14-514 L-82

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#2712

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Ms. Gail Weidman
Department of Public Welfare
Office of Long-term Care Living
P.O. Box 2675
Harrisburg, PA 17105

RE: Proposed Regulations 14-514

Dear Ms. Weidman,

I am a clinical psychologist who has specialized in practice with older adults since 1977 (31 years). I have worked as a geropsychologist in a state hospital, a community mental health center, a 1,000 bed non-profit long-term care facility, an eldercare corporate headquarters, and – for the last 5 years – as an independent practitioner in several CCRC's, AL's, and in-home. I am writing to you as someone deeply committed to best practices in eldercare.

As a geropsychologist, I am particularly sensitive to the emotional, behavioral and cognitive aspects of long-term care.

I will try to be brief in my comments and recommendations.

First, I believe that assessments and provisional service plans should be completed prior to admission, in order to allow for consumer choice in facility selection, accurate pricing, and agreement between/among parties that care needs will be met. I believe that pre-admission assessments of all individuals should include a cognitive screen such as the Mini-mental State Exam, and depression screen such as the Geriatric Depression Scale. These screening instruments would identify cognitive and emotional care needs early, so that care could be in place at the time of admission.

Second, I believe that consumers – already confused about the difference between acute care, rehab, and long-term care – deserve a clear, up-front definition of "assisted living" care in PA, and especially, how it differs from nursing home care (on the one hand) and personal care (on the other). This definition and LTC context should occur early in the regulation definitions.

Third, if I am reading correctly, these AL regs do not require the presence of a social worker. I work in several personal care homes and find those that employ a social worker to be vastly superior in identifying and meeting psychosocial needs and satisfying family concerns. If I understand correctly that these regs will allow nursing home eligible residents to live in AL, I strongly recommend mandating a social worker.

Fourth, with this high acuity population, I would strongly recommend a required Medical Director, an R.N. on site at least 8 hours per day and on-call 24, and a social worker.

Fifth, I recommend unlimited choice of providers but limited transportation to providers (the latter can become unreasonable). Facilities could designate the mile-radius of medical transportation, but provide unlimited choice within the radius.

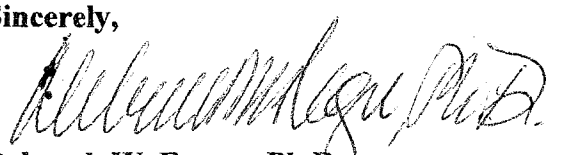
Sixth, I recommend a requirement that the essentials of choice – advance directives and designated powers of attorney for healthcare and finances – be placed at the front of the medical chart, in plastic sleeves easily sent out to hospitals, and that all staff be trained in their content/importance.

Seventh, regarding Special Care Units:

1. **No admission without empirically validated cognitive disability (e.g., physician diagnosis of dementia and MMSE<18).**
2. **No admission with psychiatric disorder (e.g., schizophrenia) without additional physician cognitive diagnosis of dementia.**
3. **Not to be used to contain behavioral problems.**
4. **"Informed consent agreement" will include resident, family/POA/guardian, and care team.**
5. **Observe, to the maximum extent possible, "least restrictive alternative" principle in behavioral health, encouraging residents to interact with general AL population at all opportunities, and not to unduly restrict egress from unit (e.g., for immobile residents or others at low or no risk of wandering).**
6. **It is unrealistic to expect residents with significant dementia to be capable of operating a keypad.**

Thank you for your consideration of these comments.

Sincerely,



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