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From: Bishop, Gene MD [Gene.Bishop@uphs.upenn.edu]
Sent: Monday, September 15, 2008 11:34 AM
To: IRRC
Subject: assisted living comments
Attachments: GB letter AL final.doc

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SEP 15 REC'D
INDEPENDENT REGULATORY REVIEW COMMISSION

I am attaching comments on the proposed assisted living regulations. I have also sent a hard copy.

Gene Bishop, MD

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SEP 1 5 REC'D

INDEPENDENT REGULATORY
REVIEW COMMISSION

Gail Weidman

Department of Public Welfare, Office of Long-Term Care Living,

P.O. Box 2675,

Harrisburg, PA 17105.

Re: Draft Regulations 14-514 Assisted Living

Dear Ms. Weidman:

I am pleased to be able to offer comments on the proposed regulations governing the licensure and operations of assisted living facilities in Pennsylvania. These regulations are an excellent start to improving the current chaotic system, in which assisted living is a marketing term and patients are unaware what services they will receive, and whether the facility will be able to meet their needs.

As Pennsylvania seeks to rebalance the proportions of elderly who receive care in nursing homes, assisted living, personal care homes, and home and community based services, it is important to remember the following statistics: only 28% of individuals who enter assisted living facilities die in those facilities. Thus the majority of residents are not aging in place. Setting strong and clear standards for care will support the philosophy of aging in place.

As a physician who is board certified in internal medicine and geriatrics, and who has practiced primary care medicine for over 25 years, I have some concerns. I have many years of experience caring for patients who are struggling to remain at home, or caring for patients who chose so-called assisted living, only to find it did not meet their needs. I have recently also had personal experience – in another state - seeking the right long-term care placement for a family member. It was of tremendous help to me that the state had clear regulations around assisted living. I am hopeful that Pennsylvania, with our large number of older residents, can be a leader and example in this field.

As a family member, there are many areas of the proposed regulations on which I could offer comments. However, I will limit my comments to those areas that are of particular concern to me as a health professional.

2800.4 Definitions

Defining assisted living is extremely important, and there is no nationally accepted definition, either in the medical, nursing, social work, gerontology, health policy or legal arenas. The term has come to be applied to a wide variety of residential settings for older adults and some younger adults with disabilities. It is my understanding that nursing facility clinically eligible persons will be able to reside in assisted living. Therefore I believe that the definition of assisted living residence must be stronger, and must state clearly that it is the ability to provide assisted living services. Assisted living services must then be defined.

Assisted living services must be defined as specifically including assistance with ADLs, assistance with IADLs, financial management, 24 hour supervision and monitoring, meals, housekeeping, laundry, activities and socialization, space and equipment for activities, medication administration, healthcare services, cognitive support services, supplemental health care services, hospice, and transportation to medical and social appointments.

2800.22 Application and admission

The draft regulations require an assisted living screening on a form supplied by the Department, and a medical evaluation. The content of the preadmission screening form has not been determined. Will this form only seek to screen for "excludable conditions?" It must be a form that can be easily used by a spectrum of practitioners seeking to help potential residents decide on the best long term care option for their needs.

While the preadmission screening must be completed prior to admission, the medical evaluation can be completed up to 15 days after admission. Most admissions to assisted living facilities are not be emergent admissions. Even following a hospitalization, a potential resident is likely to spend time in a skilled nursing /rehab facility prior to moving into assisted living. The medical evaluation is a critical component of the development of a care plan in the assisted living facility. The development of a care plan is a critical element in helping a resident or her family decide whether to enter the facility. I cannot imagine advising a patient or family to enter a facility and sign a contract without knowing at least a proposed care plan. Thus I believe the medical evaluation should be done prior to admission, with an exception allowed for an urgent admission. The proposed regulations also do not specify whether the MA-51 will be used for the medical evaluation. This form does not promote the kind of adequate evaluation needed in this setting. A proposed care plan, including an identification of needs, should be made before the resident must sign a contract.

2800.25 Resident-residence contract

The lack of standardization of assisted living is one of the most difficult problems for potential residents and families. Although the draft regulations require that facilities clearly state what they will offer, and what the costs will be, this does not offer sufficient clarity. All 64 Medicare D plans in Pennsylvania tell you what they cover and what medications will cost, but seniors are completely confused when it comes to choosing a plan. Pennsylvania must do better than that. Facilities should be required to offer 1 or more standardized core packages that can be compared across facilities. These could include a standardized package for residents of a dementia unit, a package for residents who are not cognitively impaired and who require minimal assistance with ADLs and IADLs, and a third package for those who are not cognitively impaired but have significant physical disabilities requiring more services. A potential resident should not need to read the fine print in every contract to determine whether Package A includes laundry, or whether the contract from a different facility does not include medication administration, or places a limit on the number of medications that can be administered for a core fee.

2800.57 Direct Care Staffing

As a clinician, I can appreciate the difficulty of determining staffing needs for a facility serving a population with varying functional abilities and medical problems. Nonetheless, I am disturbed by the proposed plan to determine staffing by mobility status. Assessment of mobility is critical. One important study[1] noted that there was no difference in mobility problems between residents with dementia in nursing homes and residents with dementia in assisted living facilities, but those in assisted living facilities were less likely to be assessed for mobility problems, and less likely to be offered help. This suggests that assisted living facilities could easily underestimate their residents with mobility problems, and therefore their staffing needs.

A man with advanced dementia, but no arthritis, can be quite mobile but require assistance with all ADLs and IADLs except for eating. A younger person with neurologic physical disabilities but no cognitive difficulties may be "immobile" by the definitions provided in the regulations, but have fewer care needs. A minimum number of direct care hours of two hours per resident should be required of all facilities, with additional staffing to meet unexpected emergencies. Studies in the medical literature have shown that hospitalization rates (the need to transfer a resident to the hospital) are significantly lower in facilities with higher proportions of skilled staff hours.[2]

2800.60 Additional staffing

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[1] Williams, Sharon et al. Characteristics associated with mobility limitation in long term care residents with dementia.*The Gerontologist* Vol 45 Special Issue p 62-67 2005.

[2] Stearns SC et al. Determinants and effects of nurse staffing intensity and skill mix in residential care/assisted living settings. *The Gerontologist* Vol 47 (5) 662-671. 2007

I want to especially support the proposed regulation requiring a nurse on call at all times. Without a nurse on call, the default option in any facility will be to send a resident to the emergency room for any medical symptom. It is not in the best interests of the resident, or of overall health care costs, to utilize emergency rooms in these situations. In addition, an important study of assisted living facilities demonstrated that the presence of a nurse enhanced the ability of a resident to age in place by reducing the frequency of transfer to a nursing home.[3] If assisted living in Pennsylvania is truly meant to offer an aging in place option, nurses are critical.

I also want to strongly support 2800.227, the requirement that the support plan be developed under nursing supervision. There is no requirement for a medical director for an assisted living facility. It is clear that support plans that involve the integration of multiple medical, social, and behavioural needs require the skills of a nurse.

2800.141 Resident medical evaluation and health care

In addition to the listed components of the initial medical evaluation, the physician, nurse practitioner, or physician assistant should indicate whether advanced directives, or physician orders for life-sustaining treatments (POLST) have been discussed with the potential resident or family members, and any outcomes or plans from that discussion.

The proposed regulations require that only applicants to a special dementia unit have documentation of cognitive status. However, a cognitive evaluation should be done on every applicant over 65, and anyone with a diagnosis in which cognitive impairment may be part of the problem, including those with traumatic brain injury. Dementia often goes undiagnosed and residents requiring special dementia care may have been previously undiagnosed, leading to inappropriate placement and service plans.

A repeat medical evaluation should be required every six months, or immediately following hospitalization and again 30 days later. Studies that have looked at assisted living and nursing home care for persons with dementia have found similar medical outcomes. However, hospitalization rates are much higher from assisted living facilities. Adequate medical assessment prior to entering an assisted living facility, and more frequent assessment when living in the facility, can potentially prevent initial inappropriate admissions or future transfers to hospitals or nursing homes.

2800.142. Assistance with health care and supplemental health care services

The proposed regulations allow a facility to require a resident to use health care providers designated by the facility if this is made clear at the time of admission. I

[3] Phillips CD et al. Effects of facility characteristics on departure from assisted living: results from a national study. *The Gerontologist* Vol 43(5) 690-696. 2003

suggest that if a facility requires a particular physician or ancillary provider, the facility must be required to explain to the resident who the designated providers are, what insurance they accept, and the basis on which they were chosen, including full financial disclosure if there is any connection between the AL facility and the health care provider.

The law only states that the facility can require the use of supplemental health care providers. Physicians are not supplemental health care providers and should not be affected by this provision. Facilities should allow residents to utilize the resident's chosen practitioner as long as transportation to that practitioner, if provided by the facility, is within a reasonable time/distance parameter. Such time/distance parameters may vary for urban or rural settings.

Assistance with health care and supplemental health care services also includes accompanying a resident, if the resident is cognitively impaired or requires physical assistance, to a medical appointment. The regulations should state that the facility is responsible for insuring that the direct care worker who accompanies a cognitively impaired person is carrying adequate medical records needed for the appointment, and knows the resident well enough to answer the kind of questions that family members would be able to answer if the resident was home dwelling, e.g. sleep habits, appetite, continence, or symptoms.

2800.63 Staff training

There is no reason why all direct care workers cannot receive training in basic CPR and first aid. This is not costly, and it is common sense.

The proposed regulations require that all facilities have AEDs and that staff be trained to use them. This is a large expense in both equipment and

All staff should receive training in advanced directives according to Pennsylvania law, and should understand where to look for these materials in resident records.

2800.181 Medication administration

The proposed regulations provide a significant advance to allow persons who cannot self-administer medications to safely receive medications in the assisted living setting. However, there are additional medications for which patients or family members are routinely taught administration techniques, and these should be included. Oxygen therapy, nebulizer treatments, and erythropoietin or low molecular weight heparin injections all fall under this category. The regulations should be amended to say that subcutaneous medication administration that can be safely taught to family members should be allowed in assisted living if a direct care staff member has been trained in their use.

2800.229 Excludable conditions

The excludable conditions in the regulations are taken directly from the law, and I understand that they cannot be changed by regulation. However, they are confusing. Reportable infectious conditions usually include methicillin resistant staphylococcus, and C. Difficile. Yet these are conditions commonly acquired in the hospital, and patients are discharged to both home and nursing homes with these

conditions. It is unclear if a resident could return to her home in an assisted living facility if she were colonized or infected with these organisms.

In addition, people do not lose their homes if they have non-healing vascular ulcers, or Stage 3 or 4 decubitus ulcers. It would be of concern if the latter developed in the assisted living facility, but temporary transfer to a hospital or nursing home should not automatically result in the resident's loss of home.

The second list of conditions that are excludable unless a resident is able to perform self-care are also confusing. Nebulizer treatments are frequently administered by family members. If a resident with pulmonary disease has worsening disease, and requires night time oxygen and occasional nebulizer treatments, this would seem to be consistent with aging in place and should not require transfer out of the facility. It is also possible that as a resident's condition changes, hospice or palliative care will become an option. Deciding on this option often requires days or weeks of consideration by a resident or family members. This would be an unfortunate time for a potentially unnecessary transfer to a nursing home or hospital. Although a facility can apply for an exception to keep the resident, the resident has no appeal if the facility wishes to discharge the resident.

2800.96 First Aid Kit

The proposed regulations require that every facility have a first aid kit that includes an automated electronic defibrillation device. These devices must be prescribed by a physician, and a facility must have a physician director who oversees use and training of the device. These devices have been shown to be very safe. Their locations in many public places, where they can be used by untrained staff, mean that they can be safely used in assisted living facilities. However, their easy accessibility in a facility that is likely to have residents who have requested not to be resuscitated in the event of cardiac arrest mandates that all staff have training in law and policy regarding advanced directives.

Omitted items

I have had many older patients, who are not demented, who found themselves in a Medicare HMO when they had no intention of leaving traditional Medicare, or who found themselves in a prescription plan they knew nothing about. We all know these same people are the victims of unscrupulous financial advisors, contractors, and salespeople who take advantage of the trusting elderly. Pennsylvania must protect its older citizens by prohibiting deceptive marketing practices for assisted living. The regulations must specifically prohibit facilities that are not licensed as assisted living from the use of those words in their name or advertising e.g. "assisted senior living" or other permutations should not be permissible. Other truth in marketing features, with penalties, should be added.

Conclusion

These regulations have the potential to make assisted living, a continuum in long term care living options, a safe high quality option in Pennsylvania. To do so, they must address the concerns noted above. Many current personal care homes will likely chose to

remain licensed as personal care homes. The Department of Public Welfare will need to monitor these homes to verify that residents in these facilities do not have more acute needs than can be managed in a personal care home. However, potential residents must know that when they are looking at a licensed assisted living facility in Pennsylvania, that facility meets high standards that will allow them to age in place and that will be able to care for them according to a care plan set forth at the time the admission contract is signed.

Thank you for your attention.

Sincerely,

Gene Bishop, MD
Clinical Assistant Professor of Medicine
University of Pennsylvania School of Medicine