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Testimony of the Alzheimer's Association Greater Maryland and National Capital Area Chapters

**HB 416 - Health Care Facilities – Assisted Living Programs
Memory Care and Alzheimer's Disease Unit Regulations**

Position: Favorable with Amendments

Chair Pendergrass and Vice Chair Pena-Melnyk,

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 HB 416, as amended to parallel its cross-file, SB 204.

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. 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 requires a long-overdue update of Assisted Living facilities regulations, and puts forward requirements solely for the state's 88 special care units, 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 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.

If you look at the 2015 draft Assisted living facility regulations, you will see OHCQ put forward additional protections for these units.

- 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;
- 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;
- 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.

OHCQ maintained these provisions in their 2016 second draft, despite industry objections to each of them. They recognized the need for added protections for memory care. Unfortunately, these protections were never codified into law, and without legislation they can be negotiated out.

The Alzheimer's Association supports the amended version of this bill, which has passed out of the Senate. The proposed memory care focal points, in this amended version, are dementia specific staff training and a staffing standard; two areas for which OHCQ has already developed draft regulations, which must be finalized.

I would ask the Committee, in its consideration of HB 416, to preserve this bill's intent and focus:

- Discussions of defining assisted living statute based on the level of care provided—and including that in this legislation—is a significant burden on an underfunded OHCQ, and makes it extremely likely that the bill's important deadline of December 2022 will not be reached;
- Training for dementia must be addressed as “dementia-specific training hours”;
- Training requirements must be not just for “employees”, but also for contractual staff who provide direct care on an ongoing basis;
- Replacing SB 204's “staffing standard” with alternative language moves us further away from OHCQ's goal of a staff-to-patient ratio;
- Lastly, regulations are closed for comment and must be finalized, per the language in SB 204. There is no need for the prior draft to be a starting point, considering the extensive work already completed; if we re-open them now, we jeopardize this bill's intent to finish regulations by December 2022.

In closing, I want to thank Delegate Belcastro for her extraordinary commitment to this work. This legislation is necessary, and these regulations are long overdue. Assisted living facilities treat residents with complex medical conditions in these special care units, yet they do not have a framework which holds them specifically accountable for better care.

We must put the right framework into place, which protects seniors with Alzheimer's and dementia. I urge a favorable report on this legislation, as amended to parallel SB 204

APPENDIX 1 – Existing Regulation for Alzheimer’s Special Care Unit

SOURCE: <http://mdrules.elaws.us/comar/10.07.14.30>

Sec. 10.07.14.30. Alzheimer's Special Care Unit

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Latest version.

• A. Written Description. At the time of initial licensure, an assisted living program with an Alzheimer's special care unit shall submit to the Department a written description of the special care unit using a disclosure form adopted by the Department. The description shall explain how:

(1) The form of care and treatment provided by the Alzheimer's unit is specifically designed for the specialized care of individuals diagnosed with Alzheimer's disease or a related dementia; and

(2) The care in the special care unit differs from the care and treatment provided in the nonspecial care unit.

B. At the time of license renewal, an assisted living program with an Alzheimer's special care unit shall submit to the Department a written description of any changes that have been made to the special care unit and how those changes differ from the description of the unit that is on file with the Department.

C. An assisted living program with an Alzheimer's special care unit shall disclose the written description of the special care unit to:

(1) Any person on request; and

(2) The family or resident's representative before admission of the resident to the Alzheimer's special care unit or program.

D. The description of the Alzheimer's special care unit shall include:

(1) A statement of philosophy or mission;

(2) How the services of the special care unit are different from services provided in the rest of the assisted living program;

- (3) Staff training and staff job titles, including the number of hours of dementia-specific training provided annually for all staff by job classification and a summary of training content;
- (4) Admission procedures, including screening criteria;
- (5) Assessment and service planning protocol, including criteria to be used that would trigger a reassessment of the resident's status before the customary 6-month review;
- (6) Staffing patterns, including the ratio of direct care staff to resident for a 24-hour cycle, and a description of how the staffing pattern differs from that of the rest of the program;
- (7) A description of the physical environment and any unique design features appropriate to support the functioning of cognitively impaired individuals;
- (8) A description of activities, including frequency and type, how the activities meet the needs of residents with dementia, and how the activities differ from activities for residents in other parts of the program;
- (9) The program's fee or fee structure for services provided by the Alzheimer's special care unit or program as part of the disclosure form that is required in Regulation .10 of this chapter;
- (10) Discharge criteria and procedures;
- (11) Any services, training, or other procedures that are over and above those that are provided in the existing assisted living program; and
- (12) Any other information that the Department may require.

E. The Department shall restrict admission or close the operation of a special care unit if the Department determines that the facility has not demonstrated compliance with this regulation or the health or safety of residents is at risk.

APPENDIX 2 - 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 3: 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 | Cocounsel, 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