DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
ASSISTED LIVING ADVISORY COUNCIL MEETING
MINUTES BY DORA VALENTIN TOMPKINS and Jeanne Bishop-Parise
Document for Public Comments submitted by Dr. Shawn McGivney
Date: January 17, 2019
Time: 10 AM
Meeting locations Videoconference to:

Division of Public and Behavioral Health Bureau of Health Care Quality & Compliance
727 Fairview Drive, Suite E
Carson City, Nevada 89701

Division of Public and Behavioral Health
Bureau of Health Care Quality & Compliance
4220 South Maryland Parkway, Building D, Suite 810
Las Vegas, Nevada 89119

CALL IN NUMBER: 1-888-398-2342 Access Code 1530727#
NOTE: SOME BOARD MEMBERS MAY ATTEND IN LAS VEGAS AGENDA ITEMS MAY BE TAKEN OUT OF ORDER, COMBINED FOR CONSIDERATION, AND/OR REMOVED FROM THE AGENDA AT THE CHAIRPERSON'S DISCRETION

1.Roll call. *Co-chair*
Southern ALAC Members:
Linn Thome, Merrill Gardens, Co-Chair *present*
Simona Cocea, Desert Springs Senior Living emailed that she got on call
Wendy Knorr, Morning Star Senior Living
Julie Peterson, Vintage Park
Shawn McGivney, Tender Loving Care Senior Residence *present*
Dora Valentin Tompkins, Angel Care Residential Home * *Emailed ahead about attending via phone present*
Nicole Graham, Silver Sky at Deer Springs * *Emailed ahead about attending via phone – not present at roll call*
Phil Glessner Mimi's Care Home* *Emailed ahead about attending via phone present*
Rebecca Tessa, *ADSD, on the phone present*
Darryl Fischer present

Northern ALAC Members:
Gina Stutchman, Co-Chair *present*
Paul Bailey, Baileys Group Home *present*
Margaret McConnell, BELTCA *Sandy present for her*
Chris Mirando, RFA, Majestic Management of Pahrump, Inc. * *Emailed ahead about attending via phone present*
Vangie Molino, Vista Adult Care *present*
Diane Roberts, Washoe County *present*
Patrick Ward, Five Star Senior Living * *Emailed ahead about attending via phone present*
Jeanne Bishop Parise, Park Place Assisted Living *present*

Ex Officio Member:
Robert Kidd, CEO, Perry Foundation

Others attending:
Annie Chapin, Aging and Disabilities Services Division ADSD
Helen Foley, Nevada Assisted Living Association (NALA)
Sandy Lampert, Executive Director, BELTCA
Nathan Orme, Health Care Quality and Compliance (HCQC)
Rolan Tejada, ADSD

Alex Wampler, ADSD
Nenita Wasserman, HCQC
Jennifer Williams-Woods, ADSD

Excused: Margaret McConnell, BELTCA

2**. Approval of minutes for the meeting of October 18, 2018.** *Linn Thome Co-Chair*
PUBLIC COMMENT/FOR POSSIBLE ACTION
Shawn McGivney– improve our record keeping to avoid problems, appoint position of recorder noted as next on agenda; Shawn McGivney moves to approve minutes. Second by Julie.

Jennifer Williams Woods – page 9 of minutes – she stated should read she's just as frustrated "as" providers (not "with" providers.)
Motion passed.

3. Approval of new recorder or assignment to member(s) to add detail to the meeting minutes as requested by Shawn McGivney. ***Linn Thome Co-Chair***
PUBLIC COMMENT/FOR POSSIBLE ACTION
McGivney: Discussed assignment of recorder to take notes to support and better correlate what was discussed in addition to Nenita's minutes

GINA STUTCHMAN MADE AMOTION TO APPROVE THE POSITION OF RECORD TO BE FILLED BY MEMBERS ON A ROTATING BASIS. SECONDED BY SHAWN MCGIVNEY. MOTION CARRIED UNANIMOUSLY.

Dora Valentin Tompkins volunteered with Jeanne Bishop Parise and will submit a draft Nenita Wasserman within 10 days.

Shawn asked if there will be public time today to discuss items not listed on the agenda and was directed to end of agenda under the item for public comments.

4. Make recommendation for renewal of two-year term as member of ALAC. Term expires January 2019. Linn Thomé, Merrill Gardens.

Linn Thomé states that she is resigning as the Southern Chair, but would like to remain a member.

SHAWN MCGIVNEY MOVE DTO APPROVE LYNN THOME FOR AN ADDITIONAL TWO-YEAR TERM HAVING SERVED WITH EXEMPLARY SERVICE AND WILL FIND A NEW CHAIR FOR THE SOUTH. DIANA ROBERTS SECONDED THE MOTION. MOTION PASSED UNANIMOUSLY.

5. Nominate and Possible Election of new Co-chair for the North. (Gina Stutchman steps down as co-chair of North but remains a member.) ***Linn Thome'***

Gina Stutchman steps down after this meeting as Northern Chair but remains as member.

SHAWN MCGIVNEY MOVED FOR JEANNE BISHOP PARISE TO BE NORTHERN CHAIR. GINA STUTCHMAN SECONDED THE MOTION. MOTION PASSED UNANIMOUSLY.

6. Health Care Quality and Compliance update: ***Steve Gerleman, Pat Elkins, HCQC***
a) Status of the requested written response to NALAs letter which was included in the record from the October 2018 meeting
b) Status of plans regarding Paul Shubert's letter addressing SODs Scope and Severity after the expiration on 6/2019
c) Education and Information updates - *Nathan Orme, HCQC*
HCQC update: Steve G. turned this over to Paul Shubert who stated that a response was sent, posted to Web Site and sent out on List Serv. Within his response he explained the 3 options available to facilities: 1: Physician's Determination Form (included in response), 2: get the Alzheimer's certification; and option 3: find other placement for those residents who need that higher level of supervision. Brief overview of status given.

Questions from Darryl Fisher: What precipitated this? Are there Dementia care issues surrounding diagnoses currently? Steve said: Yes, citations are being made regarding Dementia residents being in inappropriate setting related to the

regulations. Darryl questioned if these were in a non-secured setting? Steve stated again that these residents were in facilities that are not appropriate for the regulation; Darryl: So not having issues with the care?

Shawn McGivney prefaced his comments with his credentials as having completed a Board Certified fellowship in Geriatric Medicine. There is a wide range of suffering associated with the Dementia Label for example HTN to Chronic Illness. Who is making the determination of suffering with the Dementia Label if not the physician? What has changed and when?

Linn Thome: Gave an example of someone who loses keys not diagnosed to people seen by doctor but are mild Dementia to those placed in Secure Unit. Since we want to keep people in the least restrictive environment, how are providers to make the determination, when doctors don't have or take the time to make the determination?

Darryl Fischer: Here's where the rubber meets the road: His Communities have 124 residents by diagnosis living with Dementia in AL outside of Secure Memory Care who will now need to be in ALZ Secure. Is HCQC willing to change the definition?

Paul Shubert: Are we open to changing the definition? Yes. Maybe that needs to happen, to see this go through a rule-making process and then find a process of assessment for facility type and processes. We need to find a solution that works. What we don't want to happen is someone wander and go in harm's way - then it's too late.

Jenn W-W stated that she, Jennifer Cushman, and Elder Rights Attorney met with Paul Shubert yesterday to make sure that all were on the same page. When she first read the bulletin, she took it like providers that anyone with diagnosis needed to be in secure. But Paul says he doesn't want anyone to have to move but to do the proper physician determination for placement, make sure that it's the most appropriate place. If not, then look at getting the endorsement (as the fee is now waived) or find other placement…and that providers to continue to monitor as Dementia advances, so that they are appropriate to stay through monitoring and assessment.

Darryl: this is the normal process we go through.

Jennifer: not much of a change. If there is a concern, then monitor. If resident has diagnosis, then get them assessed with physician familiar with that person then monitoring behavior. If behaviors trigger, ie. going by door, then reassess. Surveyors want to see all with a baseline assessment, and as things change, on-going assessments in files… as changes – encourage guardians to find better placement. So, yes, if you are doing this, no change, just make sure correct documentation is in the file.

Diane: If inspector witnesses a behavior who will decide? Will the facility be cited? Steve: Yes, we only cite.

Gina: This is a process. If there is a letter of communication in file with resident, meeting with family, appointment with doctor, etc…, so effort in place to get to safety. But if those are in the records, then no citation?? Right?

Steve: if we are looking at a person who is going to be needing higher care, documentation, physician may say time to go or not…
Gina: provider is guided, doctor says yes or no… specialized doctor, may be hard to get those appointment…
Steve: If at facility for period of time then yes, cite. Other then discretion to occur… inspector calling supervisor when behavior is observe. Surveyors need to make decision on own in field. Every situation different – evaluate and make decision based on circumstance.

Female voice: Regulators are not trained as physicians. How then can surveyors override physician?

Paul: We train our surveyors. Surveyors have tools - here's a tool, ask questions from resident and staff…and they do a scoring system, but they won't state who has what type of dementia. They rely on facility to get physician involved.

Shawn: we have a system in place best in the nation. Already 100% required to have H&P and doctor gives certification on appropriateness of placement. Reassessment… change – requires time, there has to be a pattern of negative consequences found by surveyor – that's different. There has to be 10 incident reports… for example. annual note is

required, that's the system in place… so the annual doctor exam shows continuing ability to stay/not stay… the doctor says so, not the surveyor. It's the doctor who can be sued.

It seems that nothing is changing. except the level of enforcement – but we are not told why… or shown the reasons. Is the behavior violating …. rights of seniors. It can't just be determined that we are going to increase enforcement – seniors have rights too. Does change in enforcement behavior violate Omstead and Older Americans Act. Until pattern of behavior of negative consequences affects person and community, then no problem. It's hard unless pattern exists to be violating rights and mandate removal.

Diana: What if there is a UTI that's creating a behavior, not Dementia. The UTI may be treated, but then we just got cited?

Steve: Yes, then the provider can go to physician and can show documentation say of this UTI…surveyors can't come back to see after UTI cleared.

Shawn: How can HCQC cite on one instance. Clearly if there is a problem that needs to be cited, then it needs to be based on consistent pattern.

Steve: This came through from elopement with harm. A lot are not getting the training. Could be that all are not seeing things as insidious.

Darryl: We appreciate this, but if one looks at studies, elopements will happen again. No regulations guarantee that there will be no elopements. The process is in place with Physician Order and Assessment, Care Plan and monitoring.

Gina: HCQC received AG confirmation that the diagnosis is sufficient evidence to determine placement. How can AG make this statement if no incompetence has been determined? What did AG say about the rights of the person if confined with no guardian?
Paul: Most think Alzheimer's facility has to be a locked environment: it doesn't. Alarms and buzzers ok.
Gina: It still is restricting their ability to leave… so how does the industry get around legality of incarceration by buzzers and alarms to not allowing someone to leave if they have a mild dementia diagnosis…
Shawn: When physician, resident, staff, family all feel safe or all want.

Gina: Was the AG given both sides of the equation? Were they asked? How does the other side of resident rights apply?
Paul: Question simply what is the threshold to enforce the regulation? The rights of the people who are being surveyed was not addressed.

Shawn: Industry at last ALAC meeting requested the public complaints/ the reports of the incidents that are trying to be addressed by new level of enforcement… yet to receive.
Steve: Up North happened.
Shawn: One case?
Others leave home.
Steve: Can't do it today.
Shawn: Not today, but we would like to get copies of all incidents state-wide over past 3 years
Chris M: seconds Shawn's request. We need to look at the Independent Review Process or Informal Dispute Resolution with the surveyors… if cited for something incorrectly, what's the recourse for the facility. If fines levied to operators for years and years, never had recourse.

Steve: SNF required to self -report elopements and he'll get call that one eloped from Henderson. … and our regs at your level of care do not require locked. SNF and Advanced Medical. We're equating things that don't add up.
Shawn: Things don't add up. Agreed. Families agree with doctor; one time elopement different until on regular basis.
Daryl: Not all dementia requires locked units… unless disease process … something… more
Shawn: people choose the level of care want… if they choose the wrong level: family and doctor has to state it… it just can't legally be done.

Linn: We must move on.

Shawn: Request copies of complaints. Was told can't make motion due to not on agenda.
Gina did request Dec. 5th on agenda and was denied. Was told HCQC has final say on agenda.

b) Status of plans regarding Paul Shubert's letter addressing SODs Scope and Severity after the expiration on 6/2019

Paul: We are not assigning Scope and Severity – just listing to get facility to get doctor to assess and keep safe.
He doesn't know if it will be extended out or will work with industry on changed regulations.
Shawn: Questioned if BDR would work with Bureau if language on physician, patterns, etc.
Paul said they can't speak one way or another. They must have approval from higher up or be neutral. It could be in regulations, not necessarily in laws. Safety is the common ground – how to get there.
Paul: Would appreciate language that would work for regulation to present to Board of Health then appropriate approvals and language.
Shawn: ALAC should contact AG with concern if overreaching on enforcement and not meeting federal rights laws.
Gina gave the floor to Vangie who had been patient to wait to make a comment.
Vangie with AHONN: If HCQC relying on diagnosis only… they take care of 90% of their dementia residents on Medicaid Waiver… if they have to go, where will they go? Where are we going to place them? We're talking about a thousand people.
Paul: Look at second option - you should get the Alzheimer's Endorsement on facility.
Vangie: Most people are trying get it, but it's very expensive, we can't afford it… One AHONN member spent $20,000 – how do you get that back? To make it, follow all the rules, 1 to 6, another person at night to be awake, other expenses… when Medicaid pays $1200-1800 Level 1 or 2. How can we survive?

Shawn: Another option, that Paul didn't mention: give them 30day notice, send to hospital.
Vangie: Hospital refuses them, so question to Paul.

Shawn: If they can't pay, all you have to say is see ya. Call 911. That's a legal action. He also referenced 30 day notice for process but again reiterated that if you can't provide that level of care you not only can, you are obligated to send them to a safe place.

Vangie: Jennifer W-W is here and will attest it's not that easy to just send them to ER, hospital doesn't want to accept… hospital won't accept, Jennifer says, if alert and refuses care, ambulance won't take so would not be able to go to ER.

Helen Foley: this is a huge issue. We cannot find adequate solution within the regulatory process. None of them are at risk of hurting themselves, or others. Steve said that there was 1 elopement in the North… and now all of a sudden this whole industry is being flipped up side down… we are talking about RFFG who have been working very well; We are not talking about CBLA. We have been talking for an hour and we are nowhere near finding a solution. I am sorry, we cannot be more rational about this… if AG said that diagnosis is enough, yet, doesn't discuss early onset, vascular dementia, doctor watching, or family in place. All are at risk of being thrown out and incarcerated at the highest level of care. Then to have HCQC say we're not going to take a position and no certainty the Ombudsman will help us!
NALA says legislative response.
HCQC, Helen says, we need you to find a solution.

Jennifer W -W: Helen: I am looking at resident rights and what Paul has not stated is that if you had a diagnosis of dementia, you have to leave the Group Home. If the Physician states it's ok to remain in facility, then so be it – it's ok. So if there are no issues, they can stay… so on those bad days, that means that if cited… you have to re-assess (i.e. Diana mentioned.) No one may have experienced harm – why do we wait until someone is killed? You are all correct – all should have procedures in place.

Daryl: Could not agree with you more. So why would you ask AG if you can make citation or require ALZ locked based on diagnosis alone if the above is true?

Jennifer: Initial bulletin was a knee-jerk reaction, but we have moved away from that… really, it's not changing so much, but we are moving away from rash action, understand provider's frustrations, but HCQC is following what is the current process… assessments… small fraction of what to cover. I can hear the passion.

Helen: Why did bulletin come out? #3 Facility may obtain… Yes, but that's what these facilities have already done. Physician placement determination not required. History and Physical is.

Paul: Determination document not done on all residents in all facilities… he believes. Perhaps a portion of you are providing the best case scenario, but we don't always find the best case scenario… I recognize that you say that we do this, but
Shawn: Cite if they don't have the physician's determination, not because of the diagnosis…
Jeanne: Does Doctor's Order for placement and History and Physical suffice and meet requirement?
Paul: Behaviors observed will continue to make a difference and will still cite if behavior inbetween.
Vangie: Yes there were citation – resident sleeping on bed being cited.
Paul: Yes, but without scope and severity…

c) Education and Information updates - *Nathan Orme, HCQC*

Nathan: will work to better communicate. Make sure email is up to date in the system… also sign up for the listservs. Reminder to check spam. Anyone can sign up for the listserv… drop him an email and he'll add you to the non-medical listserv… he created a shorter url for ease DPBH.nv.gov/assistedliving – goes straight to group home regulations… etc.

Legislature: Bills of Interest and Tracking will be provided. No opinion. Can send tidbits if not able to find.

Go to Legislature system NELIS: you can track up to 10 bills for free, you will get email updates on them… email for info.

Communication frequency during session may not be as much as normal.

7. Summary and update related to assisted living facilities from Board of Examiners Long Term Care Administrators (BELTCA*) Margaret McConnell, BELTCA Board Member*.
Linn: Margaret not here, Sandy is with us. New Health Services Administrator License – allows for continuum of care, more portability, reciprocity from state to state. Nevada first to approve through Legislation. License #1 issued.
Jeanne stated that she just passed her HCBS portion test. Sandy said that she will have License #2 then.
Shawn: Congrats to Jeanne.

On Residential Facility side: Restriction on number of beds has changed to no limit in one facility from 150. One multiple facilities, then maximum beds is 150 with no more than 5 locations.

CEU's: Maximum of 8 credit hours in a twenty-four hour period for online.

315 licenses were issued with 20 beds or less and 29 issued with 20 plus beds.
There are 287 licensed administrators currently.

8. Summary and update on items related to assisted living facilities. *State Long Term Care Ombudsman- Jennifer Williams-Woods*
Jennifer: 1. Caregiver conference coming up 2/7 UNLV; 2/19 Reno; she'll moderate, lively passionate conversation, keep in mind that we had a long conversation about the Alzheimer's topic. Will have Bureau there, so not to censor, but probably not the best environment to pose questions on ALZ endorsement. We have to leave space for other questions.
Las Vegas: 3/26 – Positive Approach to Care – Train the Trainer in Vegas, looking for a location… looking someone to host, want near downtown; wants 1000 sqf. 7am t 5:30 for 2 days and 2-3 breakout rooms… providing meals would be nice.. she's working with Robert, they may be able to help with food; she'll send via Nenita, they'll have to secure the location soon… please help me in the south..

Summary and update related to assisted living facilities from Board of Examiners Long Term Care Administrators (BELTCA*) Sandy Lambert, BELTCA ChairMember.*

Sandy Lambert, Chair of BELTCA together basically much more popular based on those states and how reciprocity can work. Licensees have to be approved through NABS. Nevada is the first state in country to issue license provided licensure by statute. Residential – number of beds administrators can be responsible for has changed slightly from 100 to 150 beds For administrators who have multiple facility is 150 beds. PDUs for renewal need to be and may have me spend more than 8 hours in one 24 hour period.

NAC 654.250 Limitations on administration of multiple facilities; required notification to Board; secondary administrator's license; fee; administrative fine for violation; surrender of license; waiver; disciplinary action. (NRS 654.110**,** 654.140**,** 654.190**)**

1. Except as otherwise provided in subsection 8, a person licensed as a nursing facility administrator or health services executive may not be the administrator of record of more than one nursing facility at the same time for more than 90 days in a calendar year.

2. If a person licensed as a nursing facility administrator or health services executive is the administrator of record of more than one nursing facility, the person must:

(a) Immediately notify the Board that he or she is the administrator of record of more than one nursing facility; and

(b) Obtain a secondary administrator's license for each additional nursing facility for which he or she is the administrator of record by paying a nonrefundable fee of $100 for each license.

➥ The Board may impose an administrative fine on a licensee for failure to comply with paragraph (a). The amount of such a fine will be at least $500 for a first violation and at least $1,000 for a second or subsequent violation, but will not exceed $10,000 for each violation.

3. Except as otherwise provided in subsections 4 and 8, a person licensed as an administrator of a residential facility for groups or health services executive who is the administrator of record for more than one facility may be an administrator of record for not more than 150 beds located in not more than five residential facilities for groups. For purposes of this subsection, multiple facilities located on the same campus are deemed to be a single facility.

Gina Stutchman requested that the link be sent to Nenita Wasserman so she could send it out to members where the language has changed.

Summary and update on items related to assisted living facilities. *State Long Term Care Ombudsman- Jennifer Williams-Woods*
February 7
February 19
Caregiver conference. The Bureau will have some staff talking at the conference.
March 25 and 26, positive approach to care "Train the Trainer." They are looking for a location.

9. Summary and update of new restrictions related to assisted living facilities from ADSD on the new restrictions. *Jennifer Frischmann ADSD and Crystal Wren, Chief of Community Based Care.*
Neither one is here, as they didn't know what this was about… was asked to remove, but couldn't due to open meeting laws…

10. Report on assisted living related programs at Perry Foundation. *Robert Kidd, President and CEO, Perry Foundation*
Expo is in the works for April, traditionally offer ethics and regulations CEUs. Richard Whitley agreed to be a keynote speaker at June Endeavor Awards - excited to come back…
Med Tech – still going back and forth with HCQC email… been a major issues… still pending…
There was a big push for you guys to provide these classes… where are we now… the process is not too difficult.. They submitted, instructors are no longer there, now new ones have to take the 16 hour course before they can be submitted for instructions

The Med Tech classes are still pending due to Medication Management has not approved our license.

Robert Kidd said that we have submitted applications from north and south are RNs who have not taken a course before. Our instructors are not certified to teach. Even though they are RNs, they have not taken the 15 hour course yet and must complete it.

11. Home Based and Community Waiver Information. *Anna Olsen-Figueroa, Social Services Manager, Home and Community Based Waiver Program*

Annie Chapin Carson
December caseload: 266 ppl in waiver, 120 slots available, average wait time 90 days.. some less, priorities
Vangie: when people come in, they cannot apply until in Group Home; That's what they are told…
Answer: Welfare won't approve until they are in the GH… but process can start before placement…
It's not ADSD, it's welfare's process… Vangie shouldered loss.
Jeanne: For SNF's person can be community eligible for Medicaid and then Welfare hits switch to Institution eligible on day of admission.
Gina asked for welfare to be invited on agenda to meeting to replicate SNF process.
Jennifer: having a supervisor invited, someone who could answer and could bring back
We need Crystal Wren's counter part from Welfare
Helen: shows how broken the system is. The state should fix this issue. It falls on poor group homes. Good information.

Shawn: All licensed GH and PCA – that don't get the 100 million goes to CBLA - all impacted; you have to say no to charity cases, which we cannot afford. Annual redeterminations problematic if documents not provided or comes into any additional money can stop cash flow.

12. Discuss and make recommendations of topics for Administrator to take the State Board of Health. *Linn Thome'* PUBLIC COMMENT /FOR POSSIBLE ACTION
Shawn: NALA did take a whole bunch of concerns with CBLA regulations to the board FYI

13. Assisted Living Industry updates. *Lisa Campbell, NALA*
• Discussion on current trends.
• Regulatory Issues/Concerns from Provider Perspective
Jeanie was asked by Lisa, but nothing new to add

14. Meeting dates for 2019 at 10 a.m.: April18; July 18; October 17

15. Public Comment (No action may be taken on a matter raised under this item of the agenda until the matter itself has been specifically included on an agenda as an item upon which action will be taken.)

Any other comment?

Shawn read and then handed in his prepared public comment for the record.
He verified that HCQC is now actively involved with CBLA and HCQC is assigning staff to CBLA industry.
Paul Verified yes.

Shawn: He is concerned that the move in supervising CBLA even partially form DRC to HCQC sets up a new conflict of interest for HCQC. That is also suggested in the hospital discharge bulletin and again in their response.

Paul interjected they came from SNAMH and not from DRC.

Shawn: When HCQC says in their response that may or may not have similar standard we all know Unlicensed, state certified, CBLA now offer a clear second standard of care for the same non-medical care needs of protective supervision, medication management and individuated personal care compared to the higher, safer, standards in licensed nrs 449 RFFG care.

Shawn: He found it very misleading to foucs on "behavioral health treatments" as the sole or main factor when that is provided in ALL facility types as BST / PST. If the general caregivers in CBLA are providing BST / PST "behavioral

health treatments" and only that what training do they have? In fact, we believe CBLA is paid an hourly rate for supervision and caregiving at $15 and $19 / hr.

Shawn went on to say BST also is paid IN ALL Settings licensed and unlicensed at $37 / hr.

Paul commented he can't comment on what they are paid.

Shawn If CBLA is not doing "supervision" nor caregiving why are they paid hourly for those? If CBLA is paid an hourly rate for supervision and caregiving why are they paid hourly for those services? If CBLA is paid an hourly rate for supervision and caregiving and BST / PST how is the medication management paid for? In licensed care it is included in the flat rate billing.
It would be helpful to ALAC members for transparency to know both what services are provided and how they are paid in CBLA so the consumers and professionals who have to explain the differences to their residents can offer an informed choice. Also it seems fair to provide those details to allow RFFG who want to switch to CBLA to know who they are and rates are different.

Shawn: He wonders how HCQC as a mandatory reporter is handling this conflict when there are two standards of care for the same care needs and the continued negative string of outcomes for the relatively under-served group of disabled people in CBLA when a safer more complete, licensed care choice exists in licensed care? Only licensed offers safety of nonmedical services.

Shawn noted that both offer independence, dignity, freedom, to come and go but only licensed care offers the care and safety that is promised in both as non-medical care including supervision, medication management and caregivers when needed. Indeed, if you only need freedom to come and go you are independent and transitional living. You do not need help with medications or personal care. But if you need those you seem to need the higher standards in licensed care that practically offer those services.

Shawn: Denying that continues to put those placed in the lower level of Unlicensed CBLA care at unnecessary risk. That is most troubling when there exists a proven safe, licensed, choice.

Shawn The response sent to this board seems to confirm continued confusion or reluctance to clearly describe the difference in non-medical services by HCQC on how or if the two regulatory systems of care are indeed different for the same non-medical care needs of supervision, medication management and caregiving. If the disabled mentally ill residents in CBLA do not need supervision, nor medication management nor caregiving help why are they paid hourly for those specific services?

He goes on to say that he does believe mental illness is expected to vary. When a mental illness varies it is critical to have the supervision necessary to evaluate the need for "as needed" medications and then have the structured system to administer them. He believes not having supervision like that in licensed care is a large part for re admissions and negative outcomes that have increasingly been seen in unlicensed, state certified SLA which as of 7/2017 is called CBLA.

Shawn: Perhaps HCQC can respond in writing to clarify the two clear overlapping standards of care in Medication management in unlicensed CBLA and Licensed RFFG including how you can reasonably give as needed"PRN" medications in CBLA without 24 hr Supervision? The hospital bulletin says if you need supervision you need licensed care but then later in the same sentence says you can get medication management implying it does not require 24 hr supervision. How can any individual know in advance when the "as needed" will be needed? Clearly HCQC must know the difference in simply filling a pill box which is offered in licensed home health care and does not require 24 hr supervision and the standard of medication management that requires supervision. Help us clarify in the hospital discharge bulletin or in general and in your response how HCQC can imply in any way that CBLA is offering medication management implying it is similar to that in supervised, licensed care? If the hospital bulletin meant to say you can only get a pill box filled by a licensed home health care agency in CBLA then it would be clearer to say that. Using the same term "medication management' in both unlicensed and licensed care seems misleading and seems to continue to pose unnecessary risk of negative outcomes and re admissions for those with mental illness who need the supervision and as needed medications.

Paul: will generate a response. We cannot answer xx questions – we don't engage in the reimbursement with those facilities… we don't get into it. SNAMHs and NNAMHs can address how they pay.

Amire? Difference insofar that CBLA can have counsellors coming in – behavioral health and case worker in home ie. Mojave Health – CBLA Transitions into community.

Shawn: BST used in all setting, licensed and unlicensed. That's my quandary.

CBLAs don't have to have 24 hour care – most can live with mental health diagnosis. Treatment plan documenting service plans.

Amire: Some CBLA's do have 24 hr care and can provide 24 hour care. Client goes to job in community. Worker coming in doing pill box.

Shawn: if they are paying for protective supervision and individualized personal care, that's what licensed providers provide…

Jeanne wanted to know with regards to AB46 definitions the Fire Safety Evacuation assessment and Transitional Stay assessment with regards to Average Daily Census and Average Lengths of Stay information could be used to extrapolate. Phone conference service shut off at noon…

Jeanne asked about how long transitional stay was?
Paul said he did not know of any specific time frame.

16. Adjournment.

12:06 pm.