14-514 L-107

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INDEPENDENT REGULATORY REVIEW COMMISSION

Department of Medicine
Division of Geriatric Medicine

2712

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08 SEP 15 AM 10:33
BUR OF LTC PGMS
REFER TO____

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 writing to offer suggestions about the proposed regulations governing the licensure and operations of assisted living facilities in Pennsylvania. The regulations are a first step in setting guidelines for assisted living facilities so that the patient consumer knows exactly what services he is being offered when the term "assisted living facility" is used.

As a physician who has worked in the long term care field for more than ten years, I am pleased to submit comments on Regulation 14-514 regarding the regulations for licensure for assisted living facilities in Pennsylvania. Since I am a geriatrician, a clinical associate professor of medicine at the University of Pennsylvania, a medical director of a NH/SNFF, and a long time resident of Pennsylvania, the equitable regulation of assisted living facilities impacts my patients and my friends and ultimately my family. Housing appropriate to the needs and functions of older individuals {and of course some younger individuals} is vital to the health and well being of the individual as well as society. The opportunity and ability to age in place is at the very least a cost containment measure and at the very most an ideal for living.

I would like to comment on the following sections of regulations.

Admission - 2800.22:

The regulations require a medical evaluation 60 days pre admission or 15 days post admission and an assessment within 15 days after admission and care plan within 30 days after admission. A contract is to be signed pre admission or within 24 hours of admission. Pre admission the faculty must provide the future resident with information about services and costs.

Given the complex social and medical issues of these patients, it is vital that a complete assessment of the entering resident be done within no greater than a month before admission to establish appropriateness of the facility-resident match and to establish a reasonable care plan. A contract should not be signed until the resident knows the particulars of his care plan and at what cost he will be getting certain care. An RN or nurse practitioner with expertise in adult – ideally geriatric – issues should assess the medical, functional, and social issues. This should be done so as to complement information from the patient's primary MD. Basic information obtained should include diagnoses {active and inactive}, medications with dosages, active clinical symptoms, ADL and IADL needs including ability to self-administer meds and handle an emergency, social supports, substance use, and an emotional and cognitive as well as physical exam. An MA-51 form is not detailed enough. Templates used in many ambulatory practices or long-term care facilities reach the requisite level of comprehensiveness.

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Excludable conditions - 2800.229

A number of these excludable conditions should not require request for exemption from DPW.

Chief among these are MRSA and C dificile and VRE colonization which may persist for months to years without any functional impact on the resident. Impact on other residents would be negated with good hand washing procedures. In the climate today of antibiotic resistance, colonization is all too common.

The vascular ulcer is another entity that is frequently treated on an outpatient basis with the assistance of a visiting wound care nurse. The resident with the vascular ulcer is many times fully mobile and functional.

The list of conditions requiring DPW permission as long as the resident or a "qualified individual" or "licensed health care professional" can self administer appears reasonable; "qualified individual" should explicitly include trained family members or other representatives of choice.

Services provided in assisted living 2800.220

A core list of provided services for a fixed fee is an excellent idea. Access to behavioral health services and cognitive support services should not be an-add on. An RN on site to administer medications and an escort that is knowledgeable about the patient should be on the core list of provided services. Access to a social worker is also imperative as a core offering given the multitude of financial and social issues that can arise.

Choice of providers 2800.142

In order to provide continuity of care, facilities should not be able to limit choice of providers.

Concern about informed consent 2800.30, 2800.25

Obviously a cognitively intact patient has the right to make bad decisions but the facility still has the obligation to "intervene" if a bad decision is life threatening. The degree of intervention would be difficult to mandate and may require ethical consultation.

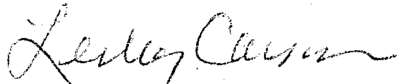
Completion of an advance directive in this population is essential.
A responsible party or medical power of attorney should be designated. This assures respect for resident rights.

Staffing levels 2800.56, 2800.57

Physician oversight of care plan should be obtained quarterly or if a hospitalization. An RN should be on site to administer needed meds.
A social worker should be readily available to residents. A recreation director should be actively involved. Physician oversight should be available for review of facility issues acutely and on a monthly basis.

These regulations are a necessary step in ensuring a quality living situation in the long term care continuum and are welcome by the medical community and community of older adults. I am grateful for the opportunity to comment.

Sincerely,



Lesley Carson, M.D.
Associate Professor of Clinical Medicine