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LeadingAgeOhio.org

September 28, 2023

Director Ursel McElroy
Ohio Department of Aging
30 E Broad St, 22nd Floor
Columbus, OH 43215-3414

RE: Proposed Chapter 173-39-02 ODA Provider Certification: Assisted Living Service

Director McElroy:

LeadingAge Ohio appreciates the opportunity to provide comments on proposed Chapter 173-39-02.16 ODA Provider Certification: Assisted Living Service. LeadingAge Ohio is Ohio's association of mission-driven providers of long-term services and supports. We represent 400+ organizations that serve Ohioans across their lifespans, including affordable housing organizations, life plan communities, adult day providers, assisted living facilities, nursing facilities, home health agencies, and hospices. Our members are located in more than 150 Ohio towns and cities, serve more than an estimated 400,000 elderly Ohioans and employ more than 35,000 Ohioans statewide.

LeadingAge Ohio commends the Ohio Department of Aging for its commitment to memory care services and meeting the needs of one of the state's most vulnerable population. LeadingAge Ohio appreciates the partnership between the association and the Department of Aging and values the opportunity to offer comments and suggestions (notated below in red) on the assisted living waiver.

173-39-02 (A)(3): Definition of Memory Care
(a) An assisted living service that occurs in a resident ~~unit~~ area that the provider designates to be an ~~single-occupancy~~ assisted living memory care ~~unit~~ area, part of an assisted living memory care section of the RCF, or in an RCF that is entirely an assisted living memory care facility.

Rationale: The word "unit" is very clinical and refers only to a bedroom, whereas the residential care facility is the home of the resident, including common areas.

One additional question is whether memory care can only be provided in single occupancy rooms, or whether the same criteria apply to memory care residents as assisted living residents under waiver services. Other residents may choose to have a roommate or reside with a spouse. LeadingAge Ohio believes that "single occupancy" should be struck from this portion of the rule and allow the same guidelines to apply.

(b) The individual receiving the service has a documented ~~diagnosis of any form of dementia~~ cognitive impairment.

Rationale: Not all individuals who live in memory care areas have a dementia diagnosis; a cognitive impairment is more inclusive language.

173-39-02 (C)(2)(c): Resident Units

(c) Resident units: A resident unit qualifies for this service only if the ~~unit~~ room or space meets all the following standards:

Rationale: Same rationale as 173-39-02 (A)(3).

173-39-02 (C)(2)(c)(ii): Locks

(ii) Lock: The resident unit has a lock that allows the individual to control access to the resident unit at all times, unless all of the following conditions exist:

(a) A physician ~~prescribes~~ documents having no lock on the resident unit or removing the individual's ability to lock the resident unit because the individual's diagnosis indicates that the individual's ability to lock the resident unit is likely to have an adverse effect on the individual.

~~(b) The physician in paragraph (C)(2)(c)(ii)(a) of this rule issued the prescription within the past three hundred sixty-five days.~~

(~~c~~b) The provider retains the prescription in paragraph (C)(2)(c)(ii)(a) of this rule.

Rationale: LeadingAge Ohio favors the previous language which indicated a physician "documents" rather than "prescribes" having no lock. Prescriptions are one narrow form of documentation, and typically reserved for medications. Additionally, dementia is a progressive disease. Once an individual with dementia loses the ability to manage door locks, this ability is not regained. The annual requirement for the physician to reassess in this particular capacity is unnecessary.

173-39-02 (C)(7): Quarterly Assessments

This section notes that an RCF should "Report and retain records"—but it is unclear who this should be reported to or by what means. Please clarify, as this is not an administrative process that currently takes place.

173-39-02 (D)(2)(a): Mission Statement

(a) The provider has a ~~mission~~ statement that includes how its memory care differs from its basic assisted living service.

Rationale: Mission statements typically pertain to the entirety of an organization, not just one service line. We agree with the intent—that there should be intentional disclosure that articulates what is included in "memory care" – but do not agree it should be within the mission statement. This may be more appropriate in the section of the rule that describes requirements for disclosures on the facility website.

173-39-02 (D)(2)(b): Therapeutic, Social or Recreational activities

(b) The provider provides or arranges for at least three therapeutic, social, or recreational activities listed in rule 3701-16-11 of the Administrative Code per day with consideration given to ~~each~~ individuals' preferences and designed to meet ~~each~~ individuals' needs. ~~The coordination of these activities is separate from the coordination in paragraph (A)(1)(b)(iv) of this rule.~~

Rationale: We don't believe that the Department is advocating for exclusively segregated activities for memory care residents, however that is how the drafted language reads. Many facilities currently provide activities shared across the community—such as a movie night hosted in a non-memory care portion of the building, or a joint activity with non-memory care residents. We agree that at least three activities that are appropriate for memory care residents should be offered.

Additionally, we suggest striking "each" because it implies that each single resident should have three activities tailored to their individual needs, which is not practical. Rather, the facility should assess residents' preferences, interests and needs individually, but build a calendar of events that best meets the preferences, interests and needs of the entire resident community.

173-39-02 (D)(2)(c): Outdoor Space

(c) The provider ensures safe access ~~at any time~~ to outdoor space for all individuals.

Rationale: "At any time" implies that residents should have unrestrained access to the outdoors at all times, which is not always practical. However, residents should be able to leave the building on a regular basis, whether in a secure outdoor space or being accompanied by staff, volunteers, or family.

173-39-02 (D)(2)(d): Call System

~~(d) The provider assists each individual who makes a call through the resident call system in person in fewer than ten minutes after the individual initiates the call.~~

Rationale: Currently, many Ohio communities do not have features that would allow them to track call response time, and installing such a feature is very costly—approaching six figures for a typical size community. Additionally, it is not practical to always respond to a resident call within 10 minutes. For example, if you have a unit where a single staff member is assigned and one resident experiences a fall, staff will necessarily remain with that resident to address safety issues while another resident will have to wait longer than 10 minutes. A better measure would be to have an average response time vs. a hard and fast rule, but again, the configuration of existing systems makes this impossible for many communities.

173-39-02 (D)(2)(e): Medical Director

(e) The provider has an ~~medical director~~ administrator, nurse, or other licensed or certified professional whose responsibilities include all of the following:

(i) Meeting periodically with management, nursing, and other professional staff to discuss clinical and administrative issues.

(ii) Acting as a liaison between the attending physicians and other health professionals caring for the individuals.

~~(iii) Being available to consult when an individual's personal physician is not available.~~

(iv) Assisting management and nursing staff in ensuring a safe and sanitary environment for individuals and staff by reviewing incidents, identifying environmental hazards to health and safety, and advising the provider on possible corrections or improvements to the facility's environment.

(v) Promoting residents' rights, adhere to the person-centered service plans, and adopt the person-centered planning principles in rule 5160-44-02 of the Administrative Code.

Rationale: LeadingAge Ohio has multiple concerns related to requiring a Medical Director. Chiefly, we do not believe that the majority of activities outlined require a medical director (i, ii, iv and v can be accomplished by an administrative position, which could be a variety of licensed and/or certified individuals). Additionally, with the shortage of trained geriatricians, this is a poor use of scarce numbers of physicians. Finally, we are concerned with the implications of requiring a Medical Director for community-based settings, and the unintended consequences of medicalizing the setting. Our suggested edits would address these concerns.

173-39-02 (D)(3)(b): Availability of Staff

(b) The provider has a sufficient number of ~~RNs, or LPNs under the direction of an RN,~~ nurses on call available at all times for individuals receiving memory care.

Rationale: We believe using inclusive language, "nurses" is sufficient, since LPNs are by licensure scope under the direction of an RN.

Question: Providers will want to understand what constitutes a "sufficient number" of nurses. Particularly, will the department develop a rubric or scoring sheet, or will they reference standards from other settings? Additionally, is it the number of nurses or the coverage of nursing hours that is most important? As written, it is too open to interpretation and impossible to respond to.

173-39-02 (D)(3)(c): Staffing Ratio

(c) The provider maintains a staffing ratio of at least one staff member who provides personal care services for up to every ten individuals receiving memory care with at least one staff member who provides personal care services on each floor of the RCF if the RCF provides memory care on multiple floors.

<u>Recommendation</u>: LeadingAge Ohio is concerned about the lack of clarity in how this would be interpreted, and concerned about setting an arbitrary ratio which is unsupported in research literature. In other areas that require staffing levels, they are not defined as ratios, but rather as hours of care per resident day. For example, nursing homes must provide 2.5 direct care hours per resident day under Ohio licensure.

This also allows for shared staffing models, like when a nursing facility and assisted living share a nurse or other staff, for example. By defining it by hour-units, staffing can be measured more flexibly.

We also encourage the Administration, if it decides to pursue staffing ratios, to consider setting different standards for waking hours and non-waking hours. While it is true that many individuals with dementia / cognitive impairment may have irregular waking hours, this is not universal and generally, daytime hours still require higher levels of staffing to assist with meals, bathing, and other activities that are typically daytime.

Taken as a whole, we are concerned that these additional requirements will make it cost-prohibitive for providers to offer memory care to waiver-eligible individuals, particularly if the add-on is at the level that has been previously discussed ($25-30 / day). However, without yet knowing definitively what payment the Administration will set for memory care, it is challenging to assess how feasible these rules on a whole. We are concerned that these requirements taken together add significant burden, and in some cases, medicalize an inherently community-based setting. We are eager to work with the Department of Aging on strategies to hit their goals for improving the quality of care for individuals with dementia and/or cognitive impairment, while minimizing regulatory burden and protecting the non-institutional nature of assisted living.

We appreciate your willingness to accept the feedback and look forward to the continued partnership.

Thank you for your consideration of our comments.

Kind regards,

Susan V. Wallace, MSW, LSW
President/CEO