

PHASE 2 ISSUES

Consumer Information

1. Develop, in an electronic format, a consumer ALF guide similar to the nursing home guide, and considering inclusion of an ALF rating system and an ALF watch list. These documents will assist people by providing important facts such as deficiencies found at inspection, the number of beds, the languages spoken, inspection results, rates charged for a standard set of services and whether the facility accepts Medicaid waivers.

ALF Administrator Qualifications

1. Create a workgroup of providers and stakeholders to evaluate the current educational requirements and curriculum for certification as an administrator of an ALF, education and training requirements for staff, continuing education requirements, and training and education requirements for administrators and staff of specialty licensed ALFs.
2. Require administrators to have a two year mentorship under an ALF administrator with no Class I or II violations.
3. Increase administrator requirements for an ECC facility. Allow a registered nurse license to satisfy the requirement.
4. Create ALF administrator licensure with a Department of Health board to track and monitor discipline and core training. No exceptions for small facilities.
5. If there are increased requirements for ALF Administrators, consider accepting licensure as a nursing home administrator or a registered nurse to satisfy requirements.
6. Prohibit facility administrators from owning or serving as administrator of any facility if an action to revoke or deny a license is upheld at a facility where they were previously employed.

Licensure

1. Seek legislative changes to s. 429, F.S. that are resident-care focused (Alzheimer's secured units, safekeeping of residents funds) and ensure that regulations are appropriately and consistently enforced (keep violations in s. 429, F.Ss) yet streamlined where appropriate (advertising – use of “ALF”, combined adverse incidents reporting).
2. Revise regulations to be appropriate for specific persons served in an ALF including persons with serious mental illness and those serving geriatric or medical needs.
3. The ALF licensure and regulatory provisions be placed back into Part I of s. 429, F.S.
4. Examine the current array of ALF specialty licenses and determine if they are still needed or should be modified.

5. Evaluate expectations for quality of life and care in an ALF. Focus cannot be limited to physical health and safety – it must extend to other quality of life factors, including staff who are kind and focused on the individual wants / needs of each resident. Consider questions raised during public testimony “Would I want to live in this facility?” or “Would I place my mother in this facility?” No lower expectation should exist for other individuals.

Resident Admission

1. Hold state and local hospitals accountable for discharge planning that matches individual needs and desires to an appropriate and available setting that best integrates individuals into the community. Modify Chapter 395, F.S., to require hospital document consideration of an individual’s choices in discharge placements. Address hospitals that do not consider the individual’s preferences and community integration in discharge planning.
2. Adopt an ALF pre-admission screening process implemented by an independent body (a simplified and expedited version of PASRR). This “single point of contact” would permit choice counseling and referral to an ALF most appropriate to align with the individual resident needs.

Resident Discharge

1. Enact legislation that provides ALF residents a formal appeal process for disputed discharge.
2. Afford ALF residents discharge protection that mandates specific reasons for relocation, provides ample notice to residents, and provides residents with an administrative appeal hearing process.

Resident Safety and Rights

1. Increase amount and quality of activities made available to ALF residents. Require ALFs to seek out individualized activities and services independent of the facility that are chosen by each resident and expedite participation in these activities and services. Activities must be meaningful activities and allow residents the opportunity for productive learning, life skills, and job experience. This may include meaningful part-time work or volunteer activities, depending on the preferences of the resident. Some structured and meaningful activities can be provided in the ALF, but those integrated in the community with non-disabled persons should be encouraged.
2. Examine ALF staffing ratios.
3. Prohibit ALF related staff from serving as Representative Payees. This creditor / debtor relationship places the resident under the control of the ALF for all aspects of their life, preventing them from moving to another ALF or a more independent living environment.
4. Prohibit any binding arbitration agreement language in resident contracts. These contract clauses limit a resident’s right to access due process whenever care disputes arise.

5. Enact legislation that encourages residents and families to establish independent groups within each ALF focused on improving conditions and care for residents without interference from staff.
6. Ensure an anonymous method of regularly seeking input from ALF residents about the nature of the care received in a facility without relying only on complaint investigations or on-site surveys. CARF provides such a mechanism, as does the LTCOC.
7. Clarify in statute that the ALF administrator is responsible for ensuring that the resident receives adequate care and services.
8. Enact public record exemption for AHCA complaints. Complaints filed with AHCA are not protected from disclosure. Consider adding confidentiality to AHCA complaints equivalent to that of the Ombudsman.

ALF Information and Reporting

1. If ALFs are required to report to the Agency occupancy rates and resident acuity, they need to have an online reporting system that requires no more than 30 minutes per quarter for data entry. ALFs will also need to be able to pull up congregate occupancy rates and resident acuity compilation data for their area in order to compare their facility demographics to the average.
2. Require AHCA to investigate the types of technology currently available for cost effective methods of collecting, reporting, and analyzing client information and allow facilities to select the type of technology most appropriate to each individual facility. Easy to use swipe / scan handheld devices may be available. The fiscal impact of equipment, software, training, and staff time must be considered.
3. Require all ALF staff to collect and identify client information that would indicate a change of condition and notify the resident's case manager to enable early intervention and prevent escalation of symptoms that might result in a transfer, discharge, Baker Act, police involvement, injury to staff or resident, or other adverse event. Electronic collection and sharing of this information will improve timely response.
4. Require AHCA to examine the "Dashboard" technology used by DCF in measuring the outcomes of Community Based Care agencies serving dependent children. Some aspects of this oversight should be applicable to long-term care settings.
5. Use a document vault where all critical documents can be stored related to an individual resident. This prevents the loss of such documents, increases access to them by authorized persons to prevent duplication of effort, and reduces costs. Protection of such documents and criminal sanctions for misuse needs to be considered to prevent fraud by unauthorized persons or for unauthorized purposes.

Enforcement

1. Utilize existing regulations to evict unethical or incompetent providers from the system. Recognize that most ALF residents are currently being well taken care of under the current regulatory environment. Do not undermine a social model of care that works.
2. Maintain current law that fines will only be imposed for low-level citations if uncorrected, to focus penalties on poor performers without adverse impact on competent providers.
3. Evaluate the ALF enforcement process beyond a punitive approach. Although the punitive approach is necessary for chronically poor performing facilities, it is not the best way to elevate quality across the ALF community. Examine the Wisconsin model for ALF regulation which is similar to the AHCA abbreviated survey with the addition of a consultative/collaborative regulatory model.
4. Give AHCA more power if necessary to place sanctions, fines, moratoriums, as well as deny, revoke or suspend licenses for poorly performing facilities. Fines for non-compliance should be increased and immediately paid. Such sanctions would be subject to due process through existing appeal processes. Agency discretion on sanctions should be discouraged or eliminated as such discretion creates the appearance or reality of unequal application of regulatory powers.
5. Evaluate discretion of sanctions and determine if some should be removed, but allow some AHCA discretion. Removing discretion more broadly may cause unintended consequences and needs to be discussed much further.
6. Revocation or denial of renewal license should be mandatory for certain violations including resident death at a facility because of intentional or negligent conduct on the part of the facility. Consider the degree of culpability.
7. Allow the monies from administrative fines to be used in the facility to correct the deficiency allowing the facility to enhance the standard of resident care.

Funding

1. Evaluate the actual cost of the current regulatory program and any proposed changes and determine full costs of any law changes before raising fees.
2. Provide AHCA the necessary resources to apply the statutory and regulatory measures necessary to protect vulnerable persons. These include political support by the Legislature through substantive laws and financially through appropriations to hire sufficient numbers and quality of staff in its field offices to provide the intensity and frequency of surveys and complaint investigations necessary to protect the public.
3. Consider options in the Senate Committee on Health Regulation Interim Report 2012-128, to fund required inspections including some combination of additional fees, especially higher fees for facilities that require greater regulatory oversight.

4. Require licensure fees for OSS beds. Florida law exempts facilities that designate their beds as OSS from licensure fees. The current fee for non-OSS beds is \$61 per bed in addition to the \$366 standard licensure fee. Some of the facilities that receive this exemption for the majority of their licensed beds require significant regulatory resources. There are currently 15,678 OSS beds in Florida, so revenues generated would be \$478,179 annually (15,678 x \$61/bed every 2 years for biennial licensure).
5. Increase the per-bed, per facility, and/or specialty licensure fees for all providers to offset program deficits.
6. Assess higher fees at renewal for those facilities that required greater regulatory oversight based on the number of complaint inspections, violations cited, follow up visits required to determine correction of violations, and adverse sanctions such as moratoria, suspension, fines, or other actions.
7. Remove the prohibition on imposing an administrative fine when a Class III or Class IV violation is corrected within the time specified.
8. Reevaluate the assisted living fee structure as it relates to paying the cost of regulation.
9. Prohibit fines from going back to the Agency to offset the costs of the licensure program.
10. Address the 15,000 people on the waiting list when asking for additional “nursing home diversion.”
11. Provide more financial support for ALF care and services including increased per diem rates and more funded slots/beds.
12. Evaluate the actual cost of assisted living facility care and apply for access to federal funds through Medicaid. Utilize the pay for performance methodology.

Resident Advocacy

1. Increase funding for the Centers for Independent Living to expand the numbers of persons served and recognize the Centers for Independent Living as an essential part of the ALF statute. Their roles of information and referral, peer monitoring, independent living skills training, advocacy and other services are ideally suited for persons who are living in ALF’s and those who wish to live more independently.

Mental Health

1. Require more education and experience for LMH facility administrators with a greater focus or specialization in mental health care such as a two year degree and two years of experience or a

four year degree with coursework in a mental health related field seems reasonable. Consider a grandfather provision for current administrators.

2. Recognize the shift of placements for persons discharged from state hospitals, now residing in ALFs.
3. Identify the features or characteristics of a good LMH for model of programs that best meet the needs of persons with serious mental illness and the associated behaviors.
4. Provide more case management services and advocacy for residents which could contribute more to the resident's quality of care and life.
5. Clarify oversight responsibilities of private case management and mental health treatment providers as it relates to community living support plans and cooperative agreements. Not all individuals in ALFs are served by DCF funded mental health providers, making DCF oversight of those providers difficult.
6. Maintain the independence between mental health services and case management in assisted living facilities. Shifting services and case management to a facility-based model instead of resident-based may place the needs of the facility over the needs of the resident, and limits resident choice in case managers and living arrangements.
7. Retain role of the designated mental health providers to manage mental health clinical issues and do not shift this role of the ALF. While close working relationships between the ALF and the mental health provider are essential, it is equally essential that no inducements or other devices limit the choice of residents as to where or from whom they receive their mental health services.
8. Do not move the Medicaid case management program from community mental health centers to the ALF. The Medicaid program is limited to eligible services for Medicaid clients. It requires extensive psychiatric oversight and linkage only available within a clinical context. This is not the "social service" program ALFs desire nor should it be facility-based and dependent on the residence where an individual lives.
9. Do not require DCF to contract with specialized community mental health centers to provide case management and other mental health services to residents of ALFs. This would more likely meet the needs of the facility at the expense of the resident. Residents often move between ALFs or to more independent settings and they need to retain the continuity of care possible through the trusted relationship with their case manager.
10. Require DCF/Managing Entity evaluate the cooperative agreements in place to ensure that they are sufficient to meet the mental health needs of LMH facility residents and that the circuit plans are consistent with the DCF/substance abuse and mental health district plans related to case management services, including access to consumer-operated drop-in centers, access to services during evenings, weekends, and holidays, supervision of clinical needs of residents, and access to emergency psychiatric care.

11. Require DCF/Managing Entity review a sample of the community living support plans at each LMH facility to ensure they represent adequate mental health supports as well as activities and services that represent the preferences of the consumers.
12. Require DCF/Managing Entity verify that each mental health resident is assigned a case management and that face-to-face contact has been documented as required by law and rule.
13. Require staff at the DCF to ensure consistency of LMH facility services and increase the monitoring responsibilities of mental resident case managers.
14. Amend s.400 and 429, F.S., to require that before an ALF or nursing home or its agent can initiate an involuntary examination under the Baker Act that it must document a series of efforts have been attempted to prevent this action. The statutory amendment would require DOEA, AHCA and DCF to collaborate in the promulgation of rules defining what these efforts would be. The Florida Health Care Association's Quality First Credentialing Foundation has adopted a Best Practice Tool governing "behavior management/aggression control & involuntary Baker Act guidelines". This Tool is incorporated in the state's Baker Act Handbook (Appendix E-9 through E-12); it could provide the basis of such rules.
15. Develop a process for persons with severe and persistent mental illness whose care is subsidized to allow that subsidy to follow that person in alternative residential settings.
16. Conduct a study to explore the methods of enhancing care for persons with severe and persistent mental illness in assisted living facilities.

Multiple Regulators

1. Form a workgroup of all agencies involved in ALF regulation and stakeholder groups to develop a new organizational structure streamlining the regulatory process. Designate AHCA as the lead agency for all regulatory activities in the interim.
2. Improve coordination between the various federal, state and local agencies with any role in long-term care facilities oversight; especially ALFs. This includes the Agency for Health Care Administration; the Long Term Care Ombudsman Program; local fire authorities; local health departments; the Department of Children and Families', Adult Protective Services and Substance Abuse and Mental Health Programs; the Department of Elder Affairs Area Agencies on Aging; local law enforcement; and the Attorney General's Office.
3. Agency responsibilities and lines of communication, coordination, and cooperation between agencies with oversight/regulatory responsibility for ALFs be clearly defined and formalized in written inter-agency agreements.
4. Limit the role of AHCA to regulatory oversight – consultation needed by the industry and its members can be obtained from organizations of their choice and at their own expense. AHCA

should promulgate rules establishing quality standards in collaboration with DOEA and DCF, and survey licensed facilities for full compliance with those laws and rules.

5. Allow AHCA to use DCF Adult Protective Services findings and pursue sanctions for repeated verified abuse findings in a facility.
6. Authorize for AHCA to deny, revoke or suspend a license if the licensee is a named perpetrator in a verified report of abuse, neglect, or exploitation, similar to APD licensure authority in s. 393.0673, F.S.
7. Authorize use of DCF Adult Protective Services finding and investigations in employment matters. s. 415.107(8), F.S., states that "...information in the Central Abuse Hotline may not be used for employment screening." The current statutory construct allows for the verified perpetrators of abuse, neglect, or financial exploitation to continue working with vulnerable populations as long as none of those cases subsequently result in prosecution and conviction (under a disqualifying criminal offense). Allowing ALFs (and other providers) to use the information from the abuse registry to screen out such employees during the hiring process would necessitate a change in this law. Such a legislative change would require that DCF offer due process hearings for perpetrators prior to the closure of all abuse investigations with verified indicators.
8. Modification of existing administrative rules should also be considered so that any licensee, direct service provider, volunteer, or any other person working in a residential facility who is an alleged named perpetrator in an active protective investigation of abuse, neglect, or exploitation of a vulnerable adult under s. 415, F.S., or abuse, abandonment, or neglect of a child under part II of s.39, F.S., are prohibited from working directly with residents or being alone with residents until the investigation is closed. The only exception to this prohibition would be if the alleged perpetrator is under the constant visual supervision of other persons working in the facility who are not also alleged named perpetrators in the same investigation. This provision would only be applicable in situations where the licensee has been made aware of the investigation.
9. Enhance DCF Adult Protective Services electronic case management system (Florida Safe Families' Network) to identify trends in abuse, neglect and exploitation by modifying the system to coding investigations by resident setting (facility type). Currently, all institutional reports are lumped under one category. The system could be modified to capture discrete types of facilities, which would enhance our ability to look for patterns and plot frequencies.
10. Consider a document vault to allow off-site compliance review and share information between regulatory agencies.
11. Retain multiple visitors in non-compliant facilities.

Home and Community Based Care

1. Enable housing choices beyond ALFs including independent and supported living settings with supports necessary to ensure success through the following:
 - Approve AHCA to implement the Money Follows the Person (MFP) funding and authorize the use of Medicaid-financed assistive care payments in facilities other than ALFs.
 - Allow Optional State Supplement (OSS) funding currently spent in facility settings to follow the person into the community.
 - Reinstate money cut from DCF institutional budgets and allow it to follow the person into the community.
 - Fund the Affordable Housing Trust Fund and eliminate funds sweeps.
 - Make supportive housing services available under Medicaid.
2. Create incentives for placement of disabled residents in Adult Family Homes and supported / independent living settings that may not have the economy of scale available to larger ALFs, but do have the ability to provide individualized attention to resident needs in a home-like setting.
3. Eliminate the waiting list for waiver programs and have open enrollment for Medicaid waiver providers. Make assisted living funding readily available similar to how institutional care is funded through the long-term care system (Medicaid reimbursement for nursing homes). Expand the assisted living waiver program and focus on facilities that prove they meet significantly higher quality of care standards.