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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 15-514 Assisted Living

Dear Ms. Weidman:

I 'm pleased that the Commonwealth is moving forward with regulations 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 may be unaware of what services they will receive and whether they will be adequate.

I'm a geriatrician who has been caring for frail, elderly Pennsylvanians for two decades in Philadelphia. Much of my practice, in large part in home care, has been with consumers receiving home and community based services that enable them to remain in their homes. A huge gap has existed in the Commonwealth when the frequently intermittent needs of frail elders are such that fixed-scheduled community supports cannot meet, necessitating institutionalization. A useful insight might be that assisted living facilities represent housing fused with home and community based services, in a single setting. Rather than moving from personal care homes as a basis for regulation, such a frame would take advantage of the well developed consumer protections and supports already existing in the various waiver programs, particularly the Aging waiver.

While there are numerous areas worthy of comment, I'd like to focus on a few areas of significant concern:

2800.141— Cognitive capacity and it's assessment is crucial for effective care and supporting disabled Pennsylvanians. Because executive capacity is crucial for safe function, part of any assessment should include a standardized minimum screen to identify both executive and memory deficits. This needs to extend beyond individuals who go to special dementia units, but to include any individual that requires the level of support of an assisted living facility (ALF). As a screen, the cognitive screen in the Home Care-MDS, or the Mini-Cog would suffice, and be brief to administer, but correctly classify potential residents.

2800.227 -- The nature of the care plan, and how it meets a consumer's needs, is a crucial concern for a resident. However, this is an area where the view of ALF as housing + Waiver needs modification. Unlike HCBS programs, the consumer must

undertake significant logistical disruption to relocate into an ALF, which makes leaving if the care plan is inadequate more difficult than in the HCBS case where the consumer is in their own home.

The waiver program might provide a useful model, however, to characterize what the service packages should look . This includes well developed regulations around the issue of consumer choice, a concern where the regulations appear to restrict choice to a single provider for "supplemental health care".

2800.220 It might be helpful to have the entire menu of services organized into a couple of basic service packages. An alternative would be to have much clearer regulations and formatting on specification of a care plan and identified needs, and mapping services to address those specific needs, and well as some model trajectories of decline and model care plans that would adapt along those trajectories. Given the complexity of long term care needs, and the variability in course that individuals can follow, some assistance to help consumers understand the longitudinal consequences of their locational choices is important.

2800.142—"supplemental health care providers" --- may be restricted to a single provider approved by the facility. From this, physicians should be excluded. Certainly if a consumer's physician wishes to continue to care for them, they shouldn't have to give up that physician in order to obtain housing. Similarly, few would choose their housing based on a particular hospice, yet at that point in one's life the care from a hospice is vitally important for a family. Many nursing facilities, while having a "preferred provider" relationship, allow consumer choice as to hospice provider. What would be helpful is to have the language made stronger, so that those choices are not restricted. Again, if an ALF is housing with waiver services, then the consumer choice requirements should also apply;

2800.229 The law specified excluded conditions, however a regulatory distinction should be made between those conditions which develop among residents (for whom the facility is their home) and those who have not been admitted. For many frail Pennsylvanians, many of the excluded conditions (such as wounds, even chronic vascular wounds; the need for oxygen, nocturnal ventilatory support [such as bi-pap], infectious diarrhea after antibiotics, or bacterial colonization after a hospitalization [e.g., with MRSA or VREC] are part of the natural course of illness, which is transient for most. They should not be reasons to lose one's home, which the current regulations permit. While the hospice portion of the regulations are excellent in their support for the concept of aging in place, they run into conflict with the fairly loose nature in which excluded conditions can be used by a facility to remove a frail elder from their home.

Certainly wounds, infectious diarrhea, or even bacterial colonization from a hospitalization would be managed in a consumer's home. To better implement the concept of Aging in place, without undue burden on the Department, the regulations should be written to make a presumption of acceptance, and to exclude a resident for those conditions only if it is shown that the resident's needs cannot be met with facility or supplemental resources (e.g., a home health agency).

A useful tool for dealing with medical complexity in the long term care setting would be to specify an integrated pre-admission assessment that would include medical conditions and functional data .would be helpful in helping to define a careplan. (For example, the Home Care-MDS).

2800.181; .182 There are a number of medications which family members are taught to administer that are excluded under the proposed regs, and should be allowed, such as some injections (such as B-12; erythropoietin, and variable dose insulin given on a specified schedule), and some treatments, such as oxygen.

2800.56 mobile/immobile dichotomy— There is no basis that I am aware of to specify the assistance hours on the basis of mobility. Indeed, for some who are relocating from the community to an ALF, it is precisely their mobility that requires the need for around-the-clock availability of care. Much of the intermittent care needs are more defined by cognitive capacity than mobility. That the requirement is really to meet the care plan needs is good; however, the minimum staffing needs specified on the basis of the mobility dichotomy is inadequate. For example, the likelihood of acute health decompensation, and subsequent supportive care needs is much higher in an ALF population. I believe that on a facility basis the minimum should be closer to 2.5 hours/resident/day.

These regulations have the potential to expand the continuum of long term living options for Pennsylvanians. However, to effectively do so, they need to address the above concerns. I'd be happy to help the Office fill this gap in our state's long term living continuum.

Sincerely,

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University of Pennsylvania, School of Medicine