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Testimony of the Alzheimer's Association Greater Maryland and National Capital Area Chapters
SB 204 - Health Care Facilities – Assisted Living Programs – Memory Care and Alzheimer's Disease Unit Regulations
Position: Favorable

Chair Kelley and Vice Chair Feldman,
My name is Eric Colchamiro, Director of Government Affairs for the Alzheimer's Association in Maryland, and here today to ask for your support of SB 204. This legislation requires the Maryland Department of Health (MDH) to promulgate specific additional regulations governing memory care units at Assisted Living facilities.

I want to acknowledge Maryland's long-term care provider organizations. During this pandemic, these organizations and their members have dealt with unprecedented challenges and costs, delivered hundreds of thousands of pieces of PPE, and dealt with frequently shifting guidance from MDH. Government funding has been provided to stabilize their operations; more so to nursing homes, and to a lesser extent, assisted living facilities. Yet as we now have the hope of potentially four vaccines, amidst a pandemic that has disproportionately impacted our long-term care industry, we must move forward stabilizing facilities and protecting their residents.

There are 1672 Assisted living facilities in our state; 91 percent of them are under 50 beds. Yet it is also important to remember that—according to data from MDH's Office of Healthcare Quality (OHCQ)—**the 9 percent of facilities over 50 beds have the majority of Maryland's assisted living population**.

The legislation today puts forward requirements solely for the state's 88 special care units, among those 1672, which house some of our most vulnerable Marylanders with Alzheimer's or other forms of dementia. A "special care unit" is defined in statute as a secured or segregated special unit or program, specifically designed for individuals with dementia, including a probable or confirmed diagnosis of Alzheimer's disease.

The residents in these units (also known as "memory care units") with Alzheimer's or other forms of dementia present unique challenges; 95 percent of them have one or more chronic condition. As their dementia progresses, these residents are unable to eat, dress, or bathe without assistance. Over time, people with Alzheimer's will lose the ability to use words and may communicate their needs through behavior. It is important that the staff who care for them have training and understand the behavioral and psychological symptoms of dementia; they need to understand how to manage increase aggression, how to manage confusion, how to manage sudden sadness.

This legislation presents a major public health issue involving the safety, protection, and quality of care for older people living with dementia. The only section in COMAR specifically on special care units at assisted living facilities is 10.14.17.30; it requires a significant amount of information to be disclosed, but it does not codify what is required. We have heard from many families that the only distinction for a memory care unit at an assisted living facility is that it is a locked door for people with dementia.

Assisted living facilities and nursing homes both serve residents with complex medical conditions; yet **assisted living facilities lack the same protections to ensure quality care;**

- special care units at nursing homes require a separate request and approval from OHCQ and the Department's Office of Capital Planning, Budgeting and Engineering Services; assisted living facilities do it just as part of the licensing process; [COMAR 10.07.02.23.A]

- Nursing homes require a more detailed process for the special care unit resident assessment, responsive to changes in the individual's condition; [COMAR 10.07.02.25.B.(2)(c)]

- Nursing homes require a quality assurance plan for their units [COMAR 10.07.02.23.C.(5)]

- Even the disclosure form—the one area that special care units at assisted living facilities specifically have—is more specific at nursing homes, which require disclosure to OHCQ about the involvement of families and family support programs; [COMAR 10.07.02.25.B.(2) (g)]

If you look at the 2015 draft Assisted living facility regulations, you will see OHCQ put forward additional protections which begins to regulate assisted living facilities as a medical environment. The 2015 draft proposed: a new role of a memory care coordinator; 30 hours of training requirements for the coordinator; and an additional 20 hours of training specifically for memory care staff. The industry, in their comments on this draft section to protect memory care patients, strongly opposed and said that this could not be administered.

OHCQ put forward a second section on memory care protections, outlining: an enhanced service plan for individuals with Alzheimer's and dementia, including their risks and activities that benefit them; and a direct care staff ratio, so that there was at least one direct care staff on each shift for every eight residents. The industry opposed these protections as duplicative.

OHCQ put forward a third section on added protections for memory care units. This section outlined appropriate care and services for memory care patients, including the need to document and address those patients at risk of frequent falls. Industry opposed these protections as redundant.

Despite these objections, OHCQ maintained these provisions in their 2016 second draft, addressing many of the same areas in this legislation before you today. They recognized the need for added protections for memory care units, and also added specific new protections for admissions and discharge, and activities which reduce social isolation. Unfortunately, they were never codified into law, and without legislation they can be negotiated out.

This legislation aims to take a moderate approach. The bill sponsors did not put forward a bill which licenses memory care units, akin to over 20 other states. The bill intentionally does not put forward specific numbers for areas like a staff-to-patient ratio, like OHCQ did in the draft regulations. Instead, this legislation flags a number of concrete areas, and final decisions have ultimately been left to OHCQ's traditional, collaborative regulatory process. The only requirement here is that people with dementia in assisted living facilities need more from our state. **We need to codify changes which provide added protections for the 88 memory care units which house patients with Alzheimer's or other forms of dementia.**

This legislation is necessary. Assisted living facilities treat residents with complex medical conditions in these special care units, and costs can be over $10,000 per month, yet they do not have a framework which holds them specifically accountable for better care. One Alzheimer's advocate shared a story with me about how her mom was on the floor for hours in an assisted living facility memory care unit, because there were no specific added protections for nighttime bed checks, and her mom's voice was too soft to be heard. **It is only with legislation that we can ensure that a new framework is enacted**, and added protections are put into place.

I ask for your help today to move this bill forward. I urge a favorable report.

APPENDIX 1 – 2015/2016 MDH DRAFT PROPOSED ADDITIONAL MEMORY CARE PROTECTIONS

SOURCE: "COMAR 10.07.14 Assisted Living Programs, AL DRAFT (6/9/2015)".
https://health.maryland.gov/ohcq/docs/Regulations%20Pages/10.07.14Draft6_19_15_NoTextUnchanged.docx

PLEASE NOTE:
I have highlighted the new memory-care specific areas from the draft regulations, and *put the new language in italics*, put LifeSpan's response in green, and put OHCQ's decision on the comment, in blue, which is reflected in their 2nd draft (accessible here).

- section 26 for memory care - outlining 1) a new proposed role of a memory care coordinator; 2) training for the coordinator; and 3) required additional training specifically for memory care staff;

A. All Alzheimer's/dementia special care units shall have a coordinator who is solely responsible for the coordination of the Alzheimer's/dementia special care unit. The coordinator shall:

(1) Be a licensed or degreed health care professional, other than the delegating nurse; and

(2) Have completed a course, consisting of a minimum of 30 hours of training, by a nationally recognized Alzheimer's/dementia caregiving resource or association; or

(3) Have substantially equivalent training and experience.

B. The coordinator shall, in collaboration with the manager and delegating nurse/case manager, coordinate as needed outside psychiatric and psychosocial services to assist with behavior modification plans.

C. Other Staff.

(1) In addition to the trainings described in Regulation .14 of this chapter, staff shall:

(a) Complete a minimum of 20 hours of documented initial training on the care of residents with Alzheimer's disease and related dementia prior to providing direct resident care; and

(b) Complete a minimum of 8 hours of documented annual training on Alzheimer's disease and related dementia;

(2) Direct care staff shall not have housekeeping, laundry, food preparation, or maintenance duties as primary responsibilities; and
(3) Certified medication technicians shall not be responsible for any direct care activities while administering medications during the assigned times

The inclusion of this new unit and its requirements are strongly opposed by LifeSpan and cannot be administered by the programs. Most troubling are the requirements for and education levels needed of a coordinator, the number of training hours for both the coordinator and other staff (page 114) and the prohibition against using a universal worker (page 115)

no change

- new section 27 for memory care, outlining 1) an enhanced service plan for individuals with Alzheimer's and dementia, including their risks and activities that benefit them; and 2) a direct care staff ratio;

.27 Alzheimer's/Dementia Special Care

A. The manager of a facility which provides care to one or more individuals with dementia, including a probable or confirmed diagnosis of Alzheimer's disease or a related disorder, shall ensure the requirements of this regulation are met.

B. An orientation manual with policies and procedures specific to Alzheimer's/dementia special care shall be maintained on-site and accessible to all staff.

C. The manager, or designee, shall ensure that an enhanced service plan is developed for all residents with Alzheimer's/dementia. The service plan shall, at a minimum, include specific interventions that address:

(1) Persistent or repetitive behaviors that affect the health and well-being of the resident or present a danger to the resident or other individuals;

(2) Environment, safety, and security;

(3) Behavior management;

(4) Staffing; and

(5) Life enrichment activities.

D. Delegating nurse/case manager.

(1) For residents receiving psychotropic or behavior-modifying medications, the delegating nurse/case manager during nursing assessments shall:

(a) Assess the resident's functional level;

(b) Identify any potential adverse effects of the medication or medications; and

(c) Consult with the authorized prescriber or pharmacist, as necessary, to determine if medication dosages should be modified or discontinued.

(2) During nursing assessments the delegating nurse/case manager shall evaluate residents with persistent or repetitive behaviors that affect the health and well-being of the resident or present a danger to the resident or other individuals to determine:

(a) A baseline of the intensity, duration, and frequency of the behavior;

(b) Antecedent behaviors and activities;

(c) Recent changes or risk factors in the resident's life;

(d) Environmental factors such as time of day, staff involved, and noise levels;

(e) The resident's medical status;

(f) Alternative, structured activities or behaviors that have been successful or unsuccessful in the past; and

(g) The effectiveness of behavioral management approaches.

(3) The results of the enhanced assessments described in §D(1) and (2) of this regulation shall be reflected in the resident's service plan.

E. The manager and delegating nurse/case manager shall coordinate outside psychiatric and psychosocial services, if appropriate, to assist with behavior modification plans.

F. When the resident census includes eight or more residents with Alzheimer's/dementia, there shall be a minimum of one direct care staff on each shift for every eight residents.

As above, LifeSpan opposed the creation of this new regulation and believes that it is duplicative given that the requirements contained in this section should be captured in the resident assessment tool and the nursing assessments and then captured in the service plan, similar to any other diagnosis. LifeSpan also is very concerned with the decision to use a ratio for direct care staff and believes further discussion must take place on this issue (page 119). OHCQ, itself, has questioned the use of ratios and, in other health care provider industries, has moved away from implementing ratios in favor of staffing to the needs of the residents. Lastly, on page 117, the reference to "probable or confirm diagnosis of Alzheimer's disease or related disorder" must be deleted. *** It is important to note that LifeSpan strongly agrees that changes are necessary to the training requirements for Alzheimer's, dementia and behavioral health. However, these changes should be focused on the training content, how the trainings are performed, the specific training needs of the residents, etc. LifeSpan has been meeting with representatives from the Alzheimer's Association and the Mental Health Association on this issue

no change

- New Section 27.H - Special Care Needs/Monitoring and Oversight

H. Special Care Needs – Monitoring and Oversight

(1) Every resident shall receive appropriate care, services, and oversight in accordance with:

(a) State and federal guidelines;

(b) Accepted standards of nursing and medical practice; and

(c) The resident-specific waiver provisions of Regulation .21 of this chapter.

(2) Resident service plans shall reflect increased monitoring and oversight, as appropriate, and as needed by residents with, but not limited to, the following special care needs:

(a) Frequent falls;

(b) Pressure ulcer care;

(c) Oxygen therapy;

(d) Enteral feedings;

(e) Foley care;

(f) Ostomy care;

(g) Therapeutic medication levels;

(h) Mental illness or psychiatric care; and

(i) Diabetic management.

(3) At a minimum, appropriate care includes:

(a) Using proper infection control techniques to prevent infection and cross contamination;

(b) Providing care and services to promote healing;

(c) Ensuring that staff have demonstrated competency to the delegating nurse in the provision of care that meets the special care needs of the resident; and

(d) Notifying, when incidents occur and there is a need for medical or nursing evaluation and treatment, the:

(i) Resident, or if appropriate, the resident representative;

(ii) Program's delegating nurse; and

(iii) Resident's health care practitioner, if appropriate.

delete Section (H) on special care needs as redundant.

No Change

APPENDIX 2: MDH July 2017 Exemption Request

- Note: The first three pages (of 54) have been inserted below, so that the Committee can see the specific exemption request
    - Document Source: Personal Communication with Kathleen Kennedy, Senior Policy Analyst | Co-counsel, AELR Committee, August 24, 2020.

REGULATORY REVIEW AND EVALUATION ACT:

EVALUATION REPORTS DUE JULY 1, 2017 FOR:

Subtitle 05 FREESTANDING AMBULATORY SURGICAL FACILITIES
Subtitle 07 HOSPITALS
Subtitle 08 HEALTH FACILITIES GRANTS

SUBMITTED BY:

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EVALUATION REPORTS

Subtitle 05 FREESTANDING AMBULATORY CARE FACILITIES
10.05.05 Freestanding Ambulatory Surgical Facilities

Subtitle 07 HOSPITALS
10.07.01 Acute General Hospitals and Special Hospitals
10.07.02 Comprehensive Care Facilities and Extended Care Facilities
10.07.06 Hospital Patient Safety Program
10.07.07 Nursing Referral Service Agencies
10.07.08 Freestanding Medical Facilities
10.07.09 Residents' Bill of Rights: Comprehensive Care Facilities and Extended Care Facilities
10.07.10 Home Health Agencies
10.07.11 Health Maintenance Organizations
10.07.12 Health Care Facilities Within Correctional Institutions
10.07.17 Limited Service Hospital
10.07.18 Comprehensive Rehabilitation Facilities
10.07.21 Hospice Care Programs

Subtitle 08 HEALTH FACILITIES GRANTS
10.08.01 Construction Funds For Public and Nonprofit Nursing Homes
10.08.02 Construction Funds For Public & Nonprofit Community Mental Health, Addiction, & DD Fac.
10.08.03 Construction Funds for Public and Nonprofit Adult Day Care Centers
10.08.04 Construction Funds for Public and Nonprofit Assisted Living Facilities
10.08.05 Construction Funds for Federally Qualified Health Centers
10.08.06 Construction Funds for Conversion of Nursing Facilities

EXEMPTIONS REQUESTED

In accordance with State Government Article, §10-132-1, Annotated Code of Maryland, the Secretary has certified to the Governor and the AELR Committee that a review of the following chapters would not be effective or cost-effective and therefore are exempt from the review process based on the fact that they were either initially adopted (IA), comprehensively amended (CA) during the preceding 8 years, or Federally mandated (FM):

Subtitle 05 FREESTANDING AMBULATORY CARE FACILITIES

10.05.01 General Requirements	CA 2/27/17 & 3-13-17
10.05.02 Freestanding Birthing Centers	CA 2/15/16
10.05.03 Freestanding Major Medical Equipment Facilities	CA 2/27/17
10.05.04 Freestanding Kidney Dialysis Centers	CA 2/18/13

Subtitle 07 HOSPITALS

10.07.03 Health Care Staff Agencies	CA 9/15/14
10.07.04 Res. Treatment Centers for Emotionally Disturbed Children & Adolescents	CA 5/22/17

10.07.05 Residential Service Agencies	CA 5/1/12
10.07.13 Forensic Residential Centers (FRCs)	IA 1/26/09
10.07.14 Assisted Living Programs	CA 12/29/08
10.07.15 License Fee Schedule for Hospitals and Related Institutions	CA 8/29/16
10.07.16 Limited Private Inpatient Facilities	IA 12/10/15
10.07.20 Intermediate Care Facilities for Individuals with Intellectual Disabilities...(ICF/IID)	CA 1/20/14
10.07.22 Hospice Care Programs: Hospice House Requirements	IA 6/10/13

CHAPTERS THAT ARE VACANT / TRANSFERRED

Subtitle 07 HOSPITALS

10.07.19 VACANT	Transferred to Title 31 Maryland Insurance Administration – COMAR 31.10.21