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#2712

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 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 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 for their individual care.

I am a licensed physician in Pennsylvania who is Board Certified in Family Medicine, Geriatrics, and Hospice and Palliative Care. I have been practicing in Pennsylvania for the past twelve years. I see patient across the continuum of settings including home, assisted living, nursing facilities, hospital and hospice units.

The realization, by a patient or family member, that the person can no longer meet his or her own needs in the family home, is almost always emotionally difficult. When trying to assess the next step, patients and families need to understand clearly what choices are available, and what the consequences of those choices are. This leads to the following concerns regarding the proposed regulations:

Section 2800.4 Definitions:

The regulations do not clearly define the services that assisted living residences must provide. Most families do not have clear lists of their needs. The definition should include all services that a licensed assisted living facility should be able to provide. These include 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

As a geriatrician and palliative care specialist, I care for many patients and families who have reached a difficult point in their lives. They often face the difficult decision regarding discontinuation of "curative" treatment, instead concentrating on quality of life and comfort. I am concerned that the definition of aging in place needs additional clarification, particularly if a person develops a potentially excludable condition, but may be considering a hospice option. Aging in place must clearly mean that the resident cannot be discharged from the facility that is their home unless the facility cannot legally or technically provide the necessary services.

I would particularly like to comment on the following areas of the regulations:

Staffing levels 2800.56 and 2800.57

The regulations require that direct care staffing levels be determined by mobility status. In geriatrics, mobility status and falls are important markers of the need for help. However, studies have shown that cognitively intact persons with mobility problems are likely to require less care than cognitively impaired persons without mobility problems. In an assisted living facility, a person with a brain injury may be able to do laps around the facility but require significant care and cueing. The category of "mobile" resident as defined in the regulations includes the aforementioned young person with a brain injury, and an older person with cognitive impairment who may take 3 minutes to rise from a chair and start using his walker. Using the terms "mobile" and "immobile" as surrogates for number of hours of required direct care is not meaningful. Given the possible acuity of residents of assisted living, I believe that a facility should offer adequate direct care staffing for the equivalent of at least 2 hours per resident per day. The facility must have the ability to meet unanticipated needs of some residents, and to meet all anticipated needs as defined in a care plan.

2800.29 Hospice Care and Services
2800.229 Excludable Conditions
2800.63 Staff training

As a hospice physician, I am pleased that hospice services are clearly stated to be available in assisted living facilities. However, I am concerned that other parts of the regulations will make it difficult for residents or their families to feel comfortable making a decision to request hospice care or services in an assisted living facility. In particular, as I stated above, it is unclear what happens if a resident develops one of the excludable conditions (2800.229) but decides to elect hospice. Requiring the assisted living facility to request an exclusion in this situation should not be necessary.

I am also concerned with the requirement that AED's be available in all facilities, but that there is no accompanying requirement regarding training of staff in advanced directives, DNR resuscitation requests, or in care of hospice patients. Direct care staff and administrators must understand the meaning of

Advanced Directives, DNR orders, and the goals of hospice and end-of-life care. This must be included in all facilities staff training. I am as concerned about staff using an AED when a resident has a DNR order to the same degree as concern of insuring transporting a patient 911 when it is appropriate. A quality facility will have staff trained and monitor all of these issues.

2800.142 Choice of providers

I understand that the assisted living law allows facilities to limit the choice of supplemental health care providers if they disclose that to prospective residents. However physicians are not supplemental health care providers. To the greatest extent possible, residents should be offered a choice of health care provider, consistent with Medicare and Medicaid law. If a resident has coverage for particular supplemental services, and this coverage includes a limited panel of providers, access to that practitioner should not be restricted. Finally, I would suggest that if a facility plans to limit the choice of practitioners available to its residents, it should be required not only to state that, but to explain who the provider is, what insurances the provider accepts, the basis for choosing that provider, and any financial relationships between the assisted living facility and the practitioner.

Clinical assessment, care, and services
2800.22
2800.225
2800.226
2800.227

Although choice is important, for patients to make informed choices they must have clear information that allows them to compare one facility with another. It is critical that the assisted living regulations define at least one or two core services packages that must be provided for a fixed fee. The current regulations require that the facility provide clear pricing, but do not require that facilities offer core comparable packages that will allow a resident or family to compare the facilities. It is not practical to say that a patient can leave a facility within 30 days if it does not meet expectations, as by this time the patient has given up his home to enter the facility.

I would like to feel secure that when I recommend to my patients or families that they require more help, and I advise them about home and community based services, personal care homes, assisted living, and nursing homes, that they will be able to easily compare packages of services and costs. The current regulations do not adequately provide this information.

The American Geriatric Society recommends that preferably before admission the facility should make available to the resident and family the elements of the care plan that the facility is willing to meet. In order to do this, an evaluation must be done before admission whenever possible.

2800.251 Resident records

As a geriatrician and palliative care physician, I feel very strongly about the importance of speaking to patients about their goals of care. In particular, this includes discussions regarding resuscitation status, living wills, and health care power of attorney. These important issues are notably missing from the regulations. Facilities should be required to have discussed this information and have this clearly documented in a prominent place in the medical record. Records should be organized such that those records that need to be available for medical care of any kind are easily denoted, copied, and transported with the resident, as needed.

These regulations have the potential to make assisted living, a continuum in long term care living options, a safe high quality option in Pennsylvania. I ask that as you consider them, you put yourself in the position of a prospective resident or family member making this important and difficult decision. I have tried to address some of these issues as a physician who will be assisting my patients with this difficult task.

Sincerely,

Robert S Warren MD