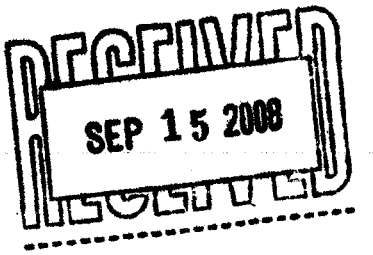
#2712 14-514 2-96

Weidman-Jones, Gail

From: Gelnett, Wanda B. [wgelnett@irrc.state.pa.us] on behalf of IRRC [IRRC@IRRC.STATE.PA.US]
Sent: Monday, September 15, 2008 8:18 AM
To: Weidman-Jones, Gail; O'Brien, Ruth
Cc: Smith, James M.; Jewett, John H.
Subject: FW: PA Assisted Living Regulations



Comments IRRC rec'd

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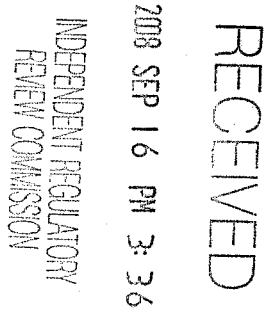

-----Original Message-----
From: Richard G Stefanacci [mailto:r.stefan@usp.edu]
Sent: Sunday, September 14, 2008 9:53 PM
To: IRRC
Subject: PA Assisted Living Regulations

Gail -

Congratulations on a great start to regulations for Pennsylvania Assisted Living Facilities. The PA regulations follow closely the recommendations made in the American Geriatrics Society Position Statement which is included below. Two additional thoughts that we would like to make are (1) the PA regulations should require Assisted Living Facilities to include as part of their staff a licensed physician to serve as the facility medical director in the same way that skilled nursing facilities have done for some time. In addition (2) I would stress that the regulations should continue to provide a protected environment for ALF residents while allowing for the flexibility and creativity that have allowed for a high variability of ALF offerings. This assures ALF residents the opportunity to find an ALF that meets their needs and price point. Regulations should guarantee a safe environment especially when it comes to medical services by requiring a licensed administrator, facility medical director and attending physicians that are aligned with the ALF. At the same time regulations should not be overly prescriptive. Requiring a minimum ceiling height requirement or pool's to have life guards is overly prescriptive and thus could have the result of eliminating for ALF residents facilities that could meet their requirements and price point.

Again I appreciate the work that you have done to date and hope that you consider the addition of a Medical Director while at the same time safe guarding against over regulations.

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www.G4theG.org<http://outlook.usip.edu/owa/UrlBlockedError.aspx>
Helping Children Affected by Cancer Achieve Their Goals

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http://www.americangeriatrics.org/products/positionpapers/ags_alfPF.shtml

Assisted Living Facilities Position Statement
Health Care Systems Committee, American Geriatrics Society

BACKGROUND

The American Geriatrics Society (AGS) believes that Assisted Living Facilities (ALF) can offer seniors an environment that could enhance their health status over other possible living arrangements. This Position Statement is to provide policymakers, administrators, health care professionals, and consumers with guidance for achieving optimum outcomes with regards to ALFs.

POSITIONS

The following principles are essential to realizing the potential benefits of ALFs

1. ALFs have a responsibility to provide complete information to prospective residents to assure that an appropriate match is made between resident and facility.

Rationale: Consumers of ALFs need to have detailed information regarding the services provided and any associated costs. In contrast to nursing facilities whose primary payor are the states through Medicaid, ALF payors tend to be the residents themselves. As a result, ALFs are subject to less state and federal regulation and are more affected by market pressures. In order for consumers to make optimal decisions, ALFs need to disclose fully the services provided, the limitations of their facility, how much functional decline they can handle effectively, and especially the criteria residents must continue to meet to remain in the ALF. In addition, the staffing levels and expertise should be discussed with all potential ALF residents.

Reference: Hawes C, Phillips C, Rose M. (2000) High Service or High Privacy Assisted Living Facilities, their Residents and Staff: Results from a National Survey. Miriam Rose, Myers Research Institute. U.S Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy (ASPE) and Research Triangle Institute, November.

2. Residents entering an ALF should have a baseline evaluation, completed within 30 days of their admission, of their physical, medical and psycho-social needs, and a detailed review of all medications, prescription, non-prescription, herbal and other remedies, completed by a qualified, licensed practitioner experienced in the care of older adults. This culturally sensitive evaluation should be the basis for the development of a care plan that indicates resident physical and psycho-social needs along with resident preferences for treatment and strategies for meeting identified needs. This care plan should be available to the resident and to the ALF staff. The ALF should clearly indicate, preferably prior to admission, the specific elements of the care plan that the ALF will meet and is willing to accommodate as well as the responsibility of the resident/family.

Rationale: A resident's move to assisted living is a critical life change event. This event offers a special opportunity for a comprehensive review of the resident's health and social needs. This move to an ALF often signals some medical, cognitive or functional need for the senior, which makes a comprehensive assessment all the more crucial at this transition of care. It also offers the opportunity to provide optimum interventions designed to maintain independence and prevent pre-existing conditions from deteriorating.

3. ALF staff should be knowledgeable and skilled in carrying out important components of geriatric care, including, but not limited to, safe medication administration, falls prevention, incontinence care, communication techniques, dementia care, skin care, and able to recognize the changes that can signal acute illness, delirium, and depression.

Rationale: Staffing levels and expertise do vary between ALFs. In a national study of ALFs, 40% reported having full time registered nurse staff, 55% had a registered nurse either full or part time, and 71% had a registered nurse or licensed practical nurse on staff full or part time. About half (52%) used outside agencies to supply registered or licensed practical nurses. Staff working on-site should be sufficient in numbers and experience to meet the on-going needs of the residents at all times. Staff should be knowledgeable regarding safe medication administration, falls prevention, incontinence care,

communication techniques, dementia care, skin care, and recognition of the changes that can signal acute illness/delirium.

Reference: Phillips, Munoz, Sherman et al (2003) Effects of Facility Characteristics on Departures from Assisted Living: Results from a National Study. Gerontologist 42 (5) 690-696.

Ambulatory Geriatric Clinical Care and Services Position Statement. Developed by the AGS Health Care Systems Committee and approved May 2000 by the AGS Board of Directors. Journal of the American Geriatrics Society, 48:845-846, 2000.

4. A primary care provider (includes geriatric nurse practitioners as well as physicians) experienced in geriatrics care should be available within each ALF to help direct staff in optimizing outcomes for each resident.

Rationale: The benefit of clinical leadership within LTC facilities was noted in 1978 in JAGS and later supported by a 1993 AGS position statement on the Physician's Role in the Long-Term Care Facility, which illustrated the importance of this involvement. This benefit is true in all long-term care facilities, including ALFs, extended care units, skilled nursing facilities, intermediate care facilities, and residential units caring for frail residents. More recently the work of the Assisted Living Workgroup highlighted the link between these clinical services and outcome for ALF residents.

Reference: Ingman SR, Lawson IR, Carbon D. (1978) Medical Direction in Long-term Care. JAGS 26(4);157-66. Assisted Living Workgroup Report to US Senate Special Committee on Aging 2003. www.aahsa.org/alw.htm <http://www.aahsa.org/alw.htm>.

5. ALFs need to become aligned with other facilities, providers and systems of care to produce optimum outcomes for seniors.

Rationale: A comprehensive system of care is able to accommodate seniors with varied needs as they traverse through different levels of health and function in their aging lifetime. Key to coordination of care is communication at each transition of care.

Reference: Improving the Quality of Transitional Care for Persons with Complex Care Needs <http://www.americangeriatrics.org/products/positionpapers/complex_care.shtml>. Developed by the AGS Health Care Systems Committee and approved May 2002 by the AGS Board of Directors. The American Geriatrics Society, New York, NY.

6. ALF resources need to be within the reach of those living in rural and low-income communities.

Rationale: The lack of non-institutional, long-term care services in many rural areas may explain why residents of nursing homes in rural areas tend to be younger and less disabled than their urban counterparts. Part of this can be accomplished with continued funding of the 1915[c] Home and Community Based Services waiver program to provide needed services. The 1915[c] Home and Community Based Services waiver is the primary Medicaid funding vehicle for low-income persons requiring assisted living services.

Reference: Spector, W., et al, (1996) Appropriate placement of nursing home residents in lower levels of care. The Millbank Quarterly. 74: 139-160.

CREDITS

American Geriatrics Society and approved by the AGS Board of Directors in May 2004. Written by the AGS Health Care Systems Committee, with special thanks to Drs. Richard Stefanacci, Leslie Wooldridge and Kenneth Brummel-Smith.
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