractively prepared meals per day served family style. Light personal care means assisting with personal hygiene tasks such as bathing, dressing, hair grooming, and supervision of self-medication.

Custodial care means providing a sheltered, family-type setting for an aged person or disabled adult to provide for the basic needs of food and shelter, and having a specific person available to help the adult meet these basic needs. A physician may prescribe temporary in-home skilled nursing services for less than 30 days and not more than two hours a day to prevent a hospital admission.

MEDICATIONS

All residents must take their own medications. The licensee is, as necessary, responsible for providing the following assistance: reminding the resident to take medications; assisting with the removal of a cap; assisting with the removal of a medication from a container for residents with a disability that prevents this act; or watching the resident take the medication. If the licensee must help the resident take medicine in any way, the licensee shall have on file a medication record noting the doses taken and not taken.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

The licensee completes a written placement agreement with the agency or person placing the elderly or disabled adult in the home that specifies the responsibilities of the licensee and the placing agency or person requesting care and the charges that will be made to the resident for care, as well as an itemized list of expenses in addition to the cost of basic care that will be charged to the resident.

PUBLIC FINANCING

The Medicaid HCBS waiver in licensed adult foster homes and assisted living facilities covers adult residential care services. Adult residential care is a bundled service that includes personal care, homemaker services, nutritional meals and snacks, medication oversight (to the extent permitted under state law), social and recreational activities, and 24-hour onsite response to ensure that the care, well-being, health, and safety needs of residents are met at all times. Adult foster homes serve fewer than 50 waiver participants, compared with more than 600 in assisted living facilities.

The payment rate is based on an assessment completed by the HCBS case manager. The basic service payment of \$652 a month covers meal service, homemaking, socialization and recreation, emergency response system, medical transportation, and 24-hour availability of staff for safety and supervision. Additional payments are calculated on the basis of ADL and other impairments. Points are calculated for each impairment. The maximum reimbursement for services is \$61.80 a day. The functions measured are

bathing, mobility, toileting, transfer, eating, grooming, medication, dressing, housekeeping, socialization, behavior management, and cognitive functioning. Each function is rated as follows:

- With aides/difficulty: needs consistent availability of mechanical assistance or expenditure of undue effort.
- With help: requires consistent human assistance to complete the activity, but the person participates actively in the completion of the activity.
- Unable: the person cannot meaningfully contribute to the completion of the task.

Each point equals \$34 a month. For example, a resident who consistently needs help with toileting would be scored a “2” and would earn \$68 a month for that impairment. The SSI payment, with state supplement, is \$689.75. The personal needs allowance is \$100.

STAFFING

An adult member of the foster family or another adult employee of the licensee must always be present when a resident is in the home, except as may be specified in a resident’s individual assessment plan.

TRAINING

Not described. Licensing agency staff are working on a proposed rule that will require first aid and CPR training for all providers and staff. Training requirements may be included in contracts with state agencies that serve individuals with mental illness and developmental disabilities.

OVERSIGHT AND MONITORING

A department social worker evaluates persons who apply to provide adult foster care. The social worker evaluates the person in terms of personal qualifications to provide such care and the physical facilities he or she will use to provide these services. The social service supervisor, who makes the final decision as to whether or not the department will certify for adult foster care, reviews the evaluation. The department may license homes for one to three years.

NEBRASKA

BACKGROUND

Standards for adult family homes are contained in a program manual. Adult family homes provide a living arrangement to meet the needs of residents who are unable to live independently but who can function adequately with minimal supervision and protection in a homelike living arrangement. Adult family homes enable adults to continue maximum normal functioning in a community. The Department of Health and Human Services is planning to revise the rules.

Web Site	Content
http://www.sos.state.ne.us/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-473/Chapter-6.pdf	Rules (scroll to chapter 6)

DEFINITION

An **adult family home** (AFH) is a residential living unit certified by the Nebraska Department of Health and Human Services to provide full-time residence and minimal supervision and guidance to not more than three residents age 19 years or older. Services include room and board, standard furnishings, equipment, household supplies, laundry service, and facilities to ensure resident comfort.

An adult family home sponsor is an adult, 19 years or older, who manages and provides caretaker responsibilities in an adult family home. The sponsor accepts responsibility for maintaining the facility and meeting the needs of residents.

ADMISSION/RETENTION CRITERIA

The sponsor and the case manager ensure that no adult family home resident has health conditions or handicaps that require ongoing medical treatment and supervision other than self-administered medications and physician office visits. An adult who requires an occasional reminder to take medications may be appropriate for adult family home care.

ASSESSMENT AND CARE PLANNING PROCESS

Local case managers are responsible for ensuring that residents receive appropriate care. They may require a potential adult family home resident or his or her representative to present any documentation regarding medications necessary to make a decision about the amount of care required in that area. If the case manager questions the resident's ability to self-administer medication, he or she may request an opinion from the resident's physician. The case manager informs the provider (with the consent and input of the resident) of the resident's background, medical history, special needs, and other relevant information, and helps the provider determine whether adult family care is appropriate. The case manager may require the provider to complete a written needs assessment and may develop a service plan with the resident if her or she has needs beyond those the sponsor can meet (e.g., transportation or adult protective services).

SERVICES

Not described.

MEDICATIONS

If a resident requires temporary assistance with administration of medication, a physician provides written approval for the resident to remain in the adult family home and for the provider to assist with the administration of the medication.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Not described.

PUBLIC FINANCING

The SSI state supplement payment standard is \$802 a month; the personal needs allowance is \$60.

STAFFING

The adult family home provider must be physically and mentally capable of assuming the responsibilities and functions involved in adult family care; must be capable of exercising good judgment in supervising adults and cooperating with the local service office; and must not have engaged in or have an ongoing history of criminal activity that could be harmful or endanger residents. Such activity may include a substantiated listing as a perpetrator on the child or adult central registries of abuse and neglect.

TRAINING

Not described.

OVERSIGHT AND MONITORING

Case managers visit the AFH to assess the appropriateness of the living arrangement and the resident's adjustment.

NEVADA

BACKGROUND

Before 2003, the state registered Homes for Individual Residential Care (HIRCs). However, owners of assisted living facilities and group residential care homes supported licensure as a way to provide uniform compliance across settings and enforce a higher level of oversight. During the early 1990s, HIRCs began to increase because of increased interest in the expansion of home-based care settings. In 2008, there were 205 HIRCS with a capacity of 410 beds.

The expansion of the HIRC market is a challenge for state licensors. State agencies are expecting budget cuts which will limit the resources they have to keep up with the growth of HIRCs.

Web Site	Content
http://leg.state.nv.us/nac/NAC-449.html#NAC449Sec15511	Rules

DEFINITION

A **home for individual residential care (HIRC)** is a home in which a provider furnishes food, shelter, assistance, and limited supervision, for compensation, to not more than two persons who are aged, infirm, mentally retarded, or handicapped, unless the persons receiving those services are related within the third degree of consanguinity or affinity to the person providing the services.

ADMISSION/RETENTION CRITERIA

Not described.

ASSESSMENT AND CARE PLANNING PROCESS

The director of the home must assess the needs of each resident upon admission and as the person's needs change. The assessment must include documentation of the abilities of the resident to function independently and a complete list of the areas in which the resident requires assistance.

SERVICES

Facilities provide personal care; a balanced daily diet that meets nutritional needs of the residents; and protective supervision and adequate services to maintain and enhance their physical, mental, and emotional well-being.

MEDICATIONS

Residents must be able to self-administer medications without provider oversight. Administrators receive eight hours of medication administration training. The administrator and staff members are responsible for knowing that a client's physical and mental condition is stable, and that the medication prescribed does not require daily assessment. The care plan must address the administration of the medication and must

include a plan, prepared under the supervision of a registered nurse or licensed pharmacist, for emergency intervention.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

The operator of a home enters into a written agreement with each resident that sets the basic rate for the services and the charges for any optional services.

PUBLIC FINANCING

Not available.

STAFFING

Directors of homes for individual residential care must be at least 21 years old and have a high school diploma or equivalent. A person who proposes to act as the director of a home must provide evidence that he or she satisfies the requirements of the regulations and possesses the appropriate knowledge, skills, and abilities to meet the needs of the residents of the home.

TRAINING

HIRCs are responsible for developing an educational program for staff to provide instruction on behavioral intervention and positive behavioral supports, including environmental modifications, teaching new skills for inappropriate behaviors, methods to enhance a patient's independence and quality of life, and a process for designing interventions. Each facility must provide additional training for staff authorized to carry out and monitor physical and mechanical restraint.

OVERSIGHT AND MONITORING

The licensing agency completes an initial onsite survey of a home and subsequent surveys not less than once every three years. There is a \$2,000 application fee.

The licensing agency investigates complaints and files reports with local and state agencies if it finds violations of the regulations during an investigation. The ombudsman investigates complaints about the administrator.

NEW HAMPSHIRE

BACKGROUND

The Department of Health and Human Services (DHHS) licenses adult family care residences (AFCRs). Adult family care started as a pilot program in one county in 2006 and served three participants in 2008. So far, 15 participants have been served. The state contracted with sponsor organizations that served persons with developmental disabilities to recruit providers, match and place participants, and monitor service delivery. The sponsors expected to recruit small group homes that serve persons with developmental disabilities, but few providers responded. The state revised its adult family care residence waiver program and plans to expand the program statewide.

The program does not serve private pay residents. DHHS plans to conduct outreach and marketing activities to recruit additional providers and sponsor organizations to expand coverage.

Web Site	Content
http://www.gencourt.state.nh.us/rules/he-p800.html	Rules (scroll down to he-p813)

DEFINITION

An **adult family care** provider is any person, agency, partnership, association, or other legal entity offering social or health services to two residents in a homelike environment. Services may include but are not limited to providing supervision, medical monitoring (including supervision of medications), and assistance with daily living activities. The residence may provide clinical services and supports if a resident needs these services.

ADMISSION/RETENTION CRITERIA

Providers may admit only those residents—

- Whose needs can be met through the programs and services offered directly by the licensee or through arrangements with other providers.
- Who are able to evacuate the residence.
- Who, if they have a pressure ulcer of stage 2 or less, have the written permission of their licensed practitioner to live in the facility.
- Who do not have a pressure ulcer of stage 3 or higher.
- Who are not a danger to themselves or others.
- Who do not require the use of restraints.
- Who would not place the health or safety of any other resident in jeopardy.

ASSESSMENT AND CARE PLANNING PROCESS

The licensee and oversight agency completes a resident assessment, using the most recent version of the department's approved assessment tool. The assessment must address the resident's preferences and needs in consultation with the resident or representative no more than 30 days before admission to the AFCR. The facility must complete an assessment on the resident every six months and following any improvement or decline in the resident's health status, behavior, or cognitive or functional abilities that could result in a change in the quality of life or service needs of the resident.

The care plan is a written guide developed by the licensee and the oversight agency, in consultation with the resident or his or her representative, for the provision of care and services that address the resident's ability to manage ADLs; physical health, including impairments of mobility, sight, hearing, and speech; intellectual functioning and mental health; need for supervision; need for medication assistance; need for family and community involvement; and need for community, social, or health services.

The care plan includes a description of the resident's problems or needs; the date each problem or need was identified; the goals and objectives of the plan; the actions or approaches to be taken; the responsible persons or positions; and the date of reevaluation, review, or resolution. Care plans are completed in consultation with the resident or his or her representative and the oversight agency within seven days after completion of the assessment. They are reviewed and updated after each subsequent assessment.

SERVICES

AFCRs provide a combination of personal care, homemaking, and other services in accordance with a care plan. Services include health and safety services to minimize the possibility of accident or injury, with protective care and oversight 24 hours a day; food service; housekeeping, laundry and maintenance services; activities designed to engage residents to sustain and increase physical, intellectual, social, and spiritual well-being; assistance in arranging appointments for residents; and supervision of residents with cognitive deficits who may pose a risk to themselves or others if they are not supervised.

Nursing services may be provided, including supervision and instruction to all caregivers by a licensed nurse regarding the delivery of nursing care; assessment and development of a nursing care plan; nursing care and monitoring; resident education needs identified by the assessment; rehabilitation services, including documentation of the licensed practitioner's order for the service, such as physical therapy, speech therapy, or occupational therapy; and behavioral health care services.

Licensees also provide or arrange for access to community programs, such as religious services, social and cultural events, educational activities, recreational activities, and opportunities for the resident to have contact with family and friends.

MEDICATIONS

All medications must be administered in accordance with the orders of the resident's prescribing licensed practitioner or other licensed professional with prescriptive authority. Medications, treatments, and therapeutic diets ordered by the licensed practitioner or other licensed professional with prescriptive authority shall be available to the resident within eight hours of being ordered.

Residents may self-administer their medications or self-administer with supervision. A nurse may delegate persons authorized by law to administer medications.

The oversight agency conducts an annual review of each resident's capabilities for self-administration of medication with supervision or self-directed medication administration.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

An admissions contract must be completed that includes the basic daily, weekly, or monthly fee; a list of the services covered by the basic fee; information regarding the timing and frequency of cost-of-care increases; the period covered by the admissions contract; the AFMR's house rules; the grounds for immediate termination of the agreement; the AFMR's responsibility for resident discharge planning; information regarding services not provided by the AFMR that explains who to contact for nursing and other health care services; the AFMR's responsibility for arranging such services, and the fees and payment for these services; the licensee's policies and procedures regarding providing transportation, arranging for third party services (such as cable television), third party services contracted directly by the resident and provided on the AFMR premises; storage of the resident's personal property; bed holds; and the licensee's medication management services.

Providers must give the resident a copy of the current version of the patient bill of rights, a notice of the resident's right to appeal an involuntary transfer or discharge, as well as the AFMR's policy and procedure for handling reports of abuse, neglect, or exploitation, and information on contacting the long-term care ombudsman.

PUBLIC FINANCING

The Medicaid HCBS waiver covers services in adult family care homes. The department reimburses two levels of care on the basis of scores derived from a standardized assessment tool. Providers receive \$55.25 a day for Level I residents and \$68.00 a day for Level II residents. Residents pay \$540 a month for room and board, and retain a personal needs allowance of \$56 a month. Any additional income is applied to the cost of services.

Sponsor agencies receive an annual fee of \$4,000 for administrative and oversight activities for Level I residents and \$5,000 for Level II residents. In addition, sponsors receive a care management fee of \$8.35 a day. However, officials are considering changes to the program. Family members (except a spouse or parent) may be allowed to be providers, and case managers outside the sponsor agency may assume some of the sponsor agency's monitoring and oversight responsibilities.

STAFFING

Licensees must be at least 21 years old and a high school graduate or GED recipient. Providers must make arrangements for substitute caregivers if they need to leave the home for an extended period or in case of emergencies.

TRAINING

Licensees must complete an orientation program that covers residents' rights, complaint procedures, emergency medical procedures, emergency and evacuation procedures, infection control, food safety, and mandatory reporting requirements. They must also

obtain at least six hours of continuing education related to the operation and services of the residence.

Licensees and caregivers who administer medication complete a minimum of two hours of in-service training annually on the medication supervision education program. The program and the annual in-service training cover infection control and proper hand washing techniques; the “five rights”: right resident, right medication, right dose, administered at the right time, and via the right route; documentation requirements; general categories of medications, such as antihypertensives and antibiotics; desired effects and potential side effects of medications; and medication precautions and interactions.

OVERSIGHT AND MONITORING

The department inspects providers annually and may impose a fine or require providers to develop a plan of correction for violations of the regulations. The department investigates all complaints that might violate the licensing regulations and reports any incidents within 72 hours.

NEW JERSEY

BACKGROUND

New Jersey operates a small adult family care program through sponsor agencies whose role is to recruit and assess clients and caregivers; develop and implement training programs for caregivers; develop a care plan for each client; match the client and the caregiver; determine financial responsibilities of the client; perform ongoing assessments of the client's health status; complete regular in-home assessments of care plan implementation; and maintain records and provide care management.

The program has six sponsoring agencies. Approximately 30 providers serve 34 participants. Providers must own or rent and live in the home. Regulations for adult foster care expired in 2001; revised regulations will be issued in 2009.

Web Site	Content
None posted	

DEFINITION

Public Law 201, Chapter 304 defines **adult family care** as a 24-hour-per-day living arrangement for persons who, because of age or physical disability, need assistance with activities of daily living, and for whom services designed to meet their individual needs are provided by licensed caregivers in approved adult family care homes. The law defines an **adult family care home** as a residence regulated by the Department of Health and Senior Services and housing no more than three residents, in which personal care and other supportive services are provided by a person who has been licensed by the department.

Adult family care is a Medicaid waiver program that enables up to three persons who are at risk of placement in a nursing facility and who meet income and resource requirements to live in a home in the community and receive support and health services from a trained caregiver.

ADMISSION/RETENTION CRITERIA

Participants must meet the criteria for admission to a nursing facility to qualify for the Medicaid HCBS waiver. There are no other admission/retention criteria.

ASSESSMENT AND CARE PLANNING PROCESS

A sponsor agency staff member prescreens residents to determine their level of interest in pursuing AFC. If the program seems appropriate for the person, he or she receives an initial assessment by a registered professional nurse to determine the need for general or health services. The sponsor agency assigns the potential resident to a care manager and a suitable caregiver. An individual care plan is developed and confirmed with the participation of the resident, the resident's family and the caregiver.

SERVICES

AFC offers all Medicaid services authorized in a plan of care except nursing facility, personal care assistant, and Medicaid hospice services. All AFC participants receive care management services. In addition, the plan of care specifies other services to be delivered, which may include personal care; meal preparation; transportation; laundry; errands; housekeeping; socialization and recreation activities; monitoring of client's funds when requested by client; up to 24 hours a day of supervision, and medication administration.

MEDICATIONS

In September 1997, the department created a manual—*Resource Guide for Medication Administration for Caregivers in the Alternate Family Care Program*—for use by the registered nurse at the sponsor agency to train a caregiver for the needs of a specific resident. The RN decides whether the caregiver understands well enough to administer medications to the resident. The training also includes how to document when medications were taken and what to do if medications were not taken or negative reactions or side effects were observed.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Not described.

FINANCING

Sponsor agencies receive \$50 a day or \$1,500 a month for Medicaid beneficiaries. The sponsor retains \$500 a month and pays the provider \$1,000 a month for services. The SSI payment standard is \$668.25. The provider receives \$573.75 a month from the participant for room and board; the resident's personal needs allowance is \$94.50 a month.

STAFFING

The caregiver must live in the home and must be screened by the sponsor agency to determine whether he or she demonstrates a caring attitude and is suited to care for people in his or her private residence. A physician must deem the caregiver physically and emotionally capable of providing required care on a daily basis.

TRAINING

A caregiver must be a graduate of a formal training program or a certified home health aide, certified nursing assistant, licensed practical nurse, or registered nurse.

OVERSIGHT AND MONITORING

The Department of Health and Senior Services, Division of Health Facilities Evaluation and Licensure is responsible for surveying the AFC sponsor agencies initially and then at least every two years to make sure they are in compliance with licensing regulations.

The Division of Aging and Community Services in the Department of Health and Senior Services conducts an audit of the sponsor agency every 18–24 months. The sponsor agency is responsible for ensuring that the AFC caregiver complies with all regulations and requirements of the program.

NEW MEXICO

BACKGROUND

Adult residential living rules cover adult foster care homes serving two or more persons unrelated to the caregiver.

Web Site	Content
http://www.health.state.nm.us/hflc/dhiadult.pdf	Rules
http://dhi.health.state.nm.us/elibrary/imbdocs/irform.pdf	Incident reporting
http://dhi.health.state.nm.us/elibrary/manuals.php	Manuals

DEFINITION

An **adult residential care facility** is any congregate residence, maternity shelter, or building for adults whose primary purpose is to provide, within the facility, either directly or through contract services, programmatic services, room and board, assistance with activities of daily living in accordance with the program narrative, or general supervision to two or more adults who have difficulty living independently or managing their own affairs.

ADMISSION/RETENTION CRITERIA

Residents may not be admitted or retained who are under the age of 18 years, except for maternity shelter facilities, or for whom the facility is unable to provide appropriate care. Facilities may not admit or retain anyone who requires continuous nursing care, which includes ventilator dependency, stage 3 or 4 pressure sores, intravenous therapy or injections directly to veins, airborne infectious diseases, conditions requiring physical or chemical restraints, nasogastric tubes/gastric tubes, and tracheotomy care; persons who present an imminent physical threat or danger to themselves or others; or persons whose physician certifies that placement is no longer appropriate. Exceptions are allowed when a team (director, resident, agent, advocate, physician, other health professional) jointly agrees and approves a service plan that identifies needs and how they will be met, ensures maintenance of the facility's evacuation rating, and safeguards the well-being of others.

ASSESSMENT AND CARE PLANNING PROCESS

Assessments are completed within five days of admission and reviewed every six months as part of an individual service plan (ISP). The resident assessment must establish a baseline in the resident's functional status and, thereafter, identify any changes through periodic reassessments.

An ISP, if prompted by the resident assessment, shall be developed and implemented within 14 days of admission and must address the areas of need identified in the assessment. The ISP must be reviewed by a licensed nurse at least every six months, revised as needed, and consistently implemented in response to the resident's needs. The ISP must include the following:

- Description of needs identified in the resident assessment.

- Description of services that will be provided.
- Who will provide the services.
- When or how often the services will be provided.
- How the services will be provided.
- Where the services will be provided.
- Goals and outcomes of the services.
- Documentation of the facility's determination that it is able to meet the needs of the resident.

SERVICES

Facilities must supervise and assist residents as necessary with health, hygiene, and grooming needs including but not limited to eating, dressing, oral hygiene, bathing, grooming, mobility, and toileting. They must provide recreation/social activities, and three meals a day, and must provide or arrange for housekeeping, laundry, and transportation services.

MEDICATIONS

Licensed health care professionals may administer medications. Staff who have completed an approved training program may assist with medications if authorized by the resident or the resident's representative. Facilities must have a consulting pharmacist who reviews medications at least quarterly.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

The agreement covers the scope of services provided, the cost of services and method of payment, circumstances under which the agreement can be terminated, and the bed hold policy. A new agreement is required when services, costs, or other material factors change. An admission/discharge agreement may provide for termination by the facility if the resident's health has improved sufficiently that he or she no longer needs the services provided by the facility. Termination of an admission agreement by the facility is permitted in emergency situations for the following reasons: a transfer or discharge is necessary for the resident's welfare; the resident's needs cannot be met in the facility; the safety or health of others in the facility is endangered; the resident has failed to pay for a stay at the facility as defined in the admission agreement; the facility ceases to operate or is no longer able to provide services; or the Department of Health has imposed sanctions or remedies on the facility.

PUBLIC FINANCING

In 2006, the state reviewed the disabled and elderly HCBS waiver that serves elders and people with disabilities. Facilities receive a flat rate of \$49.99 a day (excluding room and board). The facility and the resident negotiate room and board charges.

STAFFING

The facility must employ an administrator, as well as staff who are capable and trained to provide the basic care, assistance, and supervision required by the assessments of the

residents' needs. Direct care staff must be at least 18 years old. When residents are awake, all facilities must have at least one direct care staff person on duty and awake for every 15 residents. During resident sleeping hours, facilities with 15 or fewer residents must have at least one direct care staff person on duty and responsible for the care and supervision of residents. Facilities with 16–60 residents must have at least one direct care staff person awake at all times and at least one additional staff person available on the premises while residents are sleeping. Facilities with 61–120 residents must have two direct care staff persons awake at all times and at least one additional staff person immediately available on the premises when residents are sleeping. Facilities with more than 120 residents must have at least three direct care staff persons awake at all times and one additional staff person immediately available on the premises for each additional 40 residents or fraction thereof.

The waiver guidelines require staffing ratios and patterns that will meet the residents' needs as identified in the ISP.

TRAINING

Staff training includes, at minimum, an orientation and an ongoing (at least annual) program that includes fire safety; first aid; safe food handling practices; confidentiality of records and resident information; infection control; resident rights; reporting requirements for abuse, neglect, and exploitation; transportation safety—assisting residents and operating vehicles; and providing quality resident care based on current resident needs.

Personal care assistants must complete at least one of the following:

- A nurse aide training course approved by the Department of Health, including passing the nurse aide certification exam.
- A homemaker–home health aide training program approved by the Board of Nursing, including receiving certification.
- An equivalent training program approved by the department.

Each personal care assistant receives orientation before or upon employment, as well as ongoing in-service education regarding the concepts of assisted living.

OVERSIGHT AND MONITORING

The licensing agency conducts onsite survey/monitoring visits to determine compliance with the regulations, to investigate complaints, or to investigate the appropriateness of licensure for any alleged unlicensed facility. The licensee or facility designee may be cited for violations through an official written report of the findings at the completion of the visit or within 10 working days. The licensee or facility designee submits a plan of correction within 10 working days of receipt of the citation. The plan must address how all violations identified in the report will be corrected and when; how the facility will identify other residents who have the potential to be affected by the same deficient practice; and how the facility will monitor its corrective action. Unless the licensing authority says otherwise, providers must correct violations within 30 days from the date the agency completed the survey. The licensing authority may accept or reject the plan of correction, or negotiate modifications.

NEW YORK

BACKGROUND

The Office of Child and Family Services certifies and monitors family-type homes that provide long-term residential care, room, board, housekeeping, supervision, or personal care to four or fewer adults unrelated to the operator. The program began in 1944 to address the needs of older adults who could no longer live by themselves in the community. New York licenses 500 homes with a capacity to serve 1,500 older adults. The supply has declined over time as providers have aged out of the business. The state is making efforts to expand the supply through active public awareness and recruitment strategies. The state sees adult family care as a cost-effective way to provide personal care/supervision in a family atmosphere for vulnerable adults.

The department coordinates with local districts to assist providers with the needs of their residents who receive Supplemental Security Income, additional state payments, or home relief.

Web Site	Content
http://www.nyhealth.gov/nysdoh/phforum/nycrr18.htm	Rules (Title 18: Part 489)

DEFINITION

An **adult care facility (ACF) for family-type homes** is an establishment operated for the purpose of providing long-term residential care, room and board, personal care, and supervision for four or fewer adult persons unrelated to the operator.

ADMISSION/RETENTION CRITERIA

An operator may not accept or retain a person who needs continuous medical or nursing care or supervision; suffers from a serious mental disability; requires mental or health services that are not available or cannot be provided safely by local service providers; is likely to cause danger to self or others; has an unstable medical condition; refuses to comply with the proscribed treatment plan; is chronically bedfast or chairfast, or requires physical assistance to walk, climb, or descend; has unmanaged bowel or urinary incontinence; is unable to communicate with the operator in a common language; or refuses to inform the operator of changes in medications or other elements of medical evaluation.

The operator must determine that the home can support the person’s needs before admitting him or her.

ASSESSMENT AND CARE PLANNING PROCESS

Operators must determine that the home can support the physical and psychosocial needs of a resident before admitting him or her. The determination is based on a medical evaluation (completed 30 days before the admission date) and an interview between the operator and the resident or the resident’s representative. The home co-coordinators can arrange for professional evaluations, obtain required health and mental health

information, establish link with community resources, and, if necessary, arrange for the transfer of a resident to an appropriate level of care.

Services are determined on the basis of a written agreement following an assessment. The assessment addresses specific information regarding the applicant, including medical history; care needs and preferences; prescribed medications; medical diagnosis; significant behaviors or symptoms; history of depression, anxiety, or mental illness; functional and cognitive abilities; and activities preferences. The assessor prepares a preliminary service plan that describes the needs for services and a plan to meet them.

Within 30 days of admission, a specific plan is negotiated on the basis of the resident's needs and preferences. The facility will notify the resident or the resident's legal representative of any health changes that affect the service plan.

SERVICES

The operator is responsible for providing room and board, laundry services, supervision, personal care, and social support. Supervision includes monitoring residents' mental, behavioral, and physical conditions, as well as their attendance at meals and maintenance of personal hygiene; arranging medical services; and protecting residents from harm. Personal care services include grooming, bathing, toileting, walking, eating, recording weight, and assisting with the self-administration of medications. Operators include residents in ongoing activities in the home, such as mealtime and family activities.

MEDICATIONS

Residents who self-administer medications must be able to read and understand the medication label; open the container; follow instructions for measuring or preparing; and correctly ingest, inject, or apply the medication. Operators must periodically verify the resident's ability to self-administer. Operators may provide assistance and supervision in any of the above activities. A medication record must be maintained for residents who need supervision or assistance. Operators may only inject medications if they hold a New York State license to administer injectable medications.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

The resident agreement discloses the services provided and the costs for additional activities, services, or items. The provider and resident negotiate the rate for room and board; this rate must be specified in the agreement, as well as the facility's policies on discharge, transfer, medical leave, liability, and refunds. The agreement must also specify the resident's need for personal care services and items, planned activity programs, and meal preferences.

PUBLIC FINANCING

SSI residents receive a state supplement of \$266.48 a month in New York City and in Nassau, Rockland, Suffolk, and Westchester counties, and \$228.48 elsewhere. The state is considering increasing its SSI supplement to attract more providers.

STAFFING

The operator must live in the home; be at least 21 years old; be of good character; be able to speak, read, and write English; and be physically and mentally capable of operating a

home. The operator must not rely on the income from residents to meet household expenses. Operators must have sufficient income from other sources to maintain and support their household.

TRAINING

The local departments must provide orientation to providers and help the operator develop procedures to link residents with community resources, maintain accurate recordkeeping, and obtain health information regarding residents and prospective residents.

OVERSIGHT AND MONITORING

The local social service areas are responsible for conducting inspections and providing oversight of family-type homes. Each year, the local department must conduct an unannounced inspection of each home. The local departments are also required to arrange for professional evaluations of residents and transfer a resident to a higher level of care if needed. The Office of Child and Family Services and local districts investigate complaints. The ombudsman may also visit homes to address resident's rights and protection.

NORTH CAROLINA

BACKGROUND

The state licenses family care homes under a statute that regulates adult care homes. Family care homes serve two to six residents. In August 2008, there were 631 licensed facilities with 3,513 beds. The supply of family care homes has been stable for several years. Family care homes tend to serve residents with lower needs than other adult care homes and are more likely to serve persons with mental illness.

Chapter 131D defines an adult care home as an assisted living residence in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents, either directly or, for scheduled needs, through formal written agreements with licensed home care or hospice agencies. Some licensed adult care homes provide supervision to persons with cognitive impairments whose decisions, if made independently, could jeopardize the safety or well-being of themselves or others. Designated trained staff may administer medication in an adult care home.

While the same statutes and regulations cover larger adult care homes and family care homes, construction and staffing standards differ. In addition, the certificate of need requirement that applies to adult care homes does not cover family care homes.

Web Site	Content
http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2013%20-%20nc%20medical%20care%20commission/subchapter%20g/subchapter%20g%20rules.html	Rules
http://www.ncdhhs.gov/dhsr/acls/index.html	Provider
http://www.ncdhhs.gov/dhsr/acls/faclistings.html	List
http://www.ncdhhs.gov/dhsr/acls/licenseinfo.html	General

DEFINITION

Adult care homes that provide care to two to six unrelated residents are commonly called **family care homes**. A family care home may be no more than two stories high, and the provider may not house older adults or persons with disabilities in the upper story without providing for two direct exterior ground-level accesses to the upper story.

ADMISSION/RETENTION CRITERIA

Family care homes may serve adults 18 years or older who, because of a temporary or chronic physical condition or mental disability, need a substitute home. A person may be admitted when—in the opinion of that person, a physician, family or social worker, and the home’s administrator—the services and accommodations of the home will meet his or her particular needs.

Chapter 131D states that persons may not be served in an adult care home if they are ventilator dependent; they require continuous licensed nursing care; their physician certifies that placement is no longer appropriate; or their health needs cannot be met in the specific adult care home, except when a physician certifies that appropriate care can

be provided on a temporary basis to meet the resident's needs and prevent unnecessary relocation. The regulations state that persons may not be admitted for treatment of mental illness; alcohol or drug abuse; maternity care; professional nursing care under continuous medical supervision; or lodging if the personal assistance and supervision offered for the aged and disabled are not needed. Persons who pose a direct threat to the health or safety of others may not be admitted.

ASSESSMENT AND CARE PLANNING PROCESS

An initial assessment must be completed within 72 hours of admission. A complete assessment is required within 30 days of admission and within 10 days of a significant change (defined in the regulation). The assessment must be updated at least annually using an instrument established or approved by the Department of Health and Human Services. The assessment determines a resident's level of functioning, including psychosocial well-being, cognitive status, and physical functioning in activities of daily living. (ADLs are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating.) The assessment indicates whether the resident requires referral to a physician or other licensed health care professional; a provider of mental health, developmental disability, or substance abuse services; or a community resource. Appropriate licensed health professionals participate in the onsite review and evaluation of the resident's health status and care plan, and in the care provided for residents who require one or more of a range of personal care tasks.

A care plan is developed, based on the assessment, within 30 days of admission. The care plan is an individualized, written program of personal care for that resident and includes a statement of the care or services to be provided and the frequency of service provision.

SERVICES

Family care home staff provide personal care according to the residents' care plans and attend to any other personal care needs residents may be unable to handle themselves, as well as supervision in accordance with each resident's assessed needs, care plan, and current symptoms. The facility makes referrals and conducts follow-up to meet routine and acute health care needs.

MEDICATIONS

Family care home staff (medication aides) and their direct supervisors who successfully pass a written examination within 90 days after successful completion of the clinical skills validation portion of a competency evaluation may administer medications. Aides and staff who directly supervise the administration of medications must have six hours of continuing education training annually related to medication administration.

The competency evaluation consists of a written examination and a clinical skills evaluation to determine competency in the following areas: medical abbreviations and terminology; transcription of medication orders; obtaining and documenting vital signs; procedures and tasks involved with the preparation and administration of oral (including liquid, sublingual, and inhaler), topical (including transdermal), ophthalmic, optic, and nasal medications; infection control procedures; documentation of medication administration; monitoring for reactions to medications and procedures to follow if there appears to be a change in the resident's condition or health status; medication storage and

disposal; regulations pertaining to medication administration in adult care facilities; and the facility’s medication administration policy and procedures.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

The administrator or supervisor-in-charge must provide the following: a copy of the home’s resident contract specifying rates for resident services and accommodations, including the cost of different levels of service, if applicable; any other charges or fees, and any health needs or conditions the home has determined it cannot provide; a written copy of any house rules, including the conditions for the discharge and transfer of residents, refund policies, and the home’s policies on smoking, alcohol consumption, and visitation; a copy of the Declaration of Residents’ Rights; and a copy of the home’s grievance procedures, which tell how the resident can present complaints and make suggestions as to the home’s policies and services on behalf of him- or herself or others.

PUBLIC FINANCING

The state covers personal care services in family care homes under the Medicaid state plan personal care option. Medicaid also pays for nonemergency medical transportation. The payment includes a basic amount for personal care and an additional enhanced payment for residents with heavy care needs. “Heavy care” means a resident needs extensive assistance or is totally dependent in eating or toileting, or both, or in ambulation/locomotion. Eligibility for the additional payment is based on the adult care home’s assessment, which is verified by a county case manager. The resident’s physician must approve assessments and care plans. The State/County Special Assistance (SA) payment program covers room and board. The maximum payment in 2009 is \$1,207 month for a person with no income. The personal needs allowance is \$65 a month.

North Carolina Medicaid Rates (2008)	
Factor	Per diem
Basic personal care, 1–30 beds	\$17.50
Enhanced care factors	
Eating	+\$10.80
Toileting	+\$3.86
Eating and toileting	+\$14.66
Ambulation/locomotion	+\$2.76
Transportation	+\$0.60

STAFFING

The administrator must be in the home or reside within 500 feet of the home with a means of two-way telecommunication with the home at all times. When the administrator does not live in the licensed home, at least one staff member must be available who lives in the home on each shift. The administrator is directly responsible for ensuring that all required duties are carried out in the home. If the administrator does not live in the home or within 500 feet with two-way telecommunication at all times, he or she must employ a supervisor-in-charge to live in the home, Homes must designate an activity director.

TRAINING

The administrator must obtain 15 hours a year of continuing education credits related to the management of domiciliary homes and care of aged and disabled persons. Administrators must demonstrate an adequate working knowledge of the rules and pass a written examination.

Family care home staff must complete 25 hours of training for basic personal care tasks and up to 80 hours, depending on the personal care tasks performed. The 80-hour training program includes at least 34 hours of classroom instruction and 34 hours of supervised practical experience. The competency evaluation includes observation and documentation; basic nursing skills, including special health-related tasks; personal care skills; cognitive and behavioral skills, including interventions for persons with mental disabilities; basic restorative services; and resident rights. Experienced staff may take the competency exam without undergoing training.

Facilities must ensure that unlicensed personnel and licensed personnel who are not practicing in their licensed capacity complete a one-time competency evaluation for specific personal care tasks before performing those tasks. Facilities must also ensure training in the following areas: care of residents with diabetes for unlicensed staff prior to the administration of insulin and care of residents with medical symptoms that warrant restraints, including the use of alternatives to physical restraints and care of residents who are physically restrained. There must be at least one staff person on the premises at all times who has completed, within the previous 24 months, a course on CPR and choking management. Staff designated by the administrator must complete assessment training according to an instruction manual on resident assessment.

OVERSIGHT AND MONITORING

The licensing agency conducts an initial survey and annual inspections thereafter. County departments of social services monitor adult care homes at least quarterly. State licensing agency staff survey physical plant and life safety requirements every two years. Complaints are received centrally and forwarded to the county departments of social services for investigation.

NORTH DAKOTA

BACKGROUND

The Department of Human Services sets standards for adult family foster care homes. Seventy homes are licensed; most homes serve one person. The estimated capacity is about 90 beds. The number of homes has dropped from 130 about six years ago. The department is considering developing a marketing, recruitment, and retention program to reverse the decline in the number of homes.

Web Site	Content
http://www.legis.nd.gov/information/acdata/pdf/75-03-21.pdf	Rules
http://www.nd.gov/dhs/info/pubs/docs/aging/handbook-adult-family-foster-care-provider.pdf	Policy handbook
http://www.state.nd.us/humanservices/policymanuals/66005-508/66005.htm	Manual
http://www.nd.gov/dhs/info/pubs/docs/aging/dn179-adult-family-foster-care-brochure.pdf	Brochure

DEFINITION

A **family foster home for adults** is an occupied private residence in which the owner or lessee regularly provides foster care to four or fewer adults who are not related by blood or marriage to the owner or lessee, for hire or compensation.

Foster care for adults is the provision of food, shelter, security and safety, guidance, and comfort on a 24-hour-a-day basis, in the home of a caregiver, to a person 18 years or older who is unable or refuses to provide for his or her own care.

ADMISSION/RETENTION CRITERIA

Providers must terminate care of a resident if it is no longer required or if the provider is no longer qualified to provide the care needed by the resident. Providers who serve Medicaid beneficiaries complete a qualified service provider enrollment process to serve residents with higher needs. Providers receive an endorsement that allows them to perform a task that requires special skill and approval. An endorsement may apply to all clients who require that task, or it may be client-specific.

ASSESSMENT AND CARE PLANNING PROCESS

Care managers complete an assessment and care plan for publicly financed residents.

SERVICES

Providers may receive an endorsement to provide the following services or tasks: maintenance exercise; catheter care; medical gases (limited to oxygen); nonprescription suppository; cognitive supervision; taking blood pressure, pulse, temperature, respiration rate; surgical stockings; prosthesis/orthotics/adaptive devices; and Hoyer lift or mechanized bath chair.

Client-specific endorsements require verification of the provider's ability to provide ostomy care, postural bronchial drainage, compression stockings, specialty bed care, and apnea monitoring.

MEDICATIONS

Not described.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

The provider must furnish the following information to each prospective resident—or the resident's conservator, guardian, relative, or other person responsible for placement—before admittance to the home: any restrictions or limitations on the use of alcohol and tobacco; any restrictions or limitations on the use of the telephone; sample menus of meals served; procedure for the use and management of resident funds; procedures for billing, collecting, and reimbursing charges for room, board, and care; policies on furnishing nonemergency transportation for residents; a statement of other relevant house rules with which the resident will be expected to comply; and accurate and complete information regarding the extent and nature of the care available from the provider.

PUBLIC FINANCING

Adult family foster care is covered by two state-funded programs—Service Payment for the Elderly and Disabled (SPED) and Expanded Service Payment for the Elderly and Disabled (Ex-SPED)—as well as the Medicaid HCBS waiver program. SPED participants must be impaired in four ADLs (such as bathing, dressing, toileting, eating) or five IADLs (such as driving, managing money, shopping). Ex-SPED serves persons who are Medicaid-eligible, moderately impaired, and require some assistance with three of four IADLs—meal preparation, housework, laundry, and medications—or need supervision or a structured environment.

Ex-SPED is funded through general revenues; SPED is funded through state general revenues (95%) and county revenues (5%). The reimbursement rates and covered services are the same for SPED and Ex-SPED—facilities receive a maximum rate for services of \$52.69 a day. The maximum daily rate under the HCBS waiver is \$61.36 a day.

Rates for all three programs are based on an individual plan of care. A point system is used to convert unmet functional needs to a rate (see table below). The total points are multiplied by a factor of 8 and divided by 30 to obtain the monthly payment rate.

North Dakota Point System (2007)			
Activity	Value	Activity	Value
Take medication	10	Foot care	10
Temperature\pulse\respiration\blood pressure	1	Nail care	5
Manage money	1	Change dressings	10
Communication	1	Apply elastic bandage	10
Shopping	10	Care of prosthetic	10
Housework	10	Medical gases	10
Laundry	10	Meal preparation	20
Mobility	6	Exercise	20
Transportation	6	Water bath/heat	20
Bathing	20	Ostomy care	20
Teeth/mouth care	10	Bowel program	25
Dress/undress	15	Indwelling catheter	20
Toileting	20	Bronchial drainage	20
Transfer	15	Feeding/eating	20
Continence	15	Supervision Level I	20
Eye care	10	Supervision Level II	30
Skin care	10		

STAFFING

Providers must be 21 years of age or older; live continuously in the home in which family foster care for adults is provided; possess the strength necessary to help residents with activities of daily living; be literate and capable of understanding instructions and communicating in English; be free of communicable diseases; be in good physical and emotional health, functionally stable and not abusing drugs or alcohol; be a qualified service provider; and successfully complete criminal background check requirements. Providers may not have been found guilty of, pled guilty to, or pled no contest to listed offenses.

TRAINING

A physician, registered nurse, occupational therapist, physical therapist, or other person with a professional degree in specialized areas of personal care shall verify in writing, on forms furnished by the department, that a provider is competent in areas that include generally accepted procedure for infection control and proper hand washing methods; generally accepted procedure for handling and disposing of body fluids; tub, shower, and bed bathing techniques; hair care techniques, bed and sink shampoo, and shaving and other ADLs; basic meal planning and preparation; assisting a resident with the self-administration of medications; housekeeping; laundry; and assisting a resident with bill paying and balancing a checkbook.

OVERSIGHT AND MONITORING

Licenses are issued for 12 months by the county social service agency, which reviews all renewal documentation for accuracy and completeness and provides justification if initial licensure or license renewal is not recommended.

OHIO

BACKGROUND

Area Agencies on Aging (AAAs), using standards promulgated by the Department on Aging, certify adult foster homes that serve one or two residents. Eighty homes are certified. The Department of Health licenses a category of adult care homes that includes adult family homes, which are residences or facilities that provide accommodations to three to five unrelated adults and supervision and personal care services to at least three of those adults. There are 407 adult family homes with a capacity of 1,916 beds. Adult group homes serve 6–16 unrelated adults; they provide supervision and personal care services to at least three of the unrelated adults.

Web Site	Content
http://aging.ohio.gov/information/rules/current.aspx	Rules (adult foster care)
http://www.odh.ohio.gov/rules/final/f3701-20.aspx	Rules (adult family home)

DEFINITION

An **adult foster home** is a residence, other than a residence certified or licensed by the Ohio Department of Mental Health, in which accommodations and personal care services are provided to one or two adults who are unrelated to the owner of the residence.

An **adult family home** is a residence or facility that provides accommodations to three to five unrelated adults and supervision and personal care services to at least three of those adults.

ADMISSION/RETENTION CRITERIA

Adult foster homes may not provide, or admit or retain any resident in need of, skilled nursing care unless the care is provided on a part-time, intermittent basis for not more than 120 days in any 12-month period by a home health agency or a hospice care program.

Adult family homes may not provide, or admit or retain any resident in need of, skilled nursing care unless the care will be provided on a part-time, intermittent basis for not more than 120 days in any 12-month period by a home health agency, hospice or nursing facility.

ASSESSMENT AND CARE PLANNING PROCESS

Adult foster homes: not described.

Adult family homes: A physician or other licensed professional must conduct a health assessment. The purpose of the assessment is to ensure that a resident is not being admitted with needs beyond the facility’s capacity to provide care. The assessment must be completed within 14 days of admission. Assessments are required annually or upon significant change in condition.

Facilities may enter into a risk agreement with a resident or the resident's sponsor through which the resident or sponsor and the facility agree to share responsibility for making and implementing decisions affecting the scope and quantity of services provided by the facility to the resident. The facility also agrees to identify the risks inherent in a decision made by a resident or sponsor not to receive a service provided by the facility.

SERVICES

Adult foster home operators provide accommodations, personal care services, and supervision as needed by residents; snacks and three nutritious, well-balanced meals in accordance with the resident's dietary needs (the AAA can get a written description of the previous week's meals on request); and laundry services as needed for bed linens, towels, and resident clothing.

Adult family homes provide personal care services. If a resident requires services that the facility does not offer, the facility either shall arrange for the services to be provided or shall transfer the resident to an appropriate setting. Personal care services include but are not limited to the following: assistance with walking and moving, dressing, grooming, toileting, oral hygiene, hair care, dressing, eating, and nail care; assistance with self-administration of medication; and preparation of special diets (other than complex therapeutic diets) for residents who require them, pursuant to the instructions of a physician or licensed dietitian.

MEDICATIONS

Adult foster homes may not admit or retain any resident who is not capable of taking care of his or her own medications and biologicals, as determined and documented by the resident's personal physician, unless the medication is administered by a home health agency or hospice home care program. After receiving training, caregivers may remind a resident when to take medication and watch to ensure that the resident follows the directions on the container; they may also assist a resident in self-administration of medication by taking the medication from the locked area where it is stored and handing it to the resident. If the resident is physically unable to open the container, a caregiver may open it. Caregivers may assist a physically impaired but mentally alert resident in removing oral or topical medication from containers and in consuming or applying the medication on request by or with the consent of the resident. If the resident is physically unable to place a dose of medicine in his or her mouth without spilling it, a caregiver may place the dose in a container and help the resident get it to his or her mouth.

Adult family homes: All medications must be self-administered, except that medication may be administered to a resident by appropriately qualified health care professionals working in a home health agency, hospice care program, nursing home, mental health agency, or board of alcohol, drug addiction, and mental health services. Staff of an adult family home are not permitted to administer medication to residents. No person may be admitted to or retained by an ACF unless the person is capable of taking his or her own medication and biologicals, as determined in writing by the person's personal physician, unless the medication is administered by appropriately qualified health care professionals working in a home health agency, hospice care program, nursing home, mental health agency, or board of alcohol, drug addiction, and mental health services.

Staff may assist with self-administration of medications once they have received training. they may remind a resident when to take medication and watch to ensure that the resident follows the directions on the container; assist the resident in self-administration by taking the medication from the locked area where it is stored and handing it to the resident; verify the resident's name on the prescription label; read the label and directions to the resident on request; and remind the resident or other person designated by the resident when prescribed medication needs to be refilled.

If the resident is physically unable to open the container, a staff member may open it; on request or with consent, a staff member may help a physically impaired but mentally alert resident (such as a person with arthritis, cerebral palsy, or Parkinson's disease) remove oral or topical medication from containers and consume or apply it. If the resident is physically unable to place a dose of medicine in his or her mouth without spilling it, a staff member may place the dose in a container and help the resident get it to his or her mouth.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Adult foster home resident agreements must be signed and dated by the operator and the resident or the resident's legal representative before the move-in date. The agreement includes at least the following:

- An explanation of monthly charges for which the resident is financially responsible.
- A statement that no charges, fines, or penalties other than those stipulated in the agreement will be assessed against the resident.
- An explanation of the operator's policies for refunding monthly charges in the event of the resident's absence, discharge, or transfer from the home.
- An explanation of the extent and types of services the operator will provide to the resident.
- An explanation of resident rights.
- A clause that outlines how the agreement may be terminated by either party.

Adult family home agreements include at least the following items: an explanation of monthly charges to the resident (including security deposits, if required); a statement explaining whether the facility or the resident will pay for the initial and annual assessments; a statement that no charges, fines, or penalties will be assessed against the resident other than those stipulated in the agreement; an explanation of the facility's policy for refunding monthly charges in the event of the resident's absence, discharge, or transfer; the facility's policy for refunding security deposits; and a written explanation of the extent and types of services the facility will provide to the resident. Adult family homes must also provide residents with a copy of the facility's resident rights policy and procedures and smoking policy; a copy of procedures to be used for the referral of residents for mental health evaluation and services, and the role of the facility in the resident's receipt of appropriate services from mental health providers; and any other facility policies that residents must follow.

PUBLIC FINANCING

Residents of certified adult foster homes may receive a residential state supplement for room and board and services—housekeeping, laundry, transportation, and security. The payment standard is \$1,143 a month. Residents must require residential placement and support services (but not 24-hour care); a protective level of care; and fewer than 120 days of skilled nursing care per year. Funding is limited, and waiting lists may be established.

STAFFING

Adult foster home operators must submit contingency plans to the AAA that cover the unexpected absence, vacation, or disability of the caregiver. The AAA reviews the plans and disapproves them if they are not sufficient to protect the residents in the home. The AAA must approve these plans before the home is certified or recertified. The operator must have communication skills, including the ability to read, write, and make brief and accurate oral or written reports.

AFHs must have one staff member on site with a resident who requires ongoing supervision; assistance with walking, moving, bathing, toileting, dressing, eating, or evacuation; or PRN (as-needed) medications. When only one staff person is on duty, the facility designates another staff person to be available immediately in case of emergency.

Sufficient additional staff must be available to meet, in a timely manner, the residents' care, supervisory, and emotional needs, as well as reasonable requests for service (including ongoing supervision of residents with increased emotional needs or presenting behaviors that cause problems for the resident or other residents) and to properly provide dietary, housekeeping, laundry, and facility maintenance services and recreational activities.

TRAINING

Adult foster homes: The operator must have at least six hours of continuing education relevant to resident care during the two-year certification period and shall provide the AAA with documentation verifying completion of the training.

AFHs must provide orientation and training for all staff in job responsibilities, facility procedures, securing emergency assistance, and resident rights. ACF staff who provide personal care must have currently valid documentation of a successfully completed first aid course before they have contact with residents.

The manager and each staff member who is providing personal care services shall receive a minimum of six hours of training annually in topics relevant to persons diagnosed with mental illness who are residing in the facility. Each ACF staff member shall have training in the facility's fire control and evacuation procedures, and in how to secure emergency assistance in the event of suspected fire, medical emergency, or other crisis. ACF staff who provide personal care must successfully complete training or continuing education on the correct techniques for providing personal care services to others.

OVERSIGHT AND MONITORING

The department certifies adult foster homes every two years after the initial certification, but they may be inspected more often. Within 60 days after an initial certification or recertification visit, the AAA issues a written report to the operator that includes a list of all noncompliance findings against the home. Within 60 days after the date the AAA mails the report, the operator must submit a plan of action for correcting all the noncompliance findings. AAAs may provide technical assistance to help the operator comply with the standards.

The Department of Health inspects state or local ACFs annually. The department can make several unannounced visits during the year if it is necessary.

OKLAHOMA

BACKGROUND

The state has two categories of licensure for small facilities. Facilities that serve two or more residents may be licensed as assisted living centers. Facilities may also be licensed as residential care homes. Subchapter 21 includes rules for staffing, training, and assistance with medications that apply to facilities that serve no more than three residents. Five assisted living centers are licensed to serve six residents, and one facility has a license to serve four residents. None of the residential care homes are licensed to serve three or fewer residents; therefore, those rules are not summarized below. Fourteen have a licensed capacity of six residents; four serve five residents and two serve four residents. A Medicaid HCBS waiver covers services in assisted living centers.

Web Site	Content
http://www.ok.gov/health/Protective_Health/Health_Resources_Development_Service/Health_Facility_Systems_/Residential_Care_Home_Licensure/	Rules, tools, disclosure

DEFINITION

An **assisted living center (ALC)** is a home or establishment that offers, coordinates, or provides services to two or more persons who live there; are unrelated to the operator; by choice or functional impairment require nursing supervision or assistance with personal care; may need intermittent or unscheduled nursing care; may need medication assistance; and may need assistance with transfer or ambulation.

ADMISSION/RETENTION CRITERIA

ALCs must describe the population to be served on the basis of the population’s need for personal care, nursing supervision, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation and care or service for Alzheimer’s disease, and assistance with transfer or ambulation. Each center’s admission criteria must be included in the application for licensing.

ASSESSMENT AND CARE PLANNING PROCESS

ALCs must use a comprehensive screening instrument to determine the appropriateness of a resident’s placement in the facility. Centers may not serve anyone whose needs are inconsistent with the services provided by the facility, whose physician determines that restraints are needed, who is a threat or danger to self or others, or whose needs for privacy and dignity cannot be met by the facility.

SERVICES

ALCs must describe the services to be provided or arranged, including personal care, meals, housekeeping, laundry, intermittent or unscheduled nursing care, nursing supervision, medication administration, assistance with cognitive orientation, specialized services for people with Alzheimer’s disease, assistance with transfer or ambulation, planned programs for socialization, and activities and exercise. Nurses may delegate tasks that are within the scope of their license to perform. A home health agency may

provide intermittent nursing care and home health aide services in an assisted living facility

MEDICATIONS

Each assisted living center must provide or arrange for staff to administer medications only under a physician's order. The person responsible for administering medications prepares the dose, observes the swallowing of oral medications, and records the medication. Unlicensed personnel administering medications must complete a training program approved by the relevant department. A registered nurse and a pharmacist must review medications on a monthly and quarterly basis, respectively.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Each assisted living center must provide a complete and understandable contract to each resident. All rights, privileges, and assurances in the regulations are considered part of the contract. The contract must include the center's name and address; admission criteria; services provided; discharge criteria; dispute resolution and grievance procedure; term, renewal, and cancellation provisions; and conformity with state law. In the event the resident's condition merits transfer, the transfer shall be initiated within five days and noted in the resident's record. The written contract constitutes the entire agreement between the center and the resident "not excluding the marketing materials and the requirements of this chapter." ALCs are required to provide all the services specified in the resident's contract.

PUBLIC FINANCING

The Centers for Medicare and Medicaid Services (CMS) approved a waiver to cover services in assisted living centers in 2008. The state began implementing the waiver in 2009. A tiered rate system bases payment on ADLs and IADLs: Tier I, \$42.24 a day; Tier II, \$57.00 a day; and Tier III, \$79.73 a day.

STAFFING

Staffing shall be available based on the needs of residents. Nursing staff shall be provided or arranged to supervise skilled interventions, to document the resident's physician of choice, and to document the resident's living will or do not resuscitate (DNR) order. ALCs must have a dietary consultant, pharmacy consultant, and nurse consultant if there are no nurses on staff.

TRAINING

Assisted living center administrators must hold a state nursing home administrator's license, a residential care home administrator's certification from an institution of higher learning approved by the Department of Health or a nationally recognized assisted living certificate of training and competency that has been reviewed and approved by the department.

ALC staff providing socialization, activity, and exercise services must be qualified by training. Centers that include specialized units must ensure that staff are trained to meet the needs of these residents, and all direct care staff must be trained in first aid and CPR.

OVERSIGHT AND MONITORING

The state must inspect each assisted living center through unannounced inspections at least once every 15 months, with a statewide average of 12 months. The state must provide written notice of all violations. The facility has 10 business days to respond with a written plan of correction. The state will review and provide the facility with its response. If an assisted living center provides or arranges skilled nursing care, the state must assess the quality of that care against national standards of practice adopted by the American Nurses Association and Specialty Nursing Organizations.

OREGON

BACKGROUND

Adult foster homes (AFHs) were first established in the mid-1970s. The Division of Seniors and People with Disabilities (SPD) licenses providers. SPD delegates the licensing functions to county agencies in Multnomah and Clackamas counties.

Chapter 834 of the Acts of 2007 established collective bargaining rights for AFH providers. For purposes of collective bargaining, providers are considered employees of the state. After presenting designation cards from more than half the providers, the governor issued executive orders in June and November 2007 recognizing the Service Employees International Union, Local 503 as the bargaining agent for adult foster care and relative foster care providers. The first negotiation session was held in January 2008.

In June 2007, the program supported 4,078 waiver clients in adult foster homes, compared with 4,610 in July 2004. The number served in assisted living facilities was 3,739 in 2007 (3,886 in 2004). State officials foresee a growing need for specialized providers to serve residents with greater needs, particularly with the implementation of the Money Follows the Person demonstration program, which will serve longer stay nursing home residents. State officials reported that they are initiating steps to boost capacity and retain existing providers. SPD is creating a staff position to recruit providers to counter the gradual decline in the supply. Low rates for assisted living are one factor in the decline. Staff will assess the existing capacity and the needs being met, and gather information on successful local recruitment efforts. SPD is also planning training sessions to support and improve the competency of existing providers; however, it is difficult for small providers to allocate time to attend training, especially in rural areas. SPD is planning to develop and offer online training modules and self-training manuals.

In 2008, there were 1,735 commercial AFHs with a capacity to serve 7,749 persons; there were 1,500 relative foster homes. About 67 percent of the residents are private pay.

Web Site	Content
http://www.oregon.gov/DHS/spwpd/ltc/ltc_guide/whataremychoices.shtml#afh	Consumer guide
http://www.dhs.state.or.us/policy/spd/rules/411_050.pdf	Rules

DEFINITION

An **adult foster home** is a family home or other facility in which residential care is provided in a homelike environment for compensation to five or fewer adults who are elderly or physically disabled and are not related to the licensee or resident manager by blood, marriage, or adoption. For the purpose of this rule, adult foster home does not include any house, institution, hotel, or other similar living situation that supplies room or board only if no resident requires any element of care.

A relative adult foster home is a home in which a licensed adult family member who is 18 years or older provides services. The person receiving services must be Medicaid eligible. Spouses are not eligible for compensation as a relative adult foster care licensee.

ADMISSION/RETENTION REQUIREMENTS

An adult foster care (AFC) provider must not serve anyone whose needs are beyond the scope of its license. Before a person may be admitted into an AFC home, he or she is screened to ensure that his or her needs do not exceed the licensee's classification. The screen evaluates the person's ability to self-evacuate and determines whether the prospective resident's needs can be met in addition to caring for the other residents. Admission requirements include personal information; written orders from a physician or nurse practitioner; and information on medications, treatments, and therapies. Residents may be discharged, transferred, or moved with a minimum 30 days' notice if their medical condition becomes too complex and exceeds the provider's license classification, or they are unable to self-evacuate, or their behavior becomes a danger to themselves or others.

Providers may admit or continue to care for residents strictly on the basis of the impairment levels of residents and the classification level of the provider. Class 1 providers may admit only residents who need assistance in no more than four activities of daily living (ADLs). Class 2 providers may provide care for residents who require assistance in all ADLs but require full assistance in no more than three ADLs. Class 3 providers may provide care for residents who require full assistance in four or more ADLs.

To receive Medicaid waiver services, beneficiaries must meet one of the service priority levels (SPLs), based on information in the assessment. SPLs rate potential residents according to the cognition and amount of assistance they need with a specified ADL or combination of ADLs. Because of budget constraints, services are provided only to SPL levels 1–13. The levels are as follows:

1. Dependent in mobility, eating, toileting, eating, and cognition
2. Dependent in mobility, eating, and cognition
3. Dependent in mobility or cognition or eating
4. Dependent in toileting
5. Substantial assistance with mobility and assistance with toileting and eating
6. Substantial assistance with mobility and assistance with eating
7. Substantial assistance with mobility and assistance with toileting
8. Minimal assistance with mobility and assistance with eating and toileting
9. Assistance with eating and toileting
10. Substantial assistance with mobility
11. Minimal assistance with mobility and assistance with toileting
12. Minimal assistance with mobility and assistance with eating
13. Assistance with toileting

14. Assistance with eating
15. Minimal assistance with mobility
16. Full assistance with bathing or dressing
17. Assistance with bathing or dressing
18. Independent in the above levels but requires structured living for supervision for complex medical programs or a complex medication regimen

State officials noted that AFC participants have greater needs than other waiver participants. Fifty-nine percent of the participants in adult foster homes were in SPLs 1–3 in 2005, compared to 35 percent of assisted living residents, 24 percent of in-home services clients, and 76 percent of residential care facility and nursing home residents.

ASSESSMENT AND CARE PLANNING PROCESS

During the first 14 days of a resident's stay, the provider must continue the assessment process, documenting the resident's care needs (including social, spiritual, and emotional needs) and preferences, such as diet. The assessment and care plan must be completed within this 14-day period. The care plan must describe the resident's care needs, preferences, and physical and mental capabilities, and list the treatments, procedures or therapies that the resident will need. The care plan must document the need for specialized equipment, communication and night needs, ability to exit during an emergency, and use of medications. The provider must reassess the care plan every six months and at any significant change in the resident's condition. Case managers review care plans at least annually.

SERVICES

AFCs provide services identified in the plan of care, including activities that help residents develop skills to maintain or increase their level of functioning, or that help them with personal care, activities of daily living, or social activities.

The licensee must obtain a medical consultation and an assessment for a resident if a skilled nursing care task has been ordered or the resident has a health concern or behavioral symptom that might benefit from a nursing assessment and provider education; when written parameters are needed to clarify the physician or nurse practitioner's PRN (as-needed) order for medication and treatment; before the use of physical restraints if the licensee has not been assessed, taught, and reassessed by a physician, nurse practitioner, Christian Science practitioner, mental health clinician, physical therapist, or occupational therapist; before the use of psychoactive medications if the licensee has not been assessed, taught, and reassessed by a physician, nurse practitioner, or mental health practitioner, before requesting psychoactive medications to treat behavioral symptoms; and when care procedures have been ordered that are new for a specific resident, the licensee, or other caregivers.

MEDICATIONS

Residents who are capable of self-administration of medicine must have a physician or nurse practitioner's written approval. These residents may keep medications in their own

room in a locked storage container. Providers who administer medications must record all medications, treatments, and therapies in the medication administration record for each resident. Injections may be self-administered by the resident, a relative, or a licensed nurse. Caregivers, trained by a licensed nurse and approved by the Department of Human Services, may give subcutaneous injections; however, nurses may not delegate intramuscular and intravenous injections.

RESIDENT AGREEMENT/DISCLOSURE/CONTRACT

Before admission, the licensee must disclose policies that limit a resident's activities or preferences, transfer and discharge policies, and the Residents' Bill of Rights. Providers are responsible for serving three nutritionally balanced meals a day and posting a menu of the meals for the week. Providers must offer six hours of activities a week, not including movies or television. The provider must inform the resident about the policy on Medicaid-eligible residents and discuss the availability of long-term care assessment services for private pay residents.

The contract must include but is not be limited to the following:

- Services provided and the rates to be charged. A payment range may not be used unless the contract plainly states when a rate increase can be expected based on increased care or service needs.
- Conditions under which the rates may be changed.
- The refund policy in instances of a resident's hospitalization, death, discharge, transfer to a nursing facility or other care facility, or voluntary move.
- Policies on voluntary moves and whether or not the licensee requires written notification of a resident's intent not to return.
- Storage charges for belongings that remain in the adult foster home for more than 15 days after the resident has left.
- A statement indicating that residents are not liable for damages considered normal wear and tear on the adult foster home and its contents.

Notice of general rate increases, additions, or other modifications of the rates must be given 30 days before their effective date.

PUBLIC FUNDING

The Medicaid HCBS waiver covers adult foster care services. Medicaid waiver payments include a base rate and up to three add-on payments. The state has created separate payment rates for nonrelative and relative adult foster homes. Nonrelative homes received a base payment of \$1,229 a month in 2008; relative homes received a base rate of \$1,000 a month. Both groups received add-on payments of \$237 a month. Add-on payments are made for residents who are dependent in mobility, eating, or toileting; who demonstrate behaviors that pose a risk to the resident or others and require frequent intervention; and residents with complex health conditions who require daily assessment, observation, and monitoring by a licensed health care professional (if the home has the capacity to provide the service). Case managers may submit a request to an "exceptions

committee” for additional payments to serve high-need clients. State officials said they are developing an acuity-based payment methodology and are examining private pay rates and the mix of private pay and Medicaid residents. In June 2008, 2,502 people were served in nonrelative homes, and 1,493 were served in relative homes.

The following rates do not include room and board, which is paid by the resident. The state agency may approve rate exceptions for higher acuity residents.

Adult Foster Care Payment Rates, 2008		
Payment	Nonrelative Homes	Relative Homes
Base	\$1,229	\$1,000
Base plus 1 add-on	\$1,466	\$1,237
Base plus 2 add-ons	\$1,703	\$1,474
Base plus 3 add-ons	\$1,940	\$1,711

Data for September 2006 showed that 24.9 percent of nonrelative foster home residents received the base rate; 37.9 percent received the base rate plus one add-on; 32.0 percent received the base rate plus two add-ons; and 5.3 percent received the base rate plus three add-ons. Comparable rates for relative foster home participants were 56.7 percent, 31.0 percent, 11.0 percent, and 1.5 percent. The percentage of beds occupied by Medicaid beneficiaries ranged between 37 percent and 46 percent.

Distribution by Payment Level, September 2006		
Payment	Nonrelative AFC	Relative AFC
Base	24.9%	56.7%
Base plus 1 add-on	37.9%	31.0%
Base plus 2 add-ons	32.0%	11.0%
Base plus 3 add-ons	5.3%	1.5%

STAFFING

Adult foster care providers must pass a criminal history check, a foster home exam, and a financial background check, and must comply with structural and environmental requirements. The provider must have a resident manager or 24-hour caregiver on duty. All providers, resident managers, and substitute caregivers must meet educational standards established by the Department of Human Services and must be at least 21 years old.

TRAINING

Before they are licensed, providers must successfully complete a training curriculum that includes demonstration and practice in physical caregiving; screening for care and service needs; appropriate behavior toward residents with physical, cognitive, or mental disabilities; and an understanding of architectural accessibility. Providers must pass a test that assesses their ability to manage and respond to emergency situations, changes in medical condition, physicians’ orders, nutritional needs, residents’ needs, and conflict. Providers must complete 12 hours of continuing education credits annually related to the

care of elderly and disabled persons. Four of the hours may cover the business operation of adult foster homes.

OVERSIGHT AND MONITORING

The licensing agency conducts unannounced annual inspections, investigates complaints, and makes unscheduled inspections if it has cause to believe a home is not complying with the regulations. When violations are found, the licensing agency may attach conditions to the license; impose civil penalties; deny, suspend, revoke, or decline to renew a license; or reclassify the license. The licensing agency determines whether the home has corrected the violations.

PENNSYLVANIA

BACKGROUND

The domiciliary care or (dom care) program was created as part of Act 70 of June 1978 to provide a homelike living arrangement in the community for adults 18 years and older who need assistance with ADLs and are unable to live independently. Dom care providers open their homes to persons who need supervision, support, and encouragement in a family-like setting. The Office of Long-Term Living (OLTL) is responsible for developing regulations, supervising Dom Care services, and providing technical assistance to Area Agencies on Aging (AAAs).

AAAs are responsible for determining resident eligibility, placing residents with their consent, determining and certifying provider eligibility, and arranging for provider training.

Before 1990, dom care homes could serve up to 13 residents, but the maximum capacity was reduced to 3 residents in 1990, although homes that already served more than 3 residents were allowed to continue serving up to 13 residents. In January 2008, there were 648 certified homes with a capacity to serve 1,813 residents. Actual occupancy was 1,283, and about 98 percent of residents were SSI beneficiaries. The supply of providers has declined in recent years. Most providers are retirees or older couples. OLTL is considering strategies to increase the supply. The SSI state supplement payment standard was increased by \$60 a month in 2007 in an effort to retain providers, and options for covering services under Medicaid are being considered.

The dom care unit in each AAA is generally responsible for recruiting prospective home providers, inspecting homes for certification, assessing potential residents, helping potential SSI beneficiaries obtain the SSI state supplement, and notifying the County Assistance Office to initiate or terminate the state supplement. This unit in the AAA also ensures the appropriateness of placement, the continuing need for the provision of care, and the provision of community services for dom care residents.

The domiciliary care program has the following service goals:

- To provide supportive, homelike, community-based living arrangements for adults who cannot live independently in the community.
- To encourage and assist residents in developing and maintaining maximum initiative and self-determination in a homelike setting.
- To provide an alternative to institutionalization, and to help adults remain in the community or return to the community and, if possible to their own homes.

Web Site	Content
http://www.aging.state.pa.us/aging/cwp/view.asp?a=284&q=176977	Tools, forms
http://www.pacode.com/secure/data/006/chapter21/chap21toc.html	Regulations
http://www.aging.state.pa.us/aging/lib/aging/Dom_Care_101_Master_copy_pdf_version.pdf	Training guide

DEFINITION

Domiciliary care is a protected living arrangement in the community that includes room and board and services for persons 18 years and older who cannot live independently because of their social and economic situation (Act 70, 1978). The definition in the regulations states that domiciliary care is “a premises certified by an AAA for the purpose of providing a supervised living arrangement in a homelike setting for a period exceeding 24 consecutive hours to residents placed there by the AAA.”

ADMISSION/RETENTION CRITERIA

To receive domiciliary care service, an applicant must be 18 years or older; be independently mobile or semi-mobile; not require skilled or intermediate nursing care, or general or special hospital care on a 24-hour residential basis; have no relative or other person whose relationship with the applicant is important to the applicant’s continued well-being and who is willing or able to provide the necessary support for independent living; and be incapable of living alone regardless of available services, or requires services to live alone and the services are not available. In general, dom care homes may not serve persons who meet the nursing facility level-of-care criteria. However, a waiver of the admission/retention criteria may be approved by OLTL on the basis of individual circumstances. About 40 residents have received a waiver.

Applicants must also meet one or more of the following criteria:

- Have demonstrated difficulties in accomplishing activities of daily living—such as purchasing and preparing meals, bathing and grooming, housekeeping and laundry, financial management and taking medication in proper doses at proper times—to an extent that prevents independent living in the community.
- Have demonstrated difficulties in social or personal adjustment, usually associated with mental disability, as demonstrated by reduced, lost, or undeveloped capabilities for developing and maintaining appropriate personal relationships; dealing constructively with others; and maintaining or attaining a maximum level of functioning.
- Have demonstrated difficulties resulting from disabilities—such as blindness, deafness, amputation, paralysis, or birth defects—if the person is independently mobile or semi-mobile.

ASSESSMENT AND CARE PLANNING PROCESS

Area Agencies on Aging are responsible for the development and implementation of a plan of care for each resident. The AAA, in consultation with the resident, develops the plan, which describes the problems or needs of the resident, desired outcomes (long- and short-term goals), services or providers (informal or formal), pattern of service delivery, follow-up monitoring, and reassessment updates. Arrangements to supplement services given by the provider are included in the care plan and may be made by the AAA directly or by referral to another agency. The purpose of the supplemental service is to address special resident needs that provide the support necessary to maintain the resident in the domiciliary care home.

A follow-up assessment is required with 15 days of placement and every six months thereafter to evaluate the resident's adjustment and to modify the care plan if necessary. The AAAs conduct comprehensive annual reassessments of residents.

SERVICES

Providers help the resident develop or maintain self-help skills, personal hygiene skills, and other skills related to activities of daily living in accordance with the care plan established by the AAA.

MEDICATIONS

The provider may assist with medications by helping the resident remember the schedule in accordance with the prescription, storing the medication in a secure place, and offering the medication at the prescribed times.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

A written agreement between the provider and the resident is required that specifies the monthly charge for dom care services in accordance with the amounts established by OLTL. The agreement is completed on a form provided by OLTL and must be fully explained to the prospective resident before placement. The agreement is subject to approval by the AAA; at minimum, it includes the house rules and describes basic furnishings. The agreement outlines when the resident is expected to be present in the home and when he or she is expected to be away from the home. The purpose of this provision is to allow the resident and provider the freedom to participate in activities that are not related to dom care.

PUBLIC FINANCING

The SSI program and a state supplement cover dom care services. The supplement payment standard in 2008 was \$1,071.30, from which \$914 was paid to the provider and \$157.30 retained as a personal needs allowance. About 98 percent of the 1,283 residents are SSI beneficiaries. Private pay residents may not be charged more than the SSI beneficiaries for room and board and services. Domiciliary care is not a covered waiver service; however, residents may receive waiver services in this setting if the home receives a waiver of the admission/retention requirements from OLTL.

STAFFING

Domiciliary care home providers must 21 years or older and must live in the domiciliary care home.

At least one provider or staff person must be present and available on the premises when one or more residents are present in the home. The AAA may waive this requirement if the residents are independently mobile and the provider or staff absences would be of limited duration and not during hours when the residents are sleeping. This waiver, if granted by the AAA, is made in writing and recorded in the case record.

Staff must be 18 years or older; capable of performing home provider services; and never have been convicted of a crime involving assaultive behavior or moral turpitude.

TRAINING

AAAs are required to arrange training based on course materials identified by the Department of Aging. They must ensure that providers achieve competencies through educational programs in the following areas: major health problems of older persons; accident prevention; nutrition; the psychology of aging; interpersonal communication; general principles of cleanliness and hygiene; and recognition and response to crises and emergency situations.

OVERSIGHT AND MONITORING

Homes are inspected annually to ensure that they meet health and safety standards.

RHODE ISLAND

BACKGROUND

The state does not have separate licensing requirements for adult foster care. Assisted living residence rules apply to facilities that serve two or more adults.

Web Site	Content
http://www2.sec.state.ri.us/dar/regdocs/released/pdf/DOH/4819.pdf	Rules
http://www2.sec.state.ri.us/dar/regdocs/released/pdf/DOH/DOH_3815.pdf	Rule (administrator)
http://www.health.ri.gov/hsr/professions/alr_admin.php	Administrators

DEFINITION

An **assisted living residence** is “a publicly or privately operated residence that provides directly or indirectly by means of contracts or arrangements personal assistance to meet the resident’s changing needs and preferences, lodging, and meals to two or more adults. Assisted living residences include sheltered care homes, and board and care residences, or any other entity by any other name providing the above services which meet the definition of assisted living residence.” Levels of licensure for residential care and assisted living facilities are based on fire code requirements and the need for assistance with medications. Areas within a residence may be licensed separately. The levels are as follows:

Fire code classification:

- Level F1: Licensure for residents who are not capable of self-preservation.
- Level F2: Licensure for residents who are capable of self-preservation.

Medication classification:

- Level M1: Licensure for residents who require central storage and administration of medications.
- Level M2: Licensure for facilities that only assist residents with self-administration of medications.

ADMISSION/RETENTION CRITERIA

A resident may not require the kind of medical or nursing care that is provided in a health care facility but may—as a result of choice or physical or mental limitation—require personal assistance, lodging, meals, and possibly the administration of medication. A resident must be capable of self-preservation in emergency situations, unless the residence meets a more stringent life safety code. Persons who need medical or skilled nursing care, including daily professional observation and evaluation, and persons who are bedbound or in need of the assistance of more than one person for ambulation are not appropriate for an assisted living residence. However, an established resident may receive daily skilled nursing care or therapy from a licensed health care provider for a condition that results from a temporary illness or injury for up to 21 days or—if the resident is

under the care of a licensed hospice agency—longer, provided the assisted living residence assumes responsibility for ensuring that care is received.

ASSESSMENT AND CARE PLANNING PROCESS

A comprehensive assessment is required before admission on a form approved by the licensing agency. The assessment covers health, physical, social, functional, activity, and cognitive needs and preferences. The form demonstrates that the resident meets the residency criteria and that the residence is able to meet his or her needs. A written service plan is required within a reasonable time after admission.

SERVICES

Services include 24-hour awake adult staffing; personal services; assistance with self-administration of medication or administration of medications by appropriately licensed staff; assistance arranging for supportive services that may be reasonably required; monitoring of health, safety, and well-being; housekeeping; laundry; and reasonable recreational/social services. Nurse review is necessary under all levels of medication licensure. A registered nurse must visit the facility at least once every 30 days to monitor the medication regimen for all residents; evaluate the health status of residents; make necessary recommendations to the administrator; and follow up on previous recommendations. The RN provides written reports to the facility documenting the visits.

MEDICATIONS

In M2 facilities, unlicensed staff may only remind residents to take their medications and observe. Staff in M1 facilities may administer medications, including removing medication containers from storage, assisting with removal of a medication from a container, and directly administering the medication. Staff must have four hours of training by an RN regarding policies and procedures, and must have passed an exam based on the training.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Facilities are required to disclose the name of the owner and operator; the level of license, with an explanation; admission and discharge criteria; services available; financial terms; terms of the residency agreement; and contact information for the department, attorney general, fraud and abuse unit, ombudsperson, and local police.

The residency agreement includes resident rights, admission criteria, discharge criteria, discharge policies, the unit to be rented, shared space and facilities, services to be provided or arranged, financial terms (basic rates, extra charges at admission or in the future, deposits and advance fees, and the rate increase policy), special care provisions, resident responsibilities and house rules, initial and ongoing assessment and service plan, and the grievance procedure.

PUBLIC FINANCING

The state has two waivers covering assisted living. The Community Assisted Living waiver covers a broad range of services and includes assisted living for residents who are relocating from nursing homes. In January 2007, 21 facilities were contracting with Medicaid and serving 211 beneficiaries. Facilities receive a prospective Medicaid

payment based on their customary rate, not to exceed \$1,800 a month, including room and board covered by SSI. The facility sets the room and board charge. The SSI benefit standard, including the state supplement, was \$1,218 in 2007. Beneficiaries retain \$100 a month as a personal needs allowance. Income supplementation is not permitted. Nursing home residents receive case management to assist with relocation to the community. Case managers use community resources to cover transitional expenses.

The Rhode Island Housing Assisted Living waiver covers case management and assisted living services for elderly persons and adults with physical disabilities in a demonstration program involving the Department of Elderly Affairs and the Rhode Island Housing Mortgage and Finance Agency. In 2007, 17 facilities were serving about 200 beneficiaries (the maximum allowed by the waiver). The payment rate was \$36.32 a day. The room and board charge, usually between \$800 and \$900 a month, is separate from the Medicaid payment and is not limited by state policy. This pilot program only reimburses facilities with single-occupancy rooms with private baths.

SSI beneficiaries who do not receive waiver services retain a PNA of \$55 a month.

STAFFING

Facilities must have a responsible adult on the premises at all times who is in charge of the operation of the facility and is physically and mentally capable of communicating with emergency personnel. All facilities must provide sufficient staffing to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the residents, according to the appropriate level of licensing.

TRAINING

An administrator must be at least 18 years old and must obtain certification as a residential care/assisted living facility administrator or have equivalent training. Certification requirements include completion of a training program administered by the licensing agency and an 80-hour field experience program covering topics referenced in the regulations; or successful completion of a degree in a health care-related field that includes course work in gerontology, personnel management, and financial management, as well as 80 hours of field experience; or possession of a current Rhode Island nursing home administrator's license. Administrators must have completed at least 32 hours of continuing education within the previous two years.

New employees receive at least two hours of orientation and training in fire and emergency procedures; recognition and reporting of abuse, neglect, and mistreatment; assisted living philosophy (dignity, independence, autonomy, choice); resident rights; and confidentiality. Employees who have regular contact with residents and provide them with personal care receive at least 10 hours of orientation and training in basic sanitation and infection control (i.e., universal precautions); food service; medical emergency procedures; basic knowledge of aging-related behaviors; personal assistance; assistance with medications; safety of residents; record-keeping; service plans; reporting; and, where appropriate, basic knowledge of cultural differences. In-service training in appropriate topics is also required.

The Medicaid waiver requires a minimum 1 hour of orientation and 12 hours of annual in-service training for staff. Nursing assistants must provide the personal care services for waiver-certified residents.

OVERSIGHT AND MONITORING

Legislation passed in 2006 allows the licensing agency to determine the frequency of inspections (in addition to the annual inspection). An inspection includes but is not limited to the residence's past compliance with regulations, complaint investigations, quality of care issues, and license type. Representatives of the licensing agency have the right to enter a facility at any time without prior notice to inspect the premises and services. The licensing agency notifies the facility of any deficiencies reported as the result of an inspection or investigation. If agency staff are available, a consultation/collaboration might be implemented. The licensing agency notes the importance of having registered nurses and pharmacy consultants available to monitor the assessment process and admission and medication issues.

The rules require that residences develop, implement, and maintain a documented, ongoing quality assurance program to attain and maintain a high-quality assisted living residence through an ongoing process that monitors quality, identifies areas to improve and methods to improve them, and evaluates the progress achieved. Areas subject to quality assurance review shall include at least personal assistance and resident services; resident satisfaction; and incidents (for example, resident complaints, medication errors, resident falls, and injuries of unknown origin).

The administrator is responsible for maintaining a written plan that includes three areas for quality assurance/improvement review and that describes the monitoring, identification, and evaluation processes; tracking methods; and the person responsible for the review.

SOUTH CAROLINA

BACKGROUND

Providers that care for two or more persons are licensed as community residential care facilities. State officials are developing options for covering services in adult foster care as a demonstration service under the Money Follows the Person program. If the state determines that adult foster care will be licensed as a separate residential category, the community residential care facility law will have to be amended to raise the number of residents required for such a license.

Web Site	Content
http://www.scdhec.net/health/licen/hlcrinfo.htm	Rules, provider, consumer
http://www.scdhec.net/health/licen/hlfaclist.htm	List

DEFINITION

A **community residential care facility (CRCF)** is “a facility which offers room and board and which, unlike a boarding house, provides/coordinates a degree of personal assistance for a period of time in excess of twenty-four consecutive hours for two or more persons, eighteen years old or older, not related to the licensee within the third degree of consanguinity. It is designed to accommodate individual residents’ changing needs and preferences; maximize residents’ dignity, autonomy, privacy, independence, and safety; and encourage family and community involvement. Included in this definition is any facility (other than a hospital) which offers or represents to the public that it offers a beneficial or protected environment specifically for individuals who have mental illness or disabilities.” Facilities that meet the definition of community residential care may be referred to as assisted living.

ADMISSION/RETENTION CRITERIA

Facilities may admit only adults and may not admit person who are likely to endanger themselves or others; anyone suffering from acute mental illness; anyone who needs hospital or nursing home care; or anyone who needs continuous daily attention from a licensed nurse. Short-term, intermittent nursing needs may be met by a home health agency. Facilities must transfer anyone whose needs cannot be met by the facility in combination with services provided by hospice agencies or home health agencies. CRCFs may not serve residents who require certain kinds of care or have certain symptoms:

- Daily skilled monitoring/observation owing to an unstable/complex medical condition.
- Serious aggressive, violent, or socially inappropriate behavioral symptoms.
- Medications that require frequent dosage adjustments, or regular intramuscular or subcutaneous injections.
- Intravenous medications or fluids.

- A urinary catheter that cannot be cared for by the resident.
- Treatment of stage 2, 3, or 4 decubitus or multiple pressure sores.
- Nasogastric tube feeding.
- Suctioning.
- Tracheostomy or sterile care that cannot be managed by the resident.
- Receiving oxygen for the first time, which requires adjustment and evaluation of the concentration.
- Dependency in all ADLs for more than 14 days.
- Sterile dressing changes.

ASSESSMENT AND CARE PLANNING PROCESS

A direct care staff member must complete an assessment of resident needs no later than 72 hours after admission. The facility must develop an individualized care plan with participation by the administrator and the resident (or the sponsor or responsible party when appropriate) within seven days of admission. The plan must be reviewed and revised as changes in the resident's needs occur, but not less than semi-annually. The rules specify the content of the care plan.

SERVICES

Facilities must provide appropriate assistance with ADLs, meals, special diets, and medications, as well as at least one structured recreation activity each day and transportation. Personal care includes assistance with ADLs; assistance with making appointments and arranging transportation to receive supportive services required in the care plan; being aware of the resident's whereabouts; monitoring resident activities to ensure health, safety, and well-being, and arranging for routine and emergency health services, such as podiatry, dental services, and counseling.

MEDICATIONS

Facilities may administer medications and are responsible for ascertaining that medications are taken by residents in accordance with physicians' orders. Nonlicensed staff may administer medications if they have been trained by appropriately licensed persons. Administration of medications has been expanded to include oral and topical medications, regularly scheduled anaphylactic insulin treatments under established medical protocols, and insulin and epinephrine injections. Licensed nurses perform flu injections and TB screening. Staff must verify orders for self-administration of medications.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

The written agreement explains the specific care/services/equipment provided by the facility (e.g., administration of medications, special diets, assistance with ADLs); the fees for care/services/equipment; notice requirements for changes in fees; the dates a resident

will receive his or her personal needs allowance; transportation policy; discharge/transfer provisions; and a statement of resident rights and the grievance procedure.

PUBLIC FINANCING

The integrated personal care program implemented in 2002 provides coverage of personal care in residential settings under the Medicaid state plan. To be eligible for coverage, beneficiaries must already receive the optional state supplement to the SSI program, which is available to persons who reside in community residential care facilities and require assistance with two ADLs; those who need assistance with one ADL and have a cognitive impairment; those who are unable to live alone because of inadequate support; and those who need assistance to sustain maximum functional level. Facilities must contract with a licensed nurse at least one day a week; the nurse is responsible for providing personal care training to staff, and developing and monitoring the care plans of residents served by the integrated personal care program. Facilities that participate in the program must be able to provide medical monitoring, medication administration, and personal care, and must be ADA-compliant. The payment covers one unit (one hour) of personal care services at a rate of \$14.80 per participant day.

STAFFING

At least one staff member shall be available for every eight residents during the day and one per 30 residents at night. Facilities with more than eight residents must have one staff member awake and dressed at night. Awake staff are required in facilities of fewer than eight if there are residents with dementia. In multistory buildings, staff must be on each floor at all times that residents are present.

TRAINING

In-service training programs are provided to all personnel. They include basic first aid; procedures for checking and recording vital signs; care of persons with communicable diseases; use of restraints; medication management; care for persons with dementia (if applicable); CPR; confidentiality and residents' rights; OSHA standards for bloodborne pathogens; and fire response training. Staff receive basic information on these topics during orientation. Training shall be provided on a continuous basis and not less than annually.

OVERSIGHT AND MONITORING

Facilities are inspected before licensure and at least every three years, or more frequently if needed. Facilities must have a written quality improvement program. The program must establish desired outcomes and the criteria by which effectiveness is measured; identify and evaluate the causes of deviation from desired outcomes; develop action plans to prevent future deviations; establish quality indicators; analyze appropriateness of care plans; review all incidents and accidents, including resident deaths, and infections or other occurrences that threaten the health and safety of residents; and create a systematic method of obtaining feedback from residents and other interested parties on the level of satisfaction with care and services received.

SOUTH DAKOTA

BACKGROUND

The Department of Health licenses adult foster care homes that serve multiple populations. The department reported 32 licensed homes with a capacity of 78 beds; however, three homes recently indicated that they would not renew their licenses.

Adult foster care homes provide room and board and general supervision of personal care services in a family home. Adult foster care can meet the needs of adults who require periodic or regular assistance with activities of daily living—dressing, bathing, eating, brushing teeth, or combing hair—but do not require nursing services.

Adult foster care homes are available to private pay individuals and state-funded residents. The Department of Social Services is responsible for case management services to residents age 60 years and older who receive state payments.

Web Site	Content
http://legis.state.sd.us/rules/DisplayRule.aspx?Rule=44:04:19	Rules
http://doh.sd.gov/PDF/foster.pdf	Application

DEFINITION

An **adult foster care home** is a family-style residence that provides supervision of personal care, health services, and household services for no more than four aged, blind, physically disabled, developmentally disabled, or socially-emotionally disabled adults.

ADMISSION/RETENTION CRITERIA

The Division of Adult Services and Aging Web site describes people who are appropriate for adult foster care as those who are oriented to time, person, and place, and not a danger to themselves or others in the home; are unable to live independently; require minimal supervision or assistance in completing one or more of the following: dressing, personal hygiene, transportation, ambulation, and nutrition; are capable of taking action (with direction) for self-preservation in a fire or storm; usually have control of bowel and bladder but may have stress incontinence and are capable of meeting their own needs when incontinent.

Persons who are not appropriate for adult foster care are those who are consistently not oriented to time, person, and place to the extent that they pose a danger to themselves or others in the home; are unable or unwilling to meet their personal hygiene needs under minimal supervision; have a communicable disease or infectious condition that poses a threat to the health or safety of other residents of the home; are chronically disruptive and unable or unwilling to comply with adult foster care rules; exhibit behaviors that pose a threat to other residents; are unable to self-medicate on their own, even with supervision or monitoring; require a complex therapeutic diet; or require any other type of care that can only be provided safely by or under the supervision of a licensed practical nurse or a registered nurse.

ASSESSMENT AND CARE PLANNING PROCESS

Not described.

SERVICES

The adult foster care homeowner must provide continuous care for the resident and shall be cooperative with the department in carrying out the plan for the resident. The adult foster care homeowner shall be available to assist the resident with personal care and health supervision.

MEDICATIONS

Not described. Providers are not allowed to administer or assist with medications.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Not described.

PUBLIC FINANCING

An SSI state supplement supports a small number of participants. The payment rate is \$947 a month, and the participant retains \$60 for personal needs. The program, which once served as many as 50 residents, now serves only 12 residents. Participants tend to be over 60 years old with developmental disabilities and to receive care from relative providers. Once they move to a higher level of care, the family members are not interested in serving any other persons.

STAFFING

Any person who provides supervisory care in an adult foster care home must be at least 18 years old. Neither adult foster care homeowners nor family members who live in the residence may be habitual users of alcohol or drugs, or have a conviction for abusing or neglecting another person. The adult foster care homeowner shall be present during the day and night according to the needs of the residents. The homeowner may arrange for a substitute during an absence from the home.

TRAINING

Not described.

OVERSIGHT AND MONITORING

Not described.

TENNESSEE

BACKGROUND

The state administers a family home for adults program through the Department of Human Services (DHS) adult protective services program for adults who are frail, disabled, or victims of abuse. The department's Web site contains a description of the program.

“Is there room for one more in your home? All over Tennessee there are men and women who are frail or living with a disability who cannot live alone, but do not need to be in a nursing home or institution. They have no relatives or their relatives are unable to look after them. These individuals need homes with “new families” who will provide safety, needed care and protection from abuse and neglect. Could one of these at risk adults become part of your family? If so, the Tennessee Department of Human Services (DHS) administers a program, through Adult Protective Services, to establish family homes for adults. More homes are always needed.”

Web Site	Content
http://tennessee.gov/humanserv/adfam/aps_fh.html	Recruitment message

No further information was obtained.

TEXAS

BACKGROUND

Adult foster care (AFC) homes that serve one to three residents must comply with Medicaid contracting requirements but are not licensed. The Department of Aging and Disability Services (DADS) licenses an AFC home with four beds as a Type C assisted living facility (ALF). An AFC home that serves five to eight residents—exclusive of live-in house parents, family, or staff—must be licensed as a Type A (small) assisted living facility.

DADS receives more requests for AFC provider contracts than are needed. Provider interest is greater in rural parts of the state than in metropolitan areas. AFC is not seen as a significant service/provider type—there are 155–160 AFC providers in the state.

State law requires DADS to license ALFs that serve four or more residents. The Type C license was developed for four-bed AFC homes. Four-bed homes that meet DADS AFC contracting rules qualify for the Type C license and do not have to meet the ALF minimum licensing standards. ALFs that serve five to eight residents and contract to provide AFC must obtain the Type A license and meet the minimum licensing standards.

Web Site	Content
http://info.sos.state.tx.us/pls/pub/readtac\$ext.ViewTAC?tac_view=5&ti=40&pt=1&ch=48&sch=K&r1=Y	Medicaid standards
http://info.sos.state.tx.us/pls/pub/readtac\$ext.ViewTAC?tac_view=4&ti=40&pt=1&ch=92	Rules

DEFINITION

Adult foster care (AFC) is a 24-hour living arrangement with supervision for people who are unable to continue living independently in their own homes because of physical, mental, or emotional limitations.

ADMISSION/RETENTION CRITERIA

AFC is appropriate for persons who, because of physical, mental, or emotional limitations, are unable to continue independent functioning in their own homes, and who need and desire the support and security of family living. AFC is also appropriate for persons who do not need institutional care but are unable to resume independent living and have no relatives who can provide a home for them.

Type A residents must be physically and mentally capable of evacuating the facility unassisted. This may include mobile nonambulatory persons (such as those who are in wheelchairs or electric carts) who have the capacity to transfer and evacuate themselves in an emergency; do not require routine attendance during nighttime sleeping hours; and are capable of following directions under emergency conditions.

Type A facilities may not admit or retain residents whose needs cannot be met by the facility or for whom necessary services cannot be secured by the resident; or persons who require the services of licensed nurses on a daily or regular basis. People who have a

terminal condition or who are experiencing a short-term, acute episode are excluded from this requirement.

ASSESSMENT AND CARE PLANNING PROCESS

Services are provided according to the individual service plan, which is developed with the resident (or his or her representative), the provider, and DADS case manager.

Type A facilities must complete a comprehensive assessment and an individual plan of care within 14 days of admission. The assessment includes location in the facility; primary language; sleep cycle issues; behavioral symptoms; psychosocial issues; Alzheimer's/dementia history; ADL patterns; activities and interests; cognitive and decision-making skills; communication; continence; nutritional status; oral/dental status; diagnosis; medications; health conditions and possible medication side effects; special treatments and procedures; hospital admissions in the past six months; and preventive health needs.

SERVICES

Providers offer assistance with activities of daily living (ADLs), meal preparation, laundry, and providing or arranging for transportation. Adult foster care providers must provide or make arrangements to meet the transportation needs of a resident for medical appointments/care, shopping for personal needs, and church activities as identified by the caseworker. An escort must be provided if specified in the individual service plan for a resident.

MEDICATIONS

Providers may assist with medications and may administer medications as allowed by state law or regulation. State law allows the delegation of medication administration. Providers must ensure that residents take over-the-counter medications according to the package directions. Excessive use of these medications must be reported to the adult foster care caseworker. All medications are taken as prescribed and in a timely manner according to the instructions on the medication label or instructions from the resident's physician.

Medications in Type A facilities must be administered according to physician's orders. Residents who cannot, or choose not to, self-administer medications must have their medications administered by a person who holds a current license under state law that authorizes him or her to administer medication; or holds a current medication aide permit and acts under the authority of a person who holds a current nursing license. A medication aide functions under the direct supervision of a licensed nurse on duty or on call by the facility; he or she is trained by the nurse and is an employee of the facility to whom the administration of medication has been delegated by the nurse.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

The AFC provider must inform the resident verbally and in writing, before or at the time of admission, of his or her rights and responsibilities, including rules governing resident conduct, complaints, bed hold policies for hospital and personal leave, and eviction procedures.

Type A facilities must provide a copy of the resident bill of rights; policies regarding restraint and seclusion; and a disclosure statement. The written admission agreement must specify the services to be provided and the charges for the services, including any nursing services and supplies, with a statement that such services and supplies could be a Medicare benefit.

PUBLIC FINANCING

As of June 2008, 265 persons were receiving AFC services under HCBS waiver programs. Facilities are reimbursed on the basis of the acuity of residents. Level I residents may require assistance with personal care tasks or nursing tasks, which may require delegation by an RN. Level II residents may require the same personal care tasks or delegated nursing tasks, with the same or greater complexity, as well as a medical condition that requires more skilled tasks. Level III residents have needs that require the services of a registered nurse, licensed vocational nurse, substitute registered nurse, or substitute licensed vocational nurse. Level III residents have a medical disorder or disease, or both, with a related impairment that is so complex or of such seriousness that their care cannot be delegated to an unlicensed person. These residents require timely assessment, planning, and intervention by a licensed nurse on a 24-hour basis.

Texas AFC rates	
Level I	\$19.19 per day
Level II	\$33.10 per day
Level III	\$67.20 per day

STAFFING

Staff must be responsible, mature, healthy adults (18 years or older) who are capable of meeting the needs of the residents in the home. Substitute providers must also meet these requirements; be physically and mentally able to perform all the required duties and tasks; and be able to communicate directly with the resident and the resident's family. Staff may not be related to DADS-funded foster care residents in the provider's care. Staff must demonstrate the ability to read and comprehend the minimum standards for adult foster care, the resident and provider agreements, service plans, and DADS directives. The provider must be the primary caregiver and must live in the same household with the residents; he or she must be the owner or lessee of the adult foster home. Providers must ensure that an approved substitute provider is present in the home if at least one resident remains in the home when the provider plans to be absent for more than 3 hours in a 24-hour period. Residents whose care plans specify the need for 24-hour supervision may not be left without the supervision of an approved substitute provider for any period of time.

Substitute caregivers must receive an orientation from the provider that includes the location of fire extinguishers; evacuation procedures; location of residents' records; location of telephone numbers for the residents' physicians, the provider, and other emergency contacts; location of medications; introduction to residents; and instructions for caring for each resident.

Type A facilities must have staff who are immediately available to residents at night. They must disclose and post their normal staffing pattern to residents and family members.

TRAINING

Providers receive orientation covering the topics listed on the adult foster care orientation checklist and participate in six hours of in-service training annually on topics approved by the AFC caseworker. Ongoing training requirements do not apply to substitute providers. Training on AIDS/HIV and cultural diversity is mandatory during the first year; first aid training must be completed by the second year.

Type A facility managers have to complete at least one 24-hour educational course on management of assisted living facilities; resident characteristics; assessment and working with residents; basic principles of management; food and nutrition services; federal laws; community resources; and ethics and financial management. Managers must have 12 hours of annual training.

Type A staff must complete four hours of orientation on reporting abuse and neglect; confidentiality; universal precautions; conditions about which the manager should be notified; resident rights, and emergency and evacuation procedures.

Staff must also complete 16 hours of on-the-job supervision and training within two days of employment on resident health conditions; safety measures to prevent accidents and injuries; emergency first aid; managing disruptive behavior; and fall prevention. Six hours of annual training is required on a range of topics.

OVERSIGHT AND MONITORING

DHS inspection and survey staff conduct inspections and surveys, follow-up visits, complaint investigations, investigations of abuse or neglect, and other contact visits to licensed assisted living facilities from time to time, as they deem appropriate or as required for carrying out the responsibilities of licensing.

The inspection may be conducted by an individual surveyor or a team, depending on the purpose of the inspection or survey, the size of the facility, the services provided by the facility, and other factors.

UTAH

BACKGROUND

The Department of Human Services, Division of Aging and Adult Services (DAAS) licenses adult foster care. In 1993, the state developed AFC as an adult protective service. However, the state was unable to recruit a substantial number of AFC providers, because people preferred assisted living and other residential options. While the regulations are still in place, the department phased out the AFC program

Web Site	Content
http://www.rules.utah.gov/publicat/code/r501/r501-17.htm#T3	Rules
http://www.hslic.utah.gov/docs/checklist%20-%20adult%20foster%20care.pdf	Licensing checklist

DEFINITION

The state defines **adult foster care (AFC)** as the provision of care in homes that are conducive to the physical, social, emotional, and mental health of disabled or elderly adults who are temporarily unable to remain in their own homes because of abuse, neglect, or exploitation. An AFC facility may not accept more than three unrelated adults. Household composition may be flexible to respond to the needs of each adult and the family or provider.

ADMISSION/RETENTION CRITERIA

An older person had to file a complaint of abuse, neglect, or exploitation to be considered for AFC placement.

ASSESSMENT AND CARE PLANNING PROCESS

Not described.

SERVICES

Daily meals and snacks had to meet the components, quality, and quantity of the Recommended Daily Allowance for adults. The provider offered specialized diets for residents who required them. The AFC home provided or arranged necessary transportation.

MEDICATIONS

Consumers were responsible for administering their own medication. All adult household members responsible for medications had to keep them in a safe and proper place. Only a physician, with notification to the DAAS worker, could prescribe medication for behavior management or restraint.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Not described.

PUBLIC FINANCING

The program was funded through a mixture of public financing and private pay. Rates were determined annually, based on the child foster care rate, the actual costs of human services, and the cost of finding providers.

STAFFING

Providers had to be emotionally stable and responsible persons 21 years or older. Both legally married couples and single persons could be adult foster care providers, as long as they were in good health and able to provide physical and emotional care to the residents. Providers had a physical examination by a medical practitioner at initial licensing and self-certified their personal physical condition annually. Providers had to have sufficient income to maintain the family and shall not depend solely on the foster care payment.

TRAINING

Not described.

OVERSIGHT AND MONITORING

The department reviewed the provider's license annually. Quality issues arising in AFC homes had a contract monitor assigned to the case.

VERMONT

Assisted living and residential care home rules regulate facilities that serve three or more residents.

Web Site	Content
http://www.dad.state.vt.us/Regulations/AssistedLivingRegsFinal.pdf	Assisted living rules
http://dail.vermont.gov/dail-statutes/statutes-dlp-documents/rch-licensing-regulations	RCF rules
http://www.dad.state.vt.us/ltcinfo/alhome.htm	List

DEFINITION

An **assisted living residence (ALR)** is a program or facility that combines housing, health, and supportive services to support resident independence and aging in place. At a minimum, ALRs shall offer, in a homelike setting, a private bedroom, private bath, living space, kitchen capacity, and a lockable door. Assisted living shall promote resident self-direction and active participation in decision making, while emphasizing individuality, privacy, and dignity.

Assisted living residences must meet the applicable licensing requirements of the residential care home licensing regulations for a Level III home, and all ALR units must also meet the definition for assisted living residences above.

The licensing agency—using the same criteria and procedures set forth in the residential care home licensing regulations—may grant variances in the regulations.

A **residential care home (RCH)** is a place (excluding licensed foster homes) that provides, for profit or otherwise, room and board and personal care to three or more residents unrelated to the licensee. Level III homes are licensed to provide room and board, personal care, general supervision, medication management, and nursing overview. Level IV homes do not provide nursing overview.

ADMISSION/RETENTION CRITERIA

Assisted living residences: Persons 18 years and older may be admitted except in the event of the following conditions:

- A serious acute illness requiring medical, surgical, or nursing care provided by a general or special hospital.
- Ventilators.
- Respirators.
- Care of stage 3 or 4 pressure sores.
- Nasopharyngeal, oral, or tracheal suctioning.
- Two-person assistance to transfer from bed or chair or to ambulate.

Current residents who develop a serious acute illness may be retained as long as their care needs can be met by appropriate licensed personnel. Facilities must provide personal care and nursing services to meet a resident's needs if he or she has an ADL score of 10, provided that the resident's needs can be met by one staff person at a time; any cognitive impairment of a moderate or lesser degree of severity; and any behavioral symptoms that consistently respond to appropriate intervention.

Residents may be involuntarily discharged only if they pose a serious threat to themselves or other residents that cannot be resolved through care planning and are not capable of entering into a negotiated risk agreement; are ordered by a court to move; fail to pay rent or service or care charges; refuse to abide by the terms of the admission agreement; or have care needs beyond the mandatory scope of aging in place, and the assisted living residence can no longer meet the resident's level-of-care needs or has a policy to discharge residents with such needs.

Residential care homes: Residential care homes may retain people who need nursing services beyond nursing overview and medication management if the following conditions are met:

- The services are received less than three times a week or are provided seven days a week for no more than 60 days, and the resident's condition is improving.
- The home has an RN on staff or a contract with a home health agency,
- The home is able to meet the resident's needs without detracting from services to other residents,
- There is a written agreement concerning which nursing services the home provides or arranges, and this is explained to the resident before admission or at the time of admission. The agreement includes how services are paid for and the circumstances under which a resident will be required to move.
- Residents are fully informed of their options and agree to such care in the residential home.

Residents who require intravenous therapy, ventilators or respirators, daily catheter irrigation, feeding tubes, care of stage 3 or 4 decubitus ulcers; suctioning; or sterile dressings may be served only under a variance from the Department of Disabilities, Aging and Independent Living. Variances are considered on a case-by-case basis. A series of requirements are described for facilities that provide nursing overview, administration of medications, and nursing care.

ASSESSMENT AND CARE PLANNING PROCESS

A resident care plan must be developed and maintained that describes the assessed needs and choices of the resident and that supports the resident's dignity, privacy, choice, individuality, and independence. The plan is reviewed at least annually, or upon a significant change in condition. "Negotiated risk" means a formal, mutually agreed upon, written understanding that results after balancing a resident's choices and capabilities with the possibility that those choices will place the resident at risk of harm.

SERVICES

Assisted living residences provide services required for Level III residential homes, plus—

- A program of activities and socialization opportunities, including periodic access to community resources.
- Social services that include information, referral, and coordination with other community programs and resources.
- A negotiated risk process.

Residential care homes provide personal care, medication management, laundry, meals, toiletries, transportation, and, in Level III homes, nursing oversight. Nursing oversight means a process in which a nurse ensures that the health and psychosocial needs of the resident are met. The process includes observation, assessment, goal setting, education of staff, and the development, implementation, and evaluation of a written individualized treatment plan to maintain the resident's well-being.

Intravenous therapy; ventilators or respirators, daily catheter irrigation, feeding tubes, care of stage 3 or 4 decubitus ulcers, suctioning, and sterile dressings may not be provided to any resident unless a variance is approved by the state licensing agency.

MEDICATIONS

Residential care homes and assisted living residences provide assistance with self-administration of medications and administer medications under the supervision of and the delegation by registered nurses. Each residence must have a policy on the procedures for delegation of administration; how medications will be obtained, including choice of pharmacies; and documentation procedures. Trained staff must be designated to assist with or administer medications.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Assisted living residences must disclose policies, services, and rates on a standard disclosure form and in resident agreements. The Uniform Consumer Disclosure describes the services the ALR provides, the services it does not provide, public programs or benefits it accepts, policies that enhance or limit aging in place, and any physical plant features that enhance or limit aging in place. The disclosure includes service packages, tiers and rates, and a statement that rates may change in response to increased needs, with an explanation of the situations that would lead to an increase.

A licensee who has specialized programs such as dementia care shall include a written statement of philosophy and mission, and a description of how the assisted living residence can meet the specialized needs of residents. This must be included in the admission agreement and in the Uniform Consumer Disclosure.

Negotiated risk is a formal, mutually agreed upon, written understanding that results after balancing a resident's choices and capabilities with the possibility that those choices will place the resident at risk of harm. Negotiated risk does not constitute a waiver of liability. The enhanced residential care (ERC) home Medicaid waiver for Level III and assisted living providers includes standards covering negotiated risk, which is defined as

“allowing residents choices in accepting certain risks.” The resident, case manager, provider, and family members negotiate these choices.

For residential care homes, agreements are required before or at the time of admission that include the daily, weekly, or monthly rate charged; the services covered in the rate; all other applicable financing issues, including discharge or transfer if the resident’s status changes from private pay to SSI or assisted community care services (ACCS); and how services will be provided. The agreement also covers transfer and discharge rights, the amount and purposes of any deposits, and the refund policy. On admission, the facility must determine whether the resident has an advance directive and must explain his or her right to formulate or not formulate a directive.

Resident agreements for Level III and assisted living providers who participate in the ACCS program must disclose the provider’s policy about accepting SSI or ACCS payments. The decision to accept SSI or ACCS payments may be made on a case-by-case basis. Additional items are included in the agreements with ACCS participants: ACCS services, room and board rate, personal needs allowance amount, and the provider’s agreement to accept room and board and Medicaid as the sole payment.

PUBLIC FINANCING

The Department of Disabilities and Independent Living (DAIL) supports people in Level III residential care homes and assisted living residences through the Choices for Care demonstration and the Medicaid state plan. Choices for Care, a Section 1115 demonstration program, replaced the home and community-based and enhanced residential care waivers on October 1, 2005. The programs included under this demonstration are home-based supports, enhanced residential care, nursing facility services, flexible choices, and Program for All-Inclusive Care for the Elderly (PACE). Participants are assigned to one of three groups on the basis of an assessment: highest needs, high needs, and moderate needs. In early 2007, there were 4,073 participants: 2,134 in nursing homes; 1,171 highest and high needs, and 521 moderate needs in HCBS; and 247 in ERC.

The Medicaid state plan payment covers assistive community care services (ACCS) which includes nursing overview, personal care, health, rehabilitative, and supportive services for a standard per diem rate. The current reimbursement rate is \$33.25 a day. ACCS reimburses providers for the care of persons below the nursing level of care. Choices for Care serves people in residential settings who qualify for admission to a nursing facility.

Payments to Choices for Care providers are based on a three-tiered system that was developed using the ERC assessment tool, a review of other state reimbursement systems, and assessment data. Residents receive scores in five areas: ADLs, bladder and bowel control, cognitive and behavior status, medication administration, and special programs (behavior management, skin treatment, or rehabilitation/restorative care). Residents are assigned to a level (I or II) depending on the extent of their ADL impairments. Scores of 6–18 are assigned to Level I, and scores of 19–29 are assigned to Level II. The four remaining areas are rated and additional points are assigned. The payment tier is determined by combining the ADL level and the additional points. The rates are Tier I—\$47 a day for an RCH and \$53 for an ALR; Tier II—\$53.50 and \$58.50; and Tier III—\$60 and \$65. In addition to the ERC reimbursement, providers receive an ACCS daily rate of \$33.25. Room and board is limited to the amount of the federal SSI benefit (\$623 a month in 2007). The state supplement for personal needs is \$47.76.

STAFFING

Residential care homes and assisted living residences are required to employ a manager or administrator who works in the facility an average of 32 hours a week (including any time worked providing care or services, and including vacation and sick time).

Assisted living residences must employ sufficient staff to meet the needs of each resident. At least one personal care assistant must be on duty at all times. A registered nurse shall be employed to oversee implementation of service plans, conduct nursing assessments, and provide health services. The RN shall be onsite to the extent necessary to achieve the outcomes specified in the individual service plans.

Residential care homes must have a sufficient number of qualified staff to meet resident needs.

TRAINING

Residential care home administrators. Managers must complete a state-approved certification course.

Assisted living residence administrators. The director must be at least 21 years old and have demonstrated experience in gerontology and supervisory and management skills. Directors shall have evidence of 15 hours of training a year on assisted living and its principles, and the care of elderly and disabled persons.

Residential care home staff. Staff must receive 20 hours of training each year that includes procedures in case of fire; resident rights; and mandatory reporting of abuse, neglect, and exploitation. Training in direct care skills may be provided by a nurse.

Assisted living residence staff. All staff must be trained in the philosophy and principles of assisted living. Staff who serve residents with dementia must have training in communication skills specific to dementia.

OVERSIGHT AND MONITORING

Residential care homes and assisted living residences. The state works with RCHs and ALRs to help them comply with the regulations. The state conducts surveys at the time of application/license issuance and at least annually thereafter. The state investigates complaints, issues notices of violation of law or regulation, and requires corrective action plans to be submitted and implemented. The state may levy sanctions. The state will take “immediate enforcement action to eliminate a condition which can reasonably be expected to cause death or serious physical or mental harm to residents or staff.” Enforcement actions may also include administrative (money) penalties; action against a licensee (suspension, revocation, modification, or refusal to renew); suspension of admissions; or transfer of residents. The licensing agency and the ombudsman conduct monitoring activities.

Assisted living residences. Facilities must have a quality improvement process that includes an internal committee of the director, an RN, a staff member, and a resident. The committee must meet at least quarterly. Resident satisfaction surveys must be conducted annually and used by the committee.

VIRGINIA

BACKGROUND

The Adult Services Unit of the Department of Social Services (DSS) regulates adult foster care. It is described as a locally optional program that provides room and board, supervision, and special services to an adult who has a physical or mental health condition. The regulations apply to providers approved by county or city social services agencies. DSS issued a survey to local agencies in 2008 to identify the number of programs in the state and their capacity. About 16 areas offer adult foster care. Insufficient staff capacity in local DSS agencies to recruit providers, screen participants, and monitor care were identified as barriers to growth. DSS is considering efforts to expand interest in the program by determining why some local areas do not offer the program, preparing recruiting materials, and supporting peer-to-peer assistance.

Web Site	Content
http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+22VAC40-771-10	Rules

DEFINITION

Adult foster care is room and board, supervision, and special services to an adult who has a physical or mental condition or an emotional or behavioral problem. A single provider may provide adult foster care for up to three adults.

An **adult foster care provider** is a person who offers room and board, supervision, and special services in his or her own home for up to three adults who are unable to remain in their homes because of a physical or mental condition, or an emotional or behavioral problem. Care provided for more than three adults requires licensure by the Virginia Department of Social Services as an assisted living facility.

ADMISSION/RETENTION CRITERIA

Admission or retention of a person in an adult foster care home is prohibited if the person's care needs cannot be met by the provider as determined through an assessment by the adult services worker or the person's physician.

ASSESSMENT AND CARE PLANNING PROCESS

Social workers from local DSS offices, Area Agencies on Aging, or other organizations complete an assessment before or shortly after admission to ensure that the resident is appropriate for the level of care provided by the home.

SERVICES

AFC homes are responsible for providing a furnished room in a home that meets applicable zoning, building, and fire safety codes; housekeeping services based on the resident's needs; nutritionally balanced meals and snacks, including extra portions and special diets as necessary; clean bed linens and towels at least once a week or as needed; assistance with personal hygiene, including bathing, dressing, oral hygiene, and shampooing, shaving, and care of toenails and fingernails; care of clothing; arranging for

haircuts as needed; and care of needs associated with menstruation or occasional bladder or bowel incontinence. The homes are also responsible for assistance with the following: care of personal possessions and of personal funds, if requested by the resident and the home's policy permits it; use of telephone; arranging transportation; obtaining necessary personal items and clothing; making and keeping appointments; correspondence; securing health care and transportation when needed for medical treatment; social and recreational activities as required by the local department and consistent with licensing regulations; and general supervision for safety.

MEDICATIONS

Not described.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Not described.

PUBLIC FINANCING

The auxiliary grant program covers services; this program is a state supplement to the federal SSI payment to residents in assisted living and adult foster care homes. Before being admitted to an assisted living facility or an adult foster care home, the person is assessed by the local DSS to determine eligibility and level of care. The auxiliary grant covers room and board; minimal assistance with personal hygiene; medication administration as required by licensing regulations, including insulin injections; and generic personal toiletries. It also covers minimal assistance with the following: care of personal possessions; care of personal funds, if requested by the recipient and residence policy allows it; use of telephone; arranging transportation; obtaining necessary personal items and clothing; making and keeping appointments; and correspondence. Providers must also secure health care and transportation when needed for medical treatment, and must provide social and recreational activities as required by licensing regulations. The maximum auxiliary grant is \$1,226 a month in northern parts of the state and \$1,075 in the rest of the state. Residents retain a personal needs allowance of \$77 a month.

STAFFING

A responsible adult or approved assistant must be available to provide appropriate care for residents in case of an emergency. The local department of social services must approve any substitute arrangements the provider makes for absences of more than one day. The provider must ensure that adequate care and supervision are provided to residents and that their health, safety, and well-being are protected.

TRAINING

The local DSS provides basic orientation. Other training may be required but is not described. AFCs must provide at least two references from unrelated persons who have knowledge of the provider's ability, skill, or experience in the provision of services. Providers are assessed by the local DSS office through interviews, references, and employment history to ensure that there are knowledgeable about and physically and mentally capable of providing the necessary care for residents; able to sustain positive and constructive relationships with adults in care, and to relate to them with respect, courtesy, and understanding; capable of handling emergencies reliably and with good

judgment; and able to communicate and follow instructions sufficiently to ensure adequate care, safety, and protection for residents.

OVERSIGHT AND MONITORING

Home visits are made at least semi-annually, more often if necessary. Provider monitoring includes interviews with residents. Providers may be approved for up to 24 months if they meet the standards.

WASHINGTON

The state licenses adult family homes that serve two to six residents. Adult family homes began in the mid-1970s as an alternative to nursing homes. Owners caring for a relative in a large home began caring for a second elder who was not related to the owner. Providers were recruited through radio, television, and newspaper advertisements, and outreach through local community organizations. Recently, the state organized community meetings to inform potential providers about the program.

The Aging and Disability Services Administration Web site has numerous tools for consumers and providers. The site includes department letters to providers on pertinent issues, a manual describing monitoring principles and procedures, results from provider surveys of their satisfaction with the inspection process, the admission agreement, information about the 48-hour training requirements and a list of trainings that must be completed before a license to operate a home is, dates and locations of orientation classes, information about background checks, and links to reports on the most frequently cited deficiencies.

There are 2,747 licensed adult family homes in the state, with a capacity of 15,205 beds. Forty percent of the homes are operated by live-in providers.

Web Site	Content
http://apps.leg.wa.gov/WAC/default.aspx?cite=388-76	Rules
http://www.aasa.dshs.wa.gov/professional/afh.htm	Provider resources, facility database
http://www1.dshs.wa.gov/pdf/Publications/22-707.pdf	Consumer guide

DEFINITION

An **adult family home (AFH)** is a residential environment in which a person or entity is licensed to provide personal care, special care, and room and board to two to six adults who are unrelated to the person providing services.

ADMISSION/RETENTION REQUIREMENTS

Adult family homes may admit or continue to provide services to a person only if the home can safely and appropriately meet the assessed needs and preferences of the person with available staff and through reasonable accommodation. In addition, adult family homes may admit the resident only if the admission does not negatively affect the ability of the home to meet the needs of other residents, endanger the safety of other residents, or affect the safe evacuation all people in the home in an emergency.

Licensees must review the admission agreement with the prospective resident. Each resident must have an assessment that reflects his or her current status and a negotiated service plan, based on assessed needs, that identifies and establishes the type and quantity of services and care required. The home may have to discharge the resident if the health or physical condition of the resident changes, and the home can no longer safely meet the person's needs or safely evacuate everyone in an emergency, or the resident is at risk of endangering the life of him- or herself or others.

ASSESSMENT AND CARE PLANNING PROCESS

The provider of the adult family care home is required to develop a negotiated plan of care based on the resident assessment and preliminary service plan within 14 days from admission. The home must involve the resident, possibly the resident's family, professionals involved in the resident's care, and the case manager if the resident is receiving care and services paid for by Medicaid. Each care plan must include a list of services to be provided; who will provide the care and services; when and how the care and services will be provided; medication management, including how the resident will receive his or her medications if her or she is not in the home; the resident's activities preferences and how they will be met; other preferences and choices important to the resident, such as diet, daily routine, and grooming. The plan describes procedures to follow in the event of a crisis, for reducing tension or problem behaviors, and in responding to refusal of care or treatment. The plan identifies any communication barriers and how the home will overcome them with alternative communication techniques, the amount of time a resident may be left alone, and hospice care plan if the resident is receiving services from a licensed hospice agency.

SERVICES

Residents must have access to the highest level of physical, mental, and psychosocial care that supports choice and maintains or improves quality of life. If a home admits a resident with nursing care needs and cannot provide that care, it must contract with a registered nurse to provide the resident with services and care. Other required services include laundry services and three nutritional meals a day that meet a resident's preferences and dietary restrictions; social and recreational activities; and transportation to medical and social appointments.

MEDICATIONS

Regulations allow residents to self-administer medications. A person may request self-administration with assistance. A nonpractitioner may assist in the preparation of medications for self-administration if a practitioner has authorized the assistance as necessary and appropriate. Providers may also administer medications and deliver special care if they are legally authorized (e.g., a nurse, pharmacist, or physician). A licensed nurse may delegate specific nursing tasks to assistants who meet training requirements and successfully complete an evaluation. Registered nurse delegators must ensure that the resident is in a stable and predictable condition before delegating the administration of medications. Nurse delegators are not permitted to delegate the administration of: medications by injection, sterile procedures, central line maintenance, or acts that require nursing judgment. Adult family homes are responsible for establishing health care procedures for residents, including medication administration and emergency medical care. Providers must document medications given and keep medication records up to date. In 2008, the legislature passed a bill that allows delegation of insulin injections under specific conditions and circumstances. The state anticipated that the requirements and processes for the delegation of insulin medications would be implemented in 2009.

RESIDENT AGREEMENT/DISCLOSURE/CONTRACT

Adult family homes that require payment of an admissions fee, a deposit, or a minimum stay fee must give the resident full written disclosure including a statement of the amount

of the admissions fee, deposits, prepaid charges, or minimum stay fees; the home's advance notice or transfer requirements; and the amount of the fees and charges that will be refunded if the resident leaves the home.

The provider must inform residents, both orally and in writing, of all the rules and regulations of the home before the resident signs an agreement with the home. The adult family home must give each resident a description of his or her rights that includes a description of how the provider will protect personal funds and property, and a statement informing residents how they can file grievances and complaints.

Before admission, and at least every 24 months after admission, the provider must review availability of and charges for services, items, and activities not covered by the per diem rate. Agreements must include the basic rental rate, services, items, and activities included in the per diem rate; those offered at an additional cost; payment policy; deposit and refund policy; policy for rate changes; and termination and transfer policies. Unless there is an emergency, the provider must give at least a 30-day notice of any changes to charges or availability of services.

PUBLIC FINANCING

Services in adult family homes are covered by two federal HCBS waivers and the state plan. AFHs provide assistance with ADLs and IADLs, supervision, and nurse delegation; and may be designated to provide specialty care for people with mental illness, dementia, or developmental disabilities. The state uses a 17-level rate structure for waiver services provided in adult family homes and boarding home/assisted living settings (see below). A case manager conducts a comprehensive assessment to measure the level of need and the appropriate rate tier. A computer program reviews the assessment and determines the resident's level and payment amount. The rates include room and board, which is paid by the resident. About 2,400 facilities contract with Medicaid, and 39 percent of all residents are Medicaid beneficiaries. AFHs serve an average of 4,300 Medicaid beneficiaries each month.

ADSA -AFH rates July 1, 2008			
Classification	Daily Rate		
	Nonmetro counties	King County	Metro Counties
A Low (1)	\$48.32	\$48.32	\$48.32
A Medium (2)	\$51.58	\$54.83	\$52.66
A High (3)	\$57.01	\$61.35	\$58.08
B Low (4)	\$48.56	\$48.56	\$48.56
B Medium (5)	\$57.29	\$61.66	\$58.37
B Medium high (6)	\$61.38	\$66.06	\$62.60
B High (7)	\$69.42	\$75.53	\$73.40
C Low (8)	\$51.58	\$54.83	\$53.05
C Medium (9)	\$65.70	\$70.02	\$68.31
C Medium high (10)	\$81.98	\$91.73	\$85.23
C High (11)	\$85.52	\$93.01	\$90.43
D Low (12)	\$66.01	\$71.38	\$69.80
D Medium (13)	\$80.39	\$87.36	\$85.01
D Medium high (14)	\$96.37	\$105.12	\$101.92
D High (15)	\$109.48	\$119.69	\$115.79
E Medium (16)	\$131.92	\$144.63	\$139.53
E High (17)	\$154.36	\$169.57	\$163.27

STAFFING

Sufficient staff must be available and must have the skills and abilities to meet the needs of residents. Providers must be at least 21 years old and have a high school diploma or the equivalent. They must have at least 320 hours of direct care experience serving vulnerable adults in a licensed or contracted setting.

TRAINING

Prospective providers must attend a department orientation class before applying for a license. The orientation class provides information about the state's long-term care system, the role of adult family homes, and the characteristics of older adults served in these settings. The class also gives information about resident rights and the services and supports that must be provided to help people with ADLs and other needs, such as meals, housekeeping, transportation, access to health and medical services, security and staff availability, medication management, personal laundry services, and social and recreational services. The licensing process, requirements and provider standards are also covered in the class.

The prospective provider must successfully complete a department-approved business and planning class before the initial licensing inspection is scheduled. Both the applicant and the home must meet the licensing requirements in order to pass the inspection and obtain a license. The department requires 48 hours of class time related to management of an adult family home, including these topics: business planning and marketing; fiscal planning and management; human resource planning; resident health services; nutrition and food service; working with people who are elderly, chronically mentally ill, or developmentally disabled; the licensing process; social and recreational activities; resident rights; legal issues; physical maintenance and fire safety; and housekeeping. Operators of adult family homes who were licensed before this class became a

requirement in December 2006 and who want to operate more than one home must complete the 48-hour program.

Direct care staff must complete an orientation that covers specific topics: the care setting, characteristics and special needs of the population served, fire and life safety, communication skills, universal precautions and infection control, resident rights, and safe food handling. Basic training is arranged by the provider, using a curriculum approved by the Aging and Disability Services Administration. Staff must also receive 10 hours of annual training on a topic that is relevant to the care setting, such as resident rights, personal care, mental illness, dementia, developmental disabilities, depression, medication assistance, communication skills, positive resident behavior support, resident-centered activities, dealing with wandering or aggressive behaviors, medical conditions, and safe food handling.

OVERSIGHT AND MONITORING

Before a home provider is licensed by the department, it must pass an inspection. The department also inspects the home at least every 18 months thereafter. The department may allow a home to continue operations without inspection for two years if it has had no violations for the previous three consecutive inspections and no violations resulting from complaints. The licensing agency makes unannounced inspections and complaint investigations to ensure that providers are in compliance with licensing regulations. The department must mail or deliver a report to the provider within 10 working days of the inspection. A home with deficiencies or violations must correct them by a date acceptable to the department and must inform the department within 10 working days. A home is not required to renew its license each year unless the department takes significant enforcement action, the home closes or relinquishes its license, or fails to pay licensing fees. The license is nontransferable; it is valid only for the provider and at the address listed on the license.

WEST VIRGINIA

BACKGROUND

The Department of Health and Human Resources (DHHR), Bureau of Children and Families certifies adult family care (AFC) homes. The department is responsible for training and approving providers. Outreach and monitoring occur at the regional level. In 2008, there were 271 licensed homes with a capacity of 372 beds.

County departments are responsible for recruiting new AFC providers. Regional home finders/social workers develop a recruitment campaign that identifies the number of homes needed; develop information to be disseminated within the community to create interest in the program; and implement a recruitment campaign. The supply of providers has remained stable over time, but providers are beginning to age and drop out of the program.

The role of the home finder is to recruit providers, conduct background checks, and approve homes. Supply varies from region to region. Recruitment campaigns are developed and implemented at the county level. The *Social Services Manual* specifies specific effective approaches to market and disseminate programmatic information. Each region runs recruiting days dedicated to active outreach into the communities. Home finders use newspapers (columns, feature stories, letters to the editors, and advertisements); radio (30-second spots, interviews/discussion programs); television; church groups; civic groups; and existing AFC homes to increase awareness and supply.

The department and the State Board of Risk and Insurance Management provide liability and property damage insurance protection for AFC providers. The insurance is not intended to replace any existing property or liability insurance. The general liability insurance is limited to \$1 million per occurrence. The insurance protects the department and the provider's employees from negligent acts of the resident that cause injury or damage. Property insurance protects the provider in the event of property loss caused by a resident. Each loss is subject to a \$2,000 deductible, with the provider responsible for \$300.

AFC providers are eligible for a \$1,000 incentive payment if they help a resident improve and enable him or her to return home.

Web Site	Content
http://www.wvdhhr.org/bcf/children_adult/ars/policy.asp	Policy manuals

DEFINITION

An **adult family care home** is a placement setting within a family unit that provides support, supervision, and assistance to up to three persons over the age of 18 in a family setting.

ADMISSION/RETENTION CRITERIA

Residents must be 18 years or older and have a disability established by a physician or be over the age of 65 years and in need of supportive living.

ASSESSMENT AND CARE PLANNING PROCESS

Before a person is admitted to an AFC, the social worker must perform an assessment to gain an understanding of the person's needs, abilities, strengths, and goals. The information gathered during the initial assessment identifies any risks to the person's well-being and safety; necessity and desirability of AFC services; and the role the department will play beyond the initial assessment. The assessment process requires a short-term service plan if the case is opened for any social service or if follow-up is required. A short-term plan is primarily intended to allow the caseworker to document the tasks the agency implements until the initial assessment is complete.

The information gathered during the initial assessment carries forward into the comprehensive assessment. The social worker use the information gathered in the comprehensive assessment as the basis of the resident's service plan. The resident, provider, and family members are interviewed to gather information about demographics, services required, resident functioning, living arrangements, mental/emotional health, financial status, employment status, and legal status. The conclusions of the comprehensive assessment and the service plan developed from them are tracked in the Family and Children's Tracking System (FACTS).

Once a person has been approved for AFC services, the case manager is responsible for advising the resident of the approval; matching the resident with a provider; arranging preplacement visits with the provider; presenting information to the provider about the resident's medical, mental, and functional status (and any other information the provider needs to meet the resident's needs); arranging for moving the resident to the AFC home; arranging for a complete medical evaluation; explaining the payment process; completing all FACTS documentation; reviewing the completed payment agreement; assessing the resident's need for clothing; sending Medicare Part D information when the resident is 64 years and 9 months old; arranging for additional services as needed; and reviewing and monitoring the case. The home finder/social worker reviews the service plan every six months, or whenever the resident's health status changes.

SERVICES

The provider is responsible for obtaining any necessary medical care for the residents placed in the home and for notifying the social worker of any significant changes in a resident's physical, emotional, or mental health. Homes provide assistance with personal care and grooming.

MEDICATIONS

With approval from a registered nurse, adult family home providers and staff may administer medication to residents if they have been trained—and retrained every two years. Trained providers and staff have a limited scope of practice. They may not give injections or parenteral medications; may not administer irrigations or debriding agents in the treatment of skin; and may not accept new medication orders verbally. Untrained providers are responsible for supervising the self-administration of medication. This personal care service includes reminding residents to take medications, opening medications, reading labels to residents, observing residents while they take medication, checking the dosage against the label, and reassuring residents that they are taking the medications and dosage prescribed for them.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Payment agreements must be completed within five days of placement that describe the terms and the amount of payment due the provider and payable by the resident and/or the department. Payments include the amount for a full month of care; the daily rate for a partial month's care; the portion of the monthly payment and/or daily rate that is to be paid by the resident; the portion of the monthly payment and/or daily rate that is to be paid by the department; and the amount, if any, the provider must give the resident as a personal expense allowance.

PUBLIC FINANCING

The state uses Title XX Social Services Block Grant funds to pay the difference between a resident's income (minus the personal needs allowance of \$113) and \$861 for monthly room and board and services. The Block Grant includes a biannual clothing allowance of \$75 and incentive payments. In the past, the low payment rate was a barrier to recruiting providers. The legislature recently increased the reimbursement rate from \$831 to \$861 a month.

The state supplement—\$224—is supplied through the Block Grant. There are currently 372 residents and 271 providers. Ninety percent of residents are Medicaid beneficiaries.

STAFFING

Home finders are required to perform background checks on the providers and other adult family members to ensure that there is no criminal history. The applicant is required to submit personal and credit references. Interviews are required with the applicant, family members, and one of the personal references.

TRAINING

The home finder is responsible for arranging or providing training for providers. Providers must participate in at least six hours of training before they accept residents. The home finder, during the home study, may provide three of these hours. Topics include program guidelines, legal rights and responsibilities of the resident and provider, record keeping, confidentiality, crisis intervention, nutrition, CPR, first aid; medication, effects of institutionalization, the aging process, and end-of-life care. Providers are required to participate in at least two hours of ongoing training each quarter and may be eligible to receive a training incentive payment. Topics include nutrition; first aid; CPR; safety in the home; basic health care; medication; behavior management; meal planning and budgeting; fire prevention and safety; resident activities, both recreational and therapeutic; sanitation; using community resources; use of volunteers; topics that address specific needs or concerns; and topics of interest identified by DHHR staff or the provider.

OVERSIGHT AND MONITORING

Home finders complete annual provider reviews. In addition to the annual review, the home finder must conduct an onsite visit with the provider at least every six months. The review includes a discussion of: changes in family composition; changes in financial resources; changes in the health of the provider or a family member; the provider's feelings about being an adult family care provider; the resident's adjustment to the AFC home; the provider's ability to adequately care for the residents' needs; the provider's cooperation with DHHR; complaints received about the home; change in location of the home; expectations and requirements for a provider; and goals for the upcoming year.

WISCONSIN

BACKGROUND

In Wisconsin, licensure or certification requirements for adult family homes depend on the size of the home. The Department of Health and Family Services (DHFS) sets standards for adult family homes that serve one or two residents and are certified by counties. Within DHFS, the Division of Quality Assurance licenses adult family homes that serve three or four residents. Adult family homes were established in 1954 as a residential resource for persons with mental illness. In the late 1960s, one county received a grant to expand foster care for children to serve adults. Counties were responsible for developing standards. Following a review of the state’s home and community-based services (HCBS) Medicaid waiver in 1989, the Centers for Medicare and Medicaid Services (CMS) required that the state agency develop consistent standards for adult family homes to ensure the health and welfare of waiver participants. Smaller adult family homes primarily serve persons with developmental disabilities.

The supply of licensed adult family homes increased from 675 homes with a capacity of 2,629 beds in 2001 to 1,145 homes with the capacity to serve 4,414 persons in January 2008. Homes may serve multiple populations. About 25 percent of the licensed homes serve older adults. Most licensed homes serve persons with developmental disabilities. In 2008, there were 1,413 certified homes with 2,293 beds.

Some certified homes become licensed when counties require additional resources and ask smaller homes to increase their capacity. The supply has expanded primarily through word of mouth. State informants noted that the IRS exemption of income from public sources (Title 26, §131) offers an incentive for individual providers to participate.

Web Site	Content
http://dhfs.wisconsin.gov/bdds/waivermanual/app_j.htm	Certification standards
http://dhs.wisconsin.gov/rl_dsl/AdultFamilyHomes/AFHregs.htm	Rules, resources
http://www.legis.state.wi.us/rsb/code/dhs/dhs088.pdf	Licensing rules
http://dhfs.wisconsin.gov/rl_DSL/Publications/07-018.htm	Self reporting
http://dhs.wisconsin.gov/bqaconsumer/AssistedLiving/AsLivindex.htm	Provider profiles (survey results)
http://dhfs.wisconsin.gov/rl_DSL/AdultFamilyHomes/AFHintro.htm	Provider resources

DEFINITION

A **licensed adult family home** is a place where three or four adults not related to the licensee reside and in which care, treatment, or services above the level of room and board but not including nursing care are provided to residents as a primary function of the place. This definition does not cover a convent; a facility or private home that provides care, treatment, or services for victims of domestic violence; a shelter facility; or a lodging facility.

A **certified adult family home** is a sponsor’s residence in which care above the level of room and board is provided primarily by the sponsor to one or two adult residents; in

some counties, it may be a residence in which one or two adults reside and receive care, treatment, or services above the level of room and board. The certified provider owns, rents, or leases the residence and employs staff who provide care and services. The adult family care home is not the provider's primary domicile.

ADMISSION/RETENTION CRITERIA

Licensed facilities submit a program statement that describes the number and types of percents they are willing to accept and whether the home is accessible to persons with mobility problems. The statement includes a brief description of the home, its location, services available, who provides them, and community resources available to residents of the home. Homes may not serve residents who need more than seven hours of nursing care a week. The transfer and discharge criteria are included in the admission agreement.

ASSESSMENT AND CARE PLANNING PROCESS

Licensed home: An assessment and service plan must be completed within 30 days of admission. The assessment identifies the person's needs and abilities in the areas of ADLs; medication; health status; level of supervision required; vocational, recreational, and social activities; and transportation needs. The service plan describes the services that will be provided to meet assessed needs, identifies the level of supervision required in the home and community; describes services provided by outside agencies, and states who will monitor the plan. Plans are reviewed at least every six months.

Certified home: The care manager is responsible for coordinating services, completing all documents associated with placement (unless otherwise specified), planning, and placement. In homes that serve private pay residents and where there might not be a care manager, the sponsor assumes these responsibilities unless other arrangements are made. Before placement, the care manager—along with the prospective resident and his or her guardian, if any—determines whether the adult family home will meet the person's needs and preferences. This assessment may be in conjunction with the assessment required by all Medicaid waiver programs. In emergency situations, the assessment may be completed not more than seven working days after placement. At a minimum, the assessment identifies the person's needs, abilities, and preferences in the following areas: ADLs and IADLs; medications; current health status, and health maintenance needs; level of supervision required in the home and community; behavior support needs, if any; work, vocational program participation, or day time activities; recreational and social activities; and transportation.

Before placement, the care manager makes sure that the prospective resident has an opportunity to meet other residents, household members, and the sponsor, and to spend time at the home before entering into an agreement for services. This may include both daytime visits and overnight stays. Before or upon admission, the resident, the resident's guardian (if any), the care manager, and the adult family home sponsor develop a service plan.

The describes how all the needs and preferences identified in the placement assessment will be met by the adult family home or by other providers who come to the home to provide services and supports to residents; identifies how the resident will obtain access to community activities and services; describes other service providers who interact with the adult family home and how their services will be coordinated for the resident; and

describes any personal housekeeping the resident agrees to perform or, if applicable, any compensated work the resident has agreed to do for the sponsor, including the terms of compensation. The service plan in certified homes is reviewed by the care manager at least once every six months.

SERVICES

Licensed: Services aim to assist, teach, and supporting the resident to promote his or her health, well-being, self-esteem, independence, and quality of life. The services may include but are not limited to these:

- Supervising or assisting a resident with or teaching a resident about activities of daily living.
- Providing, arranging, transporting, or accompanying a resident to leisure and recreational activities, employment, and other activities identified in the resident's individual service plan.
- Providing, arranging, transporting, or accompanying a resident to medical or other appointments as part of the resident's individual service plan.
- Maintaining an up-to-date record of all medical visits, reports, and recommendations for a resident.
- Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary.

Licensees may arrange or provide no more than seven hours of nursing care per week.

Certified: The home provides a safe, emotionally stable environment that encourages a resident's autonomy; addresses a resident's need for physical and emotional privacy; and takes a resident's preferences, choices, and status as an adult into consideration while providing care, services, and supervision. The sponsor plans activities and services for the residents to accommodate their individual needs and preferences, and provide opportunities for the residents to participate in cultural, religious, political, social, and intellectual activities of their choice at home and in the community. A sponsor may arrange for or, if qualified, provide nursing care to residents if the care is needed and is specified in the service plan. A physician's written authorization shall be obtained if required.

MEDICATIONS

Licensed: Providers may assist with medications by helping to securely store the medication and ensuring that the resident takes the correct dose at the correct time and communicates effectively with his or her physician. Providers may dispense or administer medications if they have a written order from a physician specifying the name or position that is permitted to administer the medication and the circumstances and dosage to be administered.

Certified: Residents are permitted to refuse medication unless they are under a court order to take it. Residents may control and administer their own medications unless they are not able to do so as determined by a physician, or unless the resident or resident's

guardian, if any, requests the sponsor's assistance. Written orders from the prescribing physician must be available if the sponsor administers or assists with the administration of any prescription medication. Sponsors store the medications they administer and help the resident take the correct dosage at the correct time and communicate effectively with his or her physician or pharmacist.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

Licensed: Licensed homes shall have a service agreement with each person who is admitted, except those who are admitted for respite care. The service agreement is completed before admission and revised at least 30 days before any change in the provisions of the agreement. The service agreement specifies the names of the parties to the agreement; the services that will be provided and a description of each; charges for room and board and services, and any other applicable expenses; the amount of the security deposit; the frequency, amount, source, and method of payment; the policy on refunds; how personal funds will be handled; conditions for transfer or discharge, and the assistance a licensee will provide in relocating a resident; and a statement indicating that resident rights and grievance procedures have been explained and copies provided to the resident and the resident's guardian or designated representative.

Certified: Not described.

PUBLIC FINANCING

In 2006, Medicaid spending for adult family homes totaled \$569 million, or 17 percent of all Medicaid waiver spending. About \$85 million was spent for elders and persons with disabilities, and \$312 million was spent for services to individuals with developmental disabilities.

Medicaid waiver funds may be used to pay for care and supervision services provided to residents in the facility. The provider and county negotiate rates for Medicaid waiver services. Providers submit a rate sheet to the county based on allowable costs. Examples of costs related to care and supervision are staff salaries and fringe benefits, FICA, workers compensation, unemployment compensation, staff travel, resident travel, administrative overhead, staff/agency liability insurance, and staff development and education materials.

The resident pays room and board. Residents in adult family homes who are eligible for SSI receive a state supplement for exceptional expenses if they need more than 40 hours a month of assistance with activities of daily living or have insufficient income to pay the cost of their care. In 2008, the SSI-E payment standard was \$816.77. About 700 of the 4,000 people living in adult family homes are older adults.

STAFFING

Licensed: Licensees must ensure that someone is awake at night if a resident requires continuous care. Providers must undergo a criminal background check, and providers and the department must check the nurse aide register for staff who have experience as a home health aide, nurse assistant, or hospice aide nurse

Certified: The certifying agency must conduct a caregiver background check on the applicant and on any other adult household member. The certifying agency may deny or

revoke certification on the basis of information in a caregiver background check. The applicant or sponsor shall also arrange for caregiver background checks for all substitute providers. The background check includes a criminal history search from the records of the Wisconsin Department of Justice; a search of the Caregiver Registry maintained by the Department of Health and Family Services; and a search of the status of credentials and licensing from the records of the Wisconsin Department of Regulation and Licensing, if applicable. The background checks must be conducted at least every four years.

TRAINING

Licensed: Before or within six months of beginning to provide care, the licensee and each service provider must receive 15 hours of training approved by the licensing agency related to the health and welfare of the residents, resident's rights, and treatments appropriate for the residents served. Staff must receive eight hours of training each calendar year. Additional training may be required by the licensing agency.

Certified: The sponsor and every substitute provider must be at least 18 years old and physically, emotionally, and mentally capable of providing adult family home care. Unless the sponsor has completed similar training, has a degree or completed related course work, or has acquired substantial up-to-date knowledge, he or she must complete 10 hours during the first year of certification of agency-approved training related to the health, safety, welfare, rights, and treatment of residents. The certifying agency may require the sponsor to obtain additional training or to complete training before certification. A minimum of eight hours of annual training is required.

OVERSIGHT AND MONITORING

For licensed adult family homes, the Bureau of Quality Assurance conducts unannounced surveys every two years after the facility receives its initial license. Staff use a new survey process that recognizes effective providers with a less intensive survey, called an "abbreviated survey." The process includes a technical assistance component to interpret requirements; provide guidance to staff on resident quality of life and care; review provider systems, processes, and policies; and explain new or innovative programs. The revised process includes seven types of surveys: initial, standard, abbreviated, complaint, verification, monitoring, and self-report. The state determines which type to conduct for each facility according to a range of factors, including history of citations. Abbreviated surveys are performed for facilities that have been licensed for at least three years without any enforcement actions or substantial complaints over the past three years. In addition, the bureau investigates all complaints and conducts verification visits when necessary.

Certification for one-to-two-person adult family homes is renewed annually.

WYOMING

BACKGROUND

Chapter 219 (2007) authorized an adult foster care home pilot in three sites. The pilot is limited to five adult foster care homes, and all licensees must live in the home. Licensees will follow rules governing assisted living facilities except for sections dealing with personnel and staffing, food production and menu planning, building and physical plant, and other requirements. The regulations governing assisted living facilities do not specify a minimum number of residents, and it is possible that small facilities might be licensed under those rules.

Web Site	Content
http://soswy.state.wy.us/Rules/RULES/7158.pdf	Rules

DEFINITION

An **adult foster home** is a home in which providers care for up to five adults who are not related to the provider by blood, marriage, or adoption and who are in need of long-term care in a homelike atmosphere. Resident clients in the home shall have private rooms, which may be shared with spouses, and shall have individual handicap-accessible bathrooms. “Adult foster home” does not include any residential facility otherwise licensed or funded by the state of Wyoming.

ADMISSION/RETENTION CRITERIA

The assisted living regulations allow residents who need limited nursing services to be served. Residents may not be cared for by assisted living facility staff if they need continuous assistance with transfer and mobility, are unable to feed themselves, need total assistance with bathing and dressing, require catheter care, need continuous oxygen and monitoring, wander excessively, need wound care that requires sterile dressings, have Stage 2 or greater pressure sores, exhibit inappropriate social behavior, or demonstrate chemical abuse that puts residents at risk.

A residents may not be asked to leave without 14 days’ written notice, unless he or she poses an imminent danger to self or others. Residents may be asked to leave only for the following reasons: the facility has had its license revoked or not renewed, voluntarily surrendered the license; the resident’s level of care exceeds the level of care that can be provided by an assisted living facility; the facility cannot meet the resident’s needs; the resident or responsible person has a documented, established pattern in the facility of not abiding by agreements necessary for assisted living; the resident has failed to pay charges; or the resident engages in behavior that poses an imminent danger to self or to others.

ASSESSMENT AND CARE PLANNING PROCESS

Not described.

SERVICES

Assisted living facility core services include meals, housekeeping, and personal and other laundry services; a safe and clean environment; assistance with transportation; assistance with obtaining medical, dental, and optometric care, and social services; assistance adjusting to group living activities; maintenance of a personal fund account, if requested by the resident or the resident's responsible party, showing any and all deposits, withdrawals, and transactions; provision of appropriate recreational activities in and outside the assisted living facility; partial assistance with personal care (e.g., bathing, shampooing); limited assistance with dressing; minor nonsterile dressing changes; Stage 1 skin care (skin integrity intact); infrequent assistance with mobility (the resident may use an assistive device such as a wheelchair, walker, or cane); cueing guidance with ADLs for a visually impaired resident or an intermittently confused or agitated resident who requires occasional reminders as to time, place, and person; care of the resident who can independently manage his or her own catheter or ostomy (e.g., change his or her own catheter bags, clean and care for the ostomy); care of the resident who has bowel or bladder incontinence if he or she can manage the condition independently; registered nurse assessments; registered nurse medication review every two months or 62 days, or whenever new medication is prescribed or the resident's medication is changed; 24-hour monitoring; and provision of mechanically altered diets and dietary supplements (e.g., Ensure allowed), if they are required by a certain resident.

MEDICATIONS

Registered nurses provide medication reviews every two months or whenever new medications are ordered. A registered nurse is responsible for the supervision and management of all medication administration as required by the Wyoming Nurse Practice Act and the Wyoming Board of Nursing Rules and Regulations.

An RN or LPN may administer medications. The regulations allow assistance with self-administration by nurse aides, which includes but is not limited to reminders, removing medication from containers, assistance with removing caps, and observation of the resident taking the medication. Residents who can self-administer are allowed to keep prescription medications in their rooms, as long as it is deemed safe and appropriate by the registered nurse. For residents who share a room and self-medicate, an assessment will be made of each resident and his or her ability to safely have medications in the room.

RESIDENT AGREEMENT/CONTRACT/DISCLOSURE

An assistance plan is required that specifies the type, frequency, and duration of services, and the expected outcome. A resident agreement is not required. Management is responsible for developing policies and procedures that are available to residents and to staff who deal with resident rights, disciplinary procedures concerning substantiated cases of resident abuse, admission/transfer/bed holds, medication management, emergency care, fire/disaster plans, departure and return, smoking, visiting hours, activities, notification of changes in conditions, personnel policies, grievance procedure, per diem rate charges and fees, incident reports, notification of changes in fees, outside contractual responsibilities, and identification of changes in the resident's condition.

PUBLIC FINANCING

No provisions.

STAFFING

The owner/manager must be at least 21 years old and capable of accepting responsibility for the day-to-day operation of the adult foster home. Any person who provides supervisory care in the adult foster care home must be at least 18 years old.

Staffing levels shall be sufficient to meet resident needs. The adult foster home may not employ a person as a nurse assistant, nor shall any resident of the home function as a nurse assistant, unless that person is currently certified by the Wyoming State Board of Nursing.

If the owner/manager is not a registered nurse, the home must contract with a registered nurse to ensure regular supervision of nurse assistants, initial and periodic assessments of the residents, development of care plans, and medication management according to professional standards.

TRAINING

Not described.

OVERSIGHT AND MONITORING

Homes are inspected annually. Criminal background checks are completed for staff and other persons who live in the home. Initial licenses are approved for one year. Renewal licenses may be issued for up to 24 months.