GEORGIA STATE HEALTH PLAN

COMPONENT PLAN

PERSONAL CARE HOMES

HEALTH STRATEGIES COUNCIL
AND
DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF HEALTH PLANNING
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Planning area map has been changed effective April 1, 2003

TABLE OF CONTENTS

PREFACE

This Component Plan is a product of the Health Strategies Council and the Georgia Department of Community Health, Division of Health Planning, operating pursuant to the provisions of O.C.G.A. 31-5A-1, et seq., and 31-6-1, et seq. The purpose of the Plan is to identify and address health issues and recommend goals, objectives and system changes to achieve official state health policies.

This Plan has been produced through an open, participatory process developed and monitored by the Health Strategies Council appointed by the Governor. The Plan is effective upon approval by the Council and the Board of Community Health, and supersedes all related sections of previous editions of the State Health Plan and any existing related Component Plan.

For purposes of the administration and implementation of the Georgia Certificate of Need (CON) Program, criteria and standards for review (as stated in the Rules of the Georgia Department of Community Health, Chapters 272-1, 272-2 and 272-3) are derived from this Component Plan. The Rules, which are published separately from the Plan and which undergo a separate public review process, are an official interpretation of any official Component Plan which the review function has the legal authority to implement. The Rules are reviewed by the Health Strategies Council (prior to their adoption by the Board of Community Health) for their consistency with the Plan. The Rules, as a legal document, represent the final authority for all Certificate of Need review decisions.

Any questions or comments on this Component Plan should be directed to:

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I. INTRODUCTION

A. PLANNING PROCESS

The original Long-Term Care Personal Care Homes Component Plan was completed in 1989. The year before, the State Health Policy Council (the predecessor to the Health Strategies Council) appointed a Technical Advisory Committee (TAC) on Personal Care Homes. The TAC met from July through December 1988 for sixteen meetings. The members of the TAC included representatives from the Georgia Association of Personal Care Homes, the Senior Living Association of Georgia, developers, consultants, Georgia Department of Human Resources, State Ombudsman, and representatives of the Georgia General Assembly.

The TAC appointed six subcommittees covering topics such as levels of care, size, and financing issues. The TAC's recommendations fell into two categories: Policy and CON/Planning recommendations. The CON/Planning recommendations were incorporated into the 1989 Personal Care Home Component Plan.

In October 1991, the Agency adopted amended Certificate of Need Rules for Personal Care Homes. These rules allowed personal care homes to receive a waiver from CON review during 1992 through mid-1999. The rules stated that homes with 50 beds and under would be waived from CON review if they did not have a nurse's station, a physical therapy room, and an examination room. Personal care homes with greater than 50 beds, in addition to not having a nurse's station, physical therapy room or an examination room, had to submit documentation of a program designed to promote high quality, cost-effective services, consistent with client needs. During the years following the implementation of the waiver process, there had been a marked increase in the number of personal care homes. In 1999, the agency reinstituted CON review for personal care homes and adopted a new component plan.

The changing demographics in Georgia coupled with the growth and innovation in long-term care heightened the need to plan for long-term care services and provided the impetus for the Health Strategies Council and the Department of Community to update the Personal Care Home Plan and Rules. The first meeting of the 2001 Personal Care Home Technical Advisory Committee (See Appendix A) was held in June. Other meetings were held in July and August. Throughout these meetings, division staff emphasized the importance of structuring any changes to this plan to parallel recent changes to the Nursing Facility and Home Health Services Plans so that the revised plan could be easily structured to allow movement to an integrated Long Term Care Plan in the future.

B. CARE CONTINUUM

Personal Care Homes represent a consumer-focused model of resident housing which organizes the setting and delivery of services around the resident rather than the facility. The personal care home model is continuing to evolve and is offering a level of care that is considered to be appropriate for seniors wishing to maintain independent lifestyles. Whereas personal care homes were previously developed as a "between" level of care from a retirement community to a nursing home, today, personal care homes are now being developed as core resident models. This is evident with the increasing number of freestanding facilities.

The TAC and the Division support the development of a long-term care system, including personal care home services, which takes into account factors that influence access to this model of resident housing and which embodies the following core principles:

* Consumer-centered system
* Consumer choices with the right to take considered risks
* Maximum functional independence for consumers
* System visible to potential users
* A flexible and creative array of services provided in a variety of settings

* Needs assessment as an essential part of the system

* Coordination of services and care management

*Effective quality control, enforcement and staff training

II. OVERVIEW OF PERSONAL CARE HOME INDUSTRY

Personal Care Homes are residential care settings for persons who can no longer live independently and who require some supervision but do not require clinical care or support. They provide housing, meals, supervision, and some assistance with activities of daily living (ADL) to residents who may not need the level of skilled care provided in nursing homes. There is no uniform personal care home model. They vary in the types of services they provide and the types of residents, which they serve. Personal Care Homes range from small, freestanding, independently owned homes with a few residents to large, corporately owned facilities that offer meals, housekeeping, and limited personal assistance. Some services may be provided by the facility's staff or by staff under contract to the facility. In other instances, the facility may arrange with an outside provider to deliver some services, with residents paying the provider directly, or residents may arrange and pay for services on their own. Residents come to personal care homes from their own residences, family referrals or referrals from healthcare facilities. States have the primary responsibility for overseeing the care that personal care home facilities provide to their residents.

The terms "personal care home" and "assisted living" are synonymous. The number of states that use the term *assisted living* has increased significantly in the past two years, and there is wide variation among the states in how the term is defined. The State of Georgia uses the term Personal Care Homes. While members of the technical advisory committee (TAC) had inquired about the State of Georgia's willingness to adopt the nomenclature "assisted living facilities" the term "personal care homes" is defined in the state statute and therefore should be used to describe these facilities. In order to enact a change in the name, a corresponding change in the state statute would have to occur.

The Need for Assisted Living

A 2000 report published by PriceWaterhouseCoopers & the Assisted Living Federation of America (ALFA) indicates that there are several factors which are expected to impact the demand for personal care homes

including, the aging of the American population and the increase in life expectancy, the increase in the number of persons aged 85 and over and the increase in the number of people who live alone. Forecasters predict that the 85+ age cohort will increase 33.2 percent between 2000- 2010. The PriceWaterhouseCoopers report also suggests that the increasing number of persons 80-years of age and older with incomes sufficient to afford assisted living is increasing. According to Claritas, Inc., a nationally recognized demographic firm, over 57 percent of those individuals 80-years of age and older in 1999 had incomes of $15,000 and above and 35 percent had incomes of $25,000 and above. Other sources, including the United States Bureau of the Census have developed population projections for persons aged 85 and over. These estimates indicate that this population age group will range from 18.2 million persons to 31.1 million persons by the year 2050. (PriceWaterHouseCoopers 2000)

The National Academy for State Health Policy suggests that among the long term care trends that have been evident over the past five to ten years has been the endorsement by providers of the "aging in place" concept. This concept would allow providers to retain residents with higher levels of impairment and allow limited health related services to be provided onsite. Other trends include the provision of specialized resources for residents with Alzheimer's disease or related dementia.

The rapid growth of the frail elderly is expected to impact the demand for this resident model. Demographically, this population increase reflects an aging population in which women outlive men. This growth in the number of elderly living alone has resulted in the increasing demand for services that historically have been provided by a spouse, other family members or live-in caretakers. According to the United States Bureau of the Census, based on 1993 data, for women the likelihood of living alone increases from 32% for 65-74 year olds to 57% for those women aged 85+. Men show similar trends with 13% of the 65-to-74 year-olds living alone and 29% of the men aged 85-and-older living alone. Other changes including the rising rates of divorce have increased the number of people living alone.

Some evidence suggests that some seniors prefer living in planned communities. A 1999 telephone survey conducted by the National Investment Center (NIC), found that more than 6.3 percent of the age 60+ household, 10 percent of the age 75+ households and 12.8 percent of the age 85+ households live in a community planned specifically for older adults. It also showed that 23 percent of the age 60+ households would consider moving to senior housing in the future. (NIC, 1999)

The State of Georgia's changing demographics mirror those of the nation and demands an approach that factors in the breadth of housing options that are available in the industry. However there is a growing concern about long-term care and how to assure provision of these services, particularly when there are limited public funds to support this model of care. The TAC recognized that the lack of financial resources would continue to limit access to this resident model. In an effort to address this important issue, they have enhanced the existing favorable consideration standard in the state's component plan and accompanying rules to encourage access to a greater portion of the state's elderly population by encouraging applicants to commit to seek measurable ways to locate alternative services/payor sources for those unable to pay and to implement innovative strategies to provide services to these population groups. The TAC felt strongly that access to services is a key concern and those providers instituting mechanisms to ensure access should receive every possible consideration.

While access to care for residents in the State of Georgia is important, during the TAC's deliberations, it became evident that some providers offer access to personal care home services to a large out-of-state population or have experienced actual utilization in excess of 90% average annual occupancy, (based on the number of licensed beds for the two-year period immediately preceding the application). TAC members recommended that such providers who are able to meet this unique market need or remain at such high occupancy levels receive an exception to the state's numerical need methodology. These exceptions would recognize the high demand for these programs and the uniqueness of such providers. While the CON application would be reviewed under the exception to the need standard, all other standards would have to be addressed by the applicant during the Certificate of Need application process.

Supply of Personal Care Homes

The personal care home resident model is becoming increasingly popular for seniors and their loved ones and can often provide a wide array of programs in a less costly environment. According to the 2000 PriceWaterHouseCoopers/ALFA document, the number of residents who lived out their lives in personal care homes has gradually increased. The combine resident capacity of the largest 20 providers ballooned from 17,526 residents in 1992 to 115,583 residents in 1999. Current estimates of the number of personal care home beds in the United States range from 800,000 to 1.5 million and consumer demand is expected to grow significantly. (GAO 1999).

The long-term viability of this resident model is evolving. While there has been concern about the possible saturation in some urban markets and some providers have planned to scale back on new development, the 2000 PriceWaterhouseCoopers/ALFA study indicates that average occupancy of personal care home residences increased to 91.5 percent in 1999, compared to 90.4 percent in 1998 and 90.8 percent 1997. On the other hand, the National Investment Center for the Seniors Housing & Care Industries (NIC), in a July 2001 article, have reported a drop in the average occupancy rate to 87 percent in the last 18 months and have indicated that key financial indicators have documented that net move-in rates have slowed significantly in the recent past while average occupancy rates have dropped in personal care homes that have been opened two years or more. The National Academy for State Health Policy have indicated that "ten states reported growth in licensed facilities of between 40% and 100% in the past two years: Alaska, Arizona, Kansas, Indiana, Massachusetts, Minnesota, Nebraska, New York, South Dakota, and Texas."(2000). Medicare or enhanced Medicaid financing will likely play the greatest role in the evolution of this housing model.

Demographics of Residents in Personal Care Homes

The 2000 PriceWaterhouseCoopers/ALFA study and an adhoc survey conducted by Georgia-ALFA indicated that personal care homes serve mostly residents with an average age of about 83 years old. The Georgia –

ALFA survey focused only on facilities with 25 or more beds. The PriceWaterHouseCoopers survey indicated that over half of the residents in this age cohort have some level of Alzheimer or dementia impairment and require help with three ADL's, typically bathing, dressing and medication administration. A typical resident in a personal care home is female and is either widowed or single.

Financing of Personal Care Homes

Most residents of personal care homes pay for care out-of-pocket, through other private funding, health insurance, or long term care policies. Costs vary depending on the size of the resident's room and the types of services required by residents. Data included in the 2000 PriceWaterHouseCoopers/ALFA report indicates that the average daily fees to residents in a personal care home ranges from a low of $24.67 to a high of $206.00. The average daily cost in 1999 was $76.60, equating to approximately $28,000 annually.

Georgia's Personal Care Homes

As of June 2001, the Georgia Department of Human Resources, Office of Regulatory Services reported licensing 1,611 personal care homes with a bed capacity of 25,234 beds. While 85% (1,366) of all personal care homes in Georgia are those that have 24 beds are less, these facilities maintain only 40% of all beds. Facilities with 25 beds are greater (245) represent fifteen percent (15%) of all facilities and maintain 60% of personal care home beds. Only facilities with 25 beds are greater are currently regulated by the state's Certificate of Need process.

For many years, Georgia has relied on a simple bed need methodology, which projected a bed supply rate per 1,000 CNI population age 65+. The need for additional personal care services was projected using bed capacity available in the past. As care systems, growth and innovation in long term care and family needs change, the Georgia Department of Community Health and the Technical Advisory Committee have attempted to incorporate a methodology that would be more objective and would attempt to finetune quality, resident life safety, continuity of care standards and improved access to care for all citizens. Data from the Department of Human Resources/Office of Regulatory Services indicate that as of June 2001, Georgia has a statewide personal care home bed rate of 26 beds per 1,000 population (age 65+). The bed rates and therefore access options varied greatly in different regions through the state.

The 2001 Technical Advisory Committee recommended the adoption of a need methodology, which will capture bed supply based on weighted, rate-based age calculations, and bed need. These guidelines may not reflect actual demand because resident family, and financial status is a key consideration in accessing services. This effort will be aided by the initiation of the state's first annual personal care home survey, which will be required as a condition of the Certificate of Need process.

IV. GUIDELINES

A. USE OF GUIDELINES

The following criteria and standards outline the guidelines for the development and delivery of the Personal Care Home Services in the State of Georgia as recommended by the Health Strategies Council. The planning horizon for all types of personal care homes is three (3) years.

B. DEFINITIONS FOR THE GUIDELINES

1. "Health Planning Areas" for personal care homes means the geographic regions in Georgia defined in this component plan. (See Appendix B)

2. “Horizon Year” means the last year of a three-year projection period for need determinations for a personal care home.

3. “Official State Health Component Plan” means the document related to personal care homes developed by the Department, adopted by the Health Strategies Council, and approved by the Board of Community Health.

4. "Personal care home" means a residential facility having at least 25 beds and providing, for compensation, protective care and oversight of ambulatory, non-related persons who need a monitored environment but who do not have injuries or disabilities which require chronic or convalescent care, including medical, nursing, or intermediate care. Personal care homes include those facilities which monitor daily residents' functioning and location, have the capability for crisis intervention, and provide supervision in areas of nutrition, medication, and provision of transient medical care. Such term does not include:

(i) Old age residences which are devoted to independent living units with kitchen facilities in which residents have the option of preparing and serving some or all of their own meals; or
(ii) Boarding facilities, which do not provide personal care.

C. GUIDELINES

1. APPLICABILITY

These guidelines apply to personal care homes with 25 or more beds.

2. AVAILABILITY

STANDARD 1- NEED

The 2001 Personal Care Home Technical Advisory Committee (TAC) recommended that need for Personal Care Homes be determined through the application of a numeric formula. This three-tiered stratification formula is similar to the methodology that is used for nursing home and home health services. Need is projected on a three-year planning horizon.

The numeric need for a new or expanded personal care home facility in any planning area in the horizon year shall be determined by a population-based formula which is the sum of the following:

A ratio of 18 beds per 1,000 projected horizon year civilian noninstitutional (CNI) population age 65-74
A ratio of 40 beds per 1,000 projected horizon year civilian noninstitutional (CNI) population age 75-84;
A ratio of 60 beds per 1,000 projected horizon year civilian noninstitutional (CNI) population age 85+

The net numerical unmet need for personal care home beds in each health planning area is determined by subtracting the number of existing and approved personal care home beds in the health planning area from the projected number of personal care home beds needed in the horizon year; provided however, that if the net numerical unmet need exceeds fifty percent (50%) of the current existing and approved beds in the planning area, the net numerical unmet need shall be limited to fifty percent (50%) of the existing and approved beds at the time the calculation is made.

Rationale for Standard 1

The 2001 Personal Care Home Technical Advisory Committee recommended that the numerical need for personal care homes be determined by a numeric methodology which factors different supply expectations for various age cohorts. Bed supply is determined through weighted, rate-based age calculations and bed demand reflects actual patterns of utilization. Rates for each age stratification were developed based on a comparison of the rates that were used for the determination of need for Georgia's nursing facilities. This process would allow a higher weighting for the age category with the greatest projected need.

The methodology is a three-tiered process with bed rates for the 65-74 age cohort, almost twice that of the nursing home bed need rate; the bed rate for the 75-84 age cohort somewhat higher than that of the nursing home methodology and the bed rate for the 85+ exactly half of the nursing facility need methodology. This methodology does not factor in the 0-64 age cohort because this group rarely uses these facilities. It was designed to ensure optimal accessibility of services.

In an effort to guard against potential excessive growth within any one year, in those planning areas with large numbers of needed beds, the Health Strategies Council made the recommendation that no more than 50% of the existing and approved beds would be approved.

STANDARD 2- EXCEPTIONS TO NEED

The Division may allow an exception to the above need standard as follows:

(i) To allow expansion of an existing personal care home if actual utilization has exceeded 90 percent average annual occupancy, based on the number of licensed beds for the two-year period immediately preceding the application; or

(ii) To allow expansion of an existing personal care home if the applicant has substantial occupancy by out-of-state residents. Substantial occupancy by out-of-state residents is defined as having at least 33% of the available licensed beds in the personal care home utilized by individuals who resided outside of the State of Georgia immediately prior to moving into the personal care home; or

(iii) To remedy an atypical barrier to personal care home services based on cost, quality, financial access or geographic accessibility.

Rationale For Standard 2

The TAC unanimously recommended the inclusion of these 'Exception to Need' options to assure access to personal care home services. Members agreed that existing providers whose facilities have reached 90% occupancy over the most recent two-year period should be allowed to seek an expansion of the service. This level of utilization suggests a growing demand for these particular services, even if the overall need has not been identified. It also recognizes the role of highly utilized providers in the delivery system. Any provider requesting this exception should provide the Division with detailed documentation for the number of beds requested, financial viability of the project, and an analysis of existing services in the area.

Another exception recognizes the role of existing providers whose programs, services and geographic location meets the needs of a substantial out-of-state resident base. Recent data from the Association of Assisted Living Federation of America-Georgia Chapter suggests that in some areas of the state, facilities have attracted between 26% - 40% of their resident base from out-of-state, frequently the parents of Georgia residents. Given that the need formula relies on Georgia population data, some exception should be

granted for heavy in-migration. Personal Care Home operators who are able to carve out this niche and serve this unique community need should be granted this exception.

Finally, one exception to the need standard makes an allowance for circumstances where access to personal care home services for a specific segment of the population is limited and where unusual barriers such as cost, quality, financial or geographic access is proven to exist. The burden to substantiate any of these circumstances rests on the applicant.

STANDARD 3- FAVORABLE CONSIDERATION

In competing applications, favorable consideration may be given to any applicant for a new or expanded personal care home which historically has provided and/or provides sufficient documentation of plans to provide a higher percentage of unreimbursed services to indigent and charity residents than required by the indigent and charity standard of 272-2-.09(10)(c) 10. Favorable consideration also may be given to any applicant for a new or expanded personal care home which historically has provided and/or provides sufficient documentation of plans to provide personal care home residential services at monthly and/or annual rates that are affordable to the greatest number of individuals based on analysis of the national rate for services and the income ranges of individuals at or above age 65 and in the applicant's market area(s).

Rationale for Standard 3

Historically, personal care home developers in Georgia have built few facilities to serve low-income residents. Because personal care homes are paid for primarily through private pay and private long-term care insurance this housing option is predominantly available to families with significant financial resources. This special consideration seeks to provide incentives for existing providers to improve access to these services to a broader spectrum of the community, particularly those with sparse financial means.

Indigent Care as defined in Georgia law is an individual or family with an annual income of less than 125% of the Federal Poverty Level. Charity Care may be defined by the organization but is generally offered to individuals or families with incomes between 125% and 200% of the Federal Poverty Level on a sliding fee scale basis. For individuals who are eligible for indigent care, no charges are assessed to the individual. In the case of charity care, the individual is assessed a percentage of the charges, based on ability to pay, and the remainder is either written off or covered with other resources.

TAC members recognized both the needs of personal care home operators and the need to provide access to this model of care to a broader spectrum of the community. They recommended that personal care home facilities that work with families to ensure access, utilizing nationally accepted criteria to determine monthly or annual rates for resident selection, particularly those in 65+ age group be given favorable consideration in the regulatory review process of competing applications.

STANDARD 4- PHYSICAL PLANT STANDARDS

An applicant for a new or expanded personal care home should be approved in a health planning area only if it complies with the following physical standards:

(i) The physical plant design and the program design of a personal care home shall support the concept of a non-institutional, home-like setting; and

(ii) The proposed physical plant design is in compliance with the rules and licensure standards of the Department of Human Resources and the applicant stipulates that the services required by such rules and licensure standards will be provided and any services prohibited by such rules and licensure standards will not be provided and will not be implied to be provided either through advertising or other means; and

(iii) There shall be a designated area for staff on duty in each personal care home and on each floor in the case of a multistory facility; and

(iv) The facility has the option of building kitchens or kitchenettes in the living units as long as the facility intends to provide three meals per day to residents. The kitchens or kitchenettes must comply with the Fire Marshall's and the Department of Human Resource's minimum licensure standards; and

(v) The facility provides assurance that it will not lease or contract space within the personal care home to an outside entity to provide services that the personal care home would otherwise not be allowed to provide.

Rationale for Standard 4

This standard is intended to outline the characteristics which distinguishes a personal care home from a nursing facility in order to ensure compliance with the state's licensing authority and to clearly limit the provision of any type of clinical services or support within these facilities. It is also meant to ensure that personal care homes providers plan for resident care utilizing a concept of care that is in harmony with national and state principles, including providing a non-institutional, home like setting, and providing a physical plant and program design that promotes aging in place. It prohibits a personal care home from using deceptive advertising /marketing practices to entice residents to their facility by misrepresenting the scope of services that the facility is authorized to provide. Furthermore, it clarifies resident access to staff and to kitchen services and use of space in the personal care home for other purposes.

STANDARD 5 - CONTINUITY OF CARE

An applicant for a new or expanded personal care home should document the provision of a continuity of care plan by providing a community linkage plan which demonstrates factors such as, but not limited to, referral arrangements with appropriate services of the healthcare system and working agreements with other related community services assuring continuity of care.

Rationale for Standard 5

The importance of continuity of care cannot be over-emphasized in the planning and coordination of services for senior citizens. Increasingly, families are concerned with the availability of well-coordinated, integrated systems, which promote continuity rather than episodic care for their relatives and loved ones. Personal care homes in the State of Georgia should develop referral arrangements with nearby health care providers, which would enhance and assure continuity of care efforts so that residents could be transferred in a timely manner to an appropriate level of care as needed. These arrangements should include access to services in emergencies.

STANDARD 6- QUALITY OF CARE

An applicant for a new or expanded personal care home should provide evidence of intent to comply with all appropriate licensure requirements, resident life safety standards and operational procedures required by the Georgia Department of Human Resources.

Rationale for Standard 6

Compliance with licensure requirements pertains to the successful operation and management of a personal care home, including resident life safety.

STANDARD 7- QUALIFIED PERSONNEL

An applicant for a new or expanded personal care home should provide evidence of the intent and ability to recruit, hire, and retain qualified personnel and that such personnel are available in the proposed geographic service area.

Rationale for Standard 7

A plan should be provided which specifies measurable strategies for staff selection, training and retention. In order to promote improved outcomes for residents and families, providers must focus on the quality of its staff. The provider's ability to meet this standard should include, but not be limited to, the following areas:

a) Developing professional and support staff by offering continuing education/training;
b) Ensuring that documented costs of personnel are accurately reflected in the proforma and cost projections;

c) Providing documentation that all staff who will provide the proposed services possess state licensure's specified levels of education, credentials, experience and training to provide the proposed services in a manner consistent with high quality; and
d) Demonstrate the intent to obtain appropriate levels and number of professional and support staff to meet the requirements of the services proposed, and that the specified personnel are available in the proposed service area.

STANDARD 8: LICENSURE REQUIREMENTS

An applicant for a new or expanded personal care home should provide evidence that no existing Georgia personal care home owned and/or operated by the applicant, a related entity, or by the applicant's parent organization has had a permit or license revoked, denied or otherwise sanctioned through formal enforcement action by the Georgia Department of Human Resources within the two years immediately preceding application.

Rationale for Standard 8

Because the health and safety of residents of personal care homes is one of the primary concerns of the Department of Human Resources, a CON should not be approved for facilities or organizations that have had recent licensure sanctions. A consent or settlement reached by the parties prior to hearing is not considered to be a "formal enforcement action" as referenced in this standard.

TAC members agreed that this is an area of great importance and suggested limiting the review of safety standards to the most recent two-year period preceding the application. This time frame would best represent the current environment of the facility or organization. It also reflects current licensure guidelines.

Standard 9- QUALITY IMPROVEMENT PROGRAM

An applicant for a new or expanded personal care home should provide a plan for assuring quality of care which includes, but is not limited to, procedures and plans for staff training and a program to monitor specific quality indicators.

Rationale for Standard 9

A primary way to monitor quality is to institute a comprehensive quality improvement program. Outcome data should be compared to industry benchmarks, which address the following specific areas: (1) resident outcomes; (2) resident satisfaction; (3) consumer demand; and (4) resident rights.

STANDARD 10 - FINANCIAL ACCESSIBILITY

An applicant for a new or expanded personal care home should foster an environment that assures access to individuals by providing a written commitment that unreimbursed services to residents who are indigent or meet the guidelines of a charity policy of the personal care home will be offered at a standard which meets or exceeds one percent of annual gross revenues for the personal care home after bad debt has been deducted.

Rationale for Standard 10

Systematic comparison of access to the wide range of care and housing models to all of the state's population is an essential component to the health care planning process. In the assessment of financial access for new or expanded personal care home services, particular attention will be given to the applicant who commits to seeking measurable ways to provide services for those unable to pay and implements innovative strategies for providing services to those unable to pay.

Indigent Care as defined in Georgia law is an individual or family with an annual income of less than 125% of the Federal Poverty Level. Charity Care may be defined by the organization but is generally offered to individuals or families with incomes between 125% and 200% of the Federal Poverty Level on a sliding fee scale basis. For individuals who are eligible for indigent care, no charges are assessed to the individual. In the case of charity care, the individual is assessed a percentage of the charges, based on ability to pay, and the remainder is either written off or covered with other resources.

The equitable distribution of indigent care among providers is corollary to the equitable access to personal care homes and health care services for all citizens without regard to the ability to pay. It is characteristic of rational systems that the burden of the indigent be equitably distributed among all providers.

STANDARD 11- INFORMATION REQUIREMENTS

An applicant for a new or expanded personal care home should agree to provide the Department with requested information and statistical data related to the operation and provision of personal care homes and to report that data to the Department in the time frame and format requested.

Rationale for Standard 11

Uniform data is essential to assess the changing patterns and projected service needs relevant to the provision of this service. As additional emphasis is placed on quality, cost and efficiency indicators, the collection of data will allow more precise assessment of these factors as well as others which are important to health planning. Applicants will be required to provide requested information and statistical data related to the operation and provision of personal care home services to the Department of Community Health by the requested time.

V. GOALS, OBJECTIVES, AND RECOMMENDED ACTIONS

A. GOAL

To ensure that Georgians have access to an integrated array of long-term care services including personal care homes, that provide efficient, high-quality care in a consumer oriented environment.

B. OBJECTIVES

Improve access to cost effective personal care homes by authorizing these services based on the Guidelines in this plan and by acknowledging the need for services even if the supply is not readily available.

Ensure quality and patient safety through compliance with appropriate licensure standards;

Encourage continuity of care for residents in personal care homes

Continue to assess availability, quality and effectiveness of personal care homes through the collection of information and statistical data

C. RECOMMENDED ACTIONS

Implement Certificate of Need (CON) rules for personal care homes consistent with this component plan and approve CON applications accordingly.

Adopt an objective need standard for personal care home services

Require new or expanding personal care homes to demonstrate plans that their services are coordinated with other existing healthcare services within the community where appropriate.

Support the development of services, which will promote a long-term care system, which is a seamless, continuum of care based on the principles and models developed by the Technical Advisory Committee and Division staff.

Collect data annually, and on an ad hoc basis as needed, to maintain current, accurate information related to availability, quality, efficiency, and effectiveness of services being provided.

Reconvene the TAC within two years to review changing service and utilization patterns and to ensure that this methodology is still adequate to determine need.

VI. REFERENCES

Allen, Karen. U.S. General Accounting Office, Assisted Living Quality-of-Care and Consumer Protection Issues. (Publication no. GAO/T-HEHS-99-111) 1999

Assisted Living: Quality of Care and Consumer Protection Issues in Four States, U.S. General Accounting Office. GAO-HEHS-99-27. April 1999

Mollica, Robert. National Academy For State Health Policy (NASHP), State Assisted Living Policy: 2000. July 2000 http://www.nashp.org/salp2000/home.html

National Investment Center (NIC). "Critical Lender and Investor Alert: Understanding Lease-Up Issues." The NIC Insider. July 2001

National Investment Center (NIC). "National Housing Survey of Adults Age 60+: Opinions, Attitudes, Perceptions and Behaviors. Vol. II." NIC Resource Guide. 1999 www.nic.org

U.S. Department of Commerce, Bureau of the Census, Economics & Statistical Administration, "Statistical Brief, Sixty-five Plus in the United States", May 1995

2000 Overview of the Assisted Living Industry: PriceWaterHouseCoopers & Assisted Living Federation of America, Washington, D.C., 2000

Georgia State Health Plan
Personal Care Homes Component Plan

APPENDIX A

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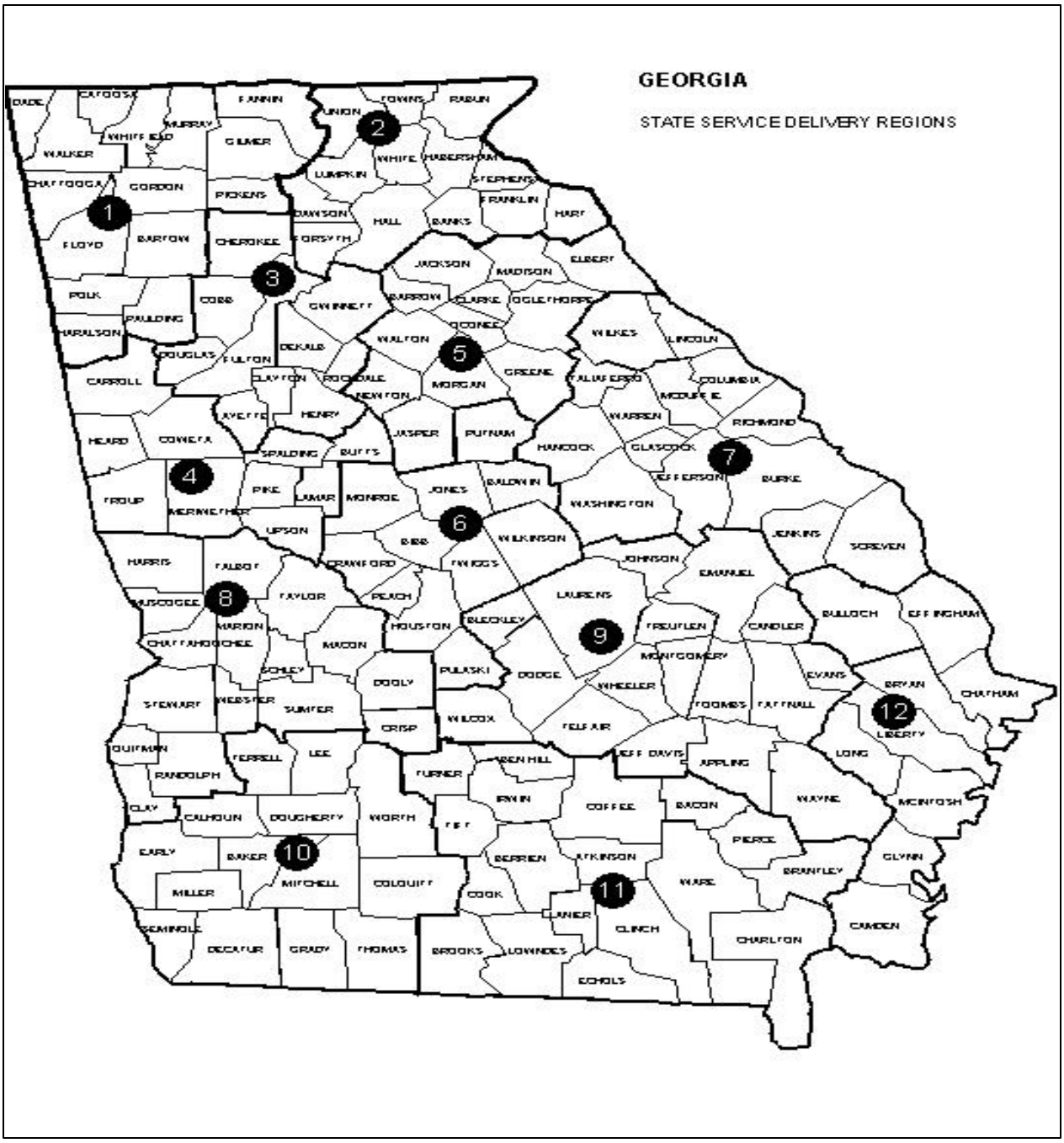
Georgia State Health Plan

Personal Care Homes Component Plan

APPENDIX B

Map

STATE SERVICE DELIVERY REGIONS


GEORGIA
STATE SERVICE DELIVERY REGIONS
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3
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9
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11
12

Georgia State Health Plan

Personal Care Homes Component Plan

APPENDIX C

Personal Care Homes
Bed Capacity by Health Planning Areas
(as of July 3, 2001)

Personal Care Homes
Bed Capacity by Health Planning Area

Health Planning Area	County		Capacity (all beds)	2001 POP (CNI)	Beds per 1,000 (age 65 and over)
HPA 1					
	Bartow		217	9,321	23.3
	Catoosa		110	7,729	14.2
	Chattooga		55	4,511	12.2
	Dade		21	2,308	9.1
	Fannin		21	4,662	4.5
	Floyd		642	16,543	38.8
	Gilmer		13	3,166	4.1
	Gordon		105	5,631	18.6
	Haralson		125	3,930	31.8
	Murray		8	3,413	2.3
	Pickens		6	3,016	2.0
	Polk		63	7,799	8.1
	Walker		99	11,787	8.4
	Whitfield		218	11,070	19.7
		TOTAL	**1,703**	**94,886**	**17.9**
HPA 2					
	Banks		0	1,830	0.0
	Dawson		16	1,572	10.2
	Franklin		35	3,812	9.2
	Habersham		133	5,600	23.8
	Hall		337	16,294	20.7
	Hart		69	4,505	15.3
	Lumpkin		120	2,278	52.7
	Rabun		54	3,079	17.5
	Stephens		155	5,047	30.7
	Towns		48	2,778	17.3
	Union		104	3,984	26.1
	White		32	3,016	10.6
		TOTAL	**1,103**	**53,795**	**20.5**

HPA 3				
Cherokee		284	10,401	27.3
Clayton		568	18,576	30.6
Cobb		1938	48,643	39.8
DeKalb		1845	73,525	25.1
Douglas		205	8,524	24.0
Fayette		275	8,134	33.8
Forsyth		271	9,185	29.5
Fulton		2999	89,360	33.6
Gwinnett		1201	29,570	40.6
Henry		322	9,967	32.3
Newton		126	7,370	17.1
Paulding		48	5,713	8.4
Rockdale		291	7,191	40.5
	TOTAL	**10,373**	**326,159**	**31.8**
HPA 4				
Barrow		124	4,912	25.2
Clarke		340	9,325	36.5
Elbert		85	3,600	23.6
Greene		88	2,187	40.2
Jackson		226	5,381	42.0
Madison		18	3,442	5.2
Morgan		55	2,320	23.7
Oconee		87	2,573	33.8
Oglethorpe		74	1,597	46.3
Walton		251	6,810	36.9
	TOTAL	**1,348**	**42,147**	**32.0**
HPA 5				
Butts		128	2,412	53.1
Carroll		323	9,955	32.4
Coweta		208	9,528	21.8
Heard		12	1,364	8.8
Lamar		0	2,435	0.0
Meriwether		46	3,791	12.1
Pike		0	1,922	0.0
Spalding		142	8,564	16.6
Troup		235	9,895	23.7
Upson		46	5,246	8.8
	TOTAL	**1,140**	**55,112**	**20.7**

HPA 6				
	Baldwin	88	4,924	17.9
	Bibb	772	27,826	27.7
	Crawford	5	1,275	3.9
	Hancock	14	1,260	11.1
	Houston	461	12,812	36.0
	Jasper	17	1,644	10.3
	Jones	29	2,769	10.5
	Monroe	49	2,367	20.7
	Peach	48	3,353	14.3
	Putnam	30	2,880	10.4
	Twiggs	32	1,460	21.9
	Washington	32	3,180	10.1
	Wilkinson	0	1,709	0.0
	TOTAL	**1,577**	**67,459**	**23.4**
HPA 7				
	Burke	111	2,924	38.0
	Columbia	373	7,289	51.2
	Emanuel	134	3,694	36.3
	Glascock	15	435	34.5
	Jefferson	39	3,067	12.7
	Jenkins	9	1,588	5.7
	Lincoln	5	1,660	3.0
	McDuffie	55	3,357	16.4
	Richmond	970	26,709	36.3
	Screven	29	2,740	10.6
	Taliaferro	26	432	60.2
	Warren	15	1,181	12.7
	Wilkes	43	2,440	17.6
	TOTAL	**1,824**	**57,516**	**31.7**
HPA 8				
	Chattaahoochee	0	353	0.0
	Clay	0	722	0.0
	Crisp	68	3,449	19.7
	Dooly	45	1,948	23.1
	Harris	0	3,928	0.0
	Macon	33	1,951	16.9
	Marion	0	960	0.0
	Muscogee	744	28,508	26.1
	Quitman	0	611	0.0
	Randolph	0	1,579	0.0
	Schley	5	688	7.3
	Stewart	6	1,199	5.0
	Sumter	333	3,989	83.5

	Talbot		0	1,203	0.0
	Taylor		3	1,595	1.9
	Webster		0	457	0.0
	TOTAL		**1,237**	**53,140**	**23.3**
HPA 9					
	Bleckley	48		1,962	24.5
	Dodge	81		3,227	25.1
	Johnson	10		1,494	6.7
	Laurens	207		7,147	29.0
	Montogomery	31		1,193	26.0
	Pulaski	31		1,690	18.3
	Telfair	24		2,319	10.3
	Treutlen	32		1,084	29.5
	Wheeler			948	0.0
	Wilcox	28		1,446	19.4
	TOTAL	**492**		**22,510**	**21.9**
HPA 10					
	Bryan	0		2,220	0.0
	Bulloch	204		5,996	34.0
	Candler	15		1,484	10.1
	Chatham	999		38,774	25.8
	Effingham	24		3,728	6.4
	Evans	64		1,623	39.4
	Liberty	112		2,757	40.6
	Long	12		980	12.2
	Tattnall	27		3,084	8.8
	Toombs	130		3,872	33.6
	TOTAL	**1,587**		**64,518**	**24.6**
HPA 11					
	Baker	0		642	0.0
	Calhoun	15		1,028	14.6
	Colquitt	182		7,494	24.3
	Decatur	135		4,788	28.2
	Dougherty	436		13,299	32.8
	Early	37		2,484	14.9
	Grady	98		3,860	25.4
	Lee	16		2,199	7.3
	Miller	15		1,363	11.0
	Mitchell	64		3,698	17.3
	Seminole	142		1,970	72.1
	Terrell	35		2,139	16.4
	Thomas	317		7,578	41.8
	Worth	73		3,401	21.5
	TOTAL	**1,565**		**55,943**	**28.0**

HPA 12				
	Ben Hill	24	2,757	8.7
	Berrien	53	2,720	19.5
	Brooks	179	2,613	68.5
	Cook	79	2,714	29.1
	Echols	0	239	0.0
	Irwin	43	1,782	24.1
	Lanier	22	1,007	21.8
	Lowndes	202	10,032	20.1
	Tift	157	5,125	30.6
	Turner	39	1,654	23.6
	TOTAL	**798**	**30,643**	**26.0**
HPA 13				
	Appling	30	2,676	11.2
	Atkinson	33	1,183	27.9
	Bacon	35	1,741	20.1
	Brantley	0	1,614	0.0
	Camden	50	3,663	31.0
	Charlton	3	1,209	0.8
	Clinch	4	1,007	3.3
	Coffee	88	4,683	87.4
	Glynn	163	12,191	34.8
	Jeff Davis	15	1,941	1.2
	McIntosh	4	1,747	2.1
	Pierce	40	2,397	22.9
	Ware	121	7,229	50.5
	Wayne	43	3,869	5.9
	TOTAL	**629**	**47,150**	**13.3**
STATE TOTALS		**25,376**	**970,978**	**26.1**

Sources: Department of Human Resources, Office of Regulatory Services, July 3, 2001

All licensed personal care homes and beds

Civilian Non-Institutional Population, Age 65 and over, 2001 Estimate from OPB