Assisted Living Forum
Auditorium - O’Connor State Office Complex
300 West Preston Street - Baltimore, Maryland

Wednesday, August 24, 2005 - 10:00 AM to 12:00 Noon

MEETING NOTES

In Attendance

1. Margaret Gunzelman, Hopkins ElderPlus
2. Barbara Newman, MBoN
3. Amy Proctor, CCNRC
4. William Dorrill, OHCQ
5. Sterling Solomon
6. Robin Somers, Keswick MultiCare Center
7. Dorinda Adams, DHR/OAS
8. Nicole Kaiser, VA
9. Yvette Daniels, VAMHCS
10. Donald Clark, D&G Home Care I & II
11. Linda Cole, MHCC
12. Lynda Meade, Catholic Charities
13. Carol Benner, OHCQ
14. Sister Irene Dunn, Victory Housing
15. Joyce Vanzile, CCDoA
16. Rosemary Burton, Assisted Living
17. Lynne Condon, OHCQ
18. Fran Blacker, Golden Age Retirement
19. Joyce Whitten, Vantage House
20. David Elliott, Elliott’s Assisted Living
21. Glinda Elliott, Elliott’s Place
22. Christina Harvin, MBoPh
23. Robin Kelly, Sun Rise Senior Living
24. Linda Willis, CCDA
25. Jackie Kegley, Sunny Acres Assisted Living
26. Linda Chere, HCOA
27. Linda Butler, BCHD
28. Linda Moore, BCHD
29. Alycia Steinberg, Medicaid
30. Mark Leeds, Medicaid
31. Kimberly Speed, All in One Nursing Services
32. Karin Lakin, Senior Network
33. Ted Meyerson, AARP
34. Kenya Johnson, Baltimore County DoA
35. Shelia Mackertich, HFAM
36. Kim Mayer, OHCQ
37. Mayer Handelman, MBoPh
38. Kevin Cysyk, Rock Spring Village
39. Beverly Harris, BCHD
40. Carolyn Caswell, Country Gardens Assisted Living
41. Mark Wah, Angel’s Touch Assisted Living
42. Dave Upton
43. Darrin Brown, AARP
44. Margaret Beziat, Mercy Ridge
45. Roy Kiewe, CHAI
46. Tammie Parlett, CCNRC
47. William Booth, Booth I
48. Carolyn Peoples, Jeremiah Housing, Inc.
49. Eugene Valtine, Fem Care Corp and Kenwood Care Corp
50. JoAnne Stough, BCDSS
51. Darlene Fabrizio, Somerford Corp
52. Leann Youth, Howard County OoA
53. Nancy Miller, Baltimore City OoA
54. Carolyn Henn, Augsburg
55. Sushant Sidd, LifeSpan
56. Barbara Bellack, NAMI
57. Michael Ware, VA
58. Victoria Eyler, VA
59. Pat Ford, VA
60. Suzanne Bartley, Krisleigh Assisted Living
61. Kim Norton, Morningside Management
62. William Vaughan, OHCQ
63. Lisa Gyell, MSH
64. Meg DeSchriver, Brooke Grove Assisted Living
65. Karyna Balbuena, Brook Grove Assisted Living
66. Susan Shubin, Legal Aid Bureau
67. Sharon Kruskamp, Atrium Village
68. Francene Hill, MC HHS/PHS
69. Debra Campbell, MC HHS/PHS
70. Anita Campbell, William Hill
71. Lisa Thomas, Sunny Acres
72. Stephaine Lyon, Alzheimer’s Association
73. Bob Dermott, Cecil County DoA
74. Nani Target, Heartlands
I. Call to Order and Introductions

Ms. Carol Benner, Director of the Office of Health Care Quality (OHCQ), called the Assisted Living Forum to order at approximately 10:00 AM. Ms. Benner thanked everyone present for their interest in Maryland’s Assisted Living Program.

II. What are the Purpose of and the Process for the Assisted Forum?

In 2003, the Department initiated a comprehensive evaluation of the Maryland’s Assisted Living Program. The Department convened an Assisted Living Forum (ALF), which is an assembly of providers, consumers, stakeholders, advocates, State and local governments, health professional regulatory boards, family members and interested parties, to provide a venue to openly discuss how the assisted living program could be strengthened to better protect the health and safety of the elderly and medically frail and compromised served by the program. Thus far, the Department has published two reports containing recommendations to improve the quality of care received and develop a more efficient regulatory process.

It is important to acknowledge that assisted living is a difficult issue. There are many different opinions on what an assisted living program should like and what level of regulation government should impose. Participants in the ALF provide input to the Department on various proposed quality standards and issues relating to assisted living. The discussions of the ALF are used as a basis for the Department’s decisions.

III. Presentation: Update on the Maryland Assisted Living Study: Prevalence, Recognition, and Treatment of Dementia and Other Psychiatric Disorders by Dr. Adam Rosenblatt, Division of Geriatric Psychiatry and Neuropsychiatry, Johns Hopkins School of Medicine

Dr. Adam Rosenblatt, provided an update on study conducted by Johns Hopkins concerning the prevalence, recognition and treatment of dementia in Maryland assisted living programs. The study was prompted because of the lack of knowledge concerning individuals who live in assisted living and their clinical characteristics. It is widely know that dementia is very common in the elderly, progressive in nature and frequently undiagnosed. While it was believed that many individuals in assisted living have dementia, Alzheimer’s Disease or other psychological needs that go undiagnosed and untreated, there was no data at that time to support that conclusion. This was the first comprehensive study conducted to look at this issue using direct examination of randomly sampled individuals.

Phase I of the study was a cross-sectional study of 198 participants from 22 randomly selected small and large assisted living programs. This type of sampling ensures the study was conducted statistically sound manner. (The presentation can be accessed on-line at www.dhmh.state.md.us/ohcq/alforum.htm) The evaluation of individuals participating in the study was conducted by a team of experienced professionals, including geriatric
neuropsychiatrist, nurses, psychometrician and research assistants. Comprehensive histories were obtained from the resident, family members, and staff. The evaluation team reviewed the resident’s chart for diagnoses, medications and treatments, laboratory studies. Residents vital signs were taken and were given a mental status exam and neurologic exam. All of the data gathered was then reviewed by the consensus panel to determine diagnosis, whether dementia was fully evaluated or whether dementia or psychiatric disorder was fully treated.

The majority of the assisted living programs randomly selected for the study were licensed to serve level of care 3 residents and had been in operation for approximately 10.9 years (mean). Some of the programs (6) had locked or dementia special care units. The day staff per resident ranged from 1:20 to 2:3. The median monthly facility cost was $2,900.

The study found that the overall profile of a typical assisted living resident was on average 85.6 years old; 75% are over the age of 80; gender - 78% are female and 22% are male; mean length of residence in an assisted living program – 25 months; ethnicity – 83% Caucasian, 16% African American, and 2% other ethnicity; and the primary reason for moving into assisted living – 62% decline in independent function, 24% medical conditions, 7% behavioral problem, and 4% loss of caregiver.

With regard to the prevalence of dementia and psychiatric disorders, the study found that 67.7% of the individuals had diagnosed with dementia, an active psychiatric diagnosis, such as mood, psychological disorders or delirium, and 26.3% neuropsychiatric symptoms, such as behavioral problems. However, only about 52% of those individuals diagnosed with dementia received full treatment, 33% received partial treatment and 15% received no treatment. Dr. Rosenblatt indicated that the panel was extremely generous in what it considered partial treatment.

The study also looked into the effect of diagnoses on the amount of caregiver time required. Those individuals with no diagnosis received approximately 50 minutes per day caregiver time, whereas those individuals who had a dementia and/or psychiatric diagnosis received much more caregiver time per day (ranging between 200 to 250 minutes per day).

Phase II of the study is a five-year longitudinal study. Researchers will return to the same facilities, follow the original cohort and identify another 200-member cohort to follow. The aim of the study is to describe longitudinal course, detection, treatment, effects on quality of life and effects on the time of death or discharge.

Phase II preliminary findings indicate that 14 individuals from the original cohort had no dementia; 27 had dementia at both intervals; and 3 converted to a diagnosis of dementia. The findings indicate treatment matters: morbidity increases when treatment is not received.

Phase III will look toward implementation of interventional measures, such as behavior management, exercise/restorative nursing, dementia medication optimization, incontinence training, wandering management and the outcome of such interventions.

IV. Presentation: American Society of Consultant Pharmacists Study Concerning the Role of the Pharmacist Recommendations in Reducing Potentially Inappropriate Medications in the Assisted Living Setting and Recommendations of the Maryland Board of Pharmacy’s Long Term Care Task Force by Dr. John Balch, Maryland Board of Pharmacy

It is known from national studies that most residents in assisted living will have multiple diagnoses, some debilitating, and will take on average 9 to 14 medications per day benefit from drug regimen reviews (DRR). The Fleetwood Project demonstrates the health and cost benefits of utilizing DRR. Pharmacists can play a role in the assisted living setting. They can identify drug interactions, inappropriate medications, address medication-related questions, etc. DRR can greatly benefit providers through potential cost savings on their
pharmaceuticals expenses, as well as providing an effective means of preventing or correcting drug-related problems.

V. Discussion: Quality Standards

- Disclosure Requirements for Special Care Units or Programs (SCU). – In the past eight years, the Department has noted that many assisted living programs advertise SCU specializing in Alzheimer’s care, or rehabilitation care. In 2002, the General Assembly passed Senate Bill 746 that required assisted living programs to disclose the nature of special care units to the Department and to potential residents.

Typically, assisted living programs charge additional fees to residents who receive services in a SCU. Most residents with cognitive disorders, such as Alzheimer’s Disease, decline in a progressive manner resulting in an ongoing loss of functional ability. Therefore, the services to those individuals in SCU should be different in nature to those offered in the rest of the assisted living program.

Current law provides that an assisted living program operating a SCU must disclose how the care of unit is specifically designed for individuals with Alzheimer’s Disease or a related disorder. It also requires that a SCU provide at the time of licensure or licensure renewal to the Department a written description that includes:

- Statement of mission and philosophy;
- Staff training and job titles;
- Admission procedures and screening criteria;
- Staffing patterns;
- Description of physical environment, including any special features;
- Description of activities;
- Charges to residents; and,
- Discharge procedures.

It is proposed that an assisted living program that operates a SCU should at the time of licensure provide the Department with the written description of the program as already required. At the time of licensure renewal, the assisted living program should provide a written description of any changes that have been made to the SCU and how those changes differ from the description of the unit on file with the Department. The Department should also have the authority to restrict or close the operation of a SCU if the Department determines that the health and safety of the residents are risk. Assisted Living Program should also be required to disclose how the SCU services are different from those provided in the rest of the program. There was no dissension noted to this proposal.

- Change of Initial Application Process. – During the 2004 General Assembly Session, legislative leaders requested that the Office of Health Care Quality (OHCQ) develop a work plan for Fiscal Year 2005 and 2006 because of their concern about the loss of survey staff. In order to better allocate scarce resources, it is proposed that assisted living programs seeking initial licensure be required to provide prerequisite licensure documents, such as policies and procedures, educational training, fire inspection, zoning, criminal background checks – managers and assistant managers, before an application will be sent to the provider and an on-site pre-licensure inspection scheduled. The Department has begun to implement this recommendation.

- Minimum Licensing Standards. – The Department, through its survey experience, has noted that minimum licensing standards need to be strengthened to ensure that assisted living program operators have appropriate experience to operate a program. Therefore, it is proposed that COMAR 10.07.14.06(B) be strengthen to: The Secretary [may] shall require an applicant to submit: (a) information concerning the applicant’s past or current operation of health or residential facilities or similar health care program; (b) information demonstrating financial [or] and administrative ability to operate an ALP in compliance with this chapter;
• **Bond Requirements.** – During the 2005 General Assembly Session House Bill 1425 was introduced by Delegate McComas, this bill would have required evaluation of the effectiveness of care provided by Adult Family Homes (assisted living programs licensed to serve four or fewer individuals) in Maryland specifically addressing issues, such as requirements for liability insurance, notification, surety bonds, etc. COMAR 10.07.14.28(E)(3) already requires that an assisted living program that manages residents’ personal funds, regardless of the amount managed, shall maintain a bond, a letter of credit or net assets 1 ½ times the average monthly balance of all of the funds held or managed by the program. The bond, letter of credit or list of assets shall be kept at the ALP for inspection by the Department or its designee. This is similar to requirements for other licensed health care facilities in Maryland. It is proposed that no additional requirements for bonds be required for assisted living programs. There was no dissension noted to this proposal.

• **Liability Insurance.** - Also contemplated in House Bill 1425 from the 2005 General Assembly Session was whether or not it should be mandatory to require all assisted living programs to have liability insurance. Liability insurance is not required for any other licensed health care facility in Maryland. Providers indicated that they had problems finding companies that will provide liability insurance coverage. Some providers have, therefore, “self” insured. The Small Assisted Living Alliance noted that they are conducting a mailing to their members to determine who has liability insurance and whether or not it is professional or general liability insurance. Another provider shared that liability insurance is cost prohibitive and that they have purchased individual liability insurance for caregivers and nurses at a cost of $89 per month. The availability and affordability of requiring liability insurance for assisted living facilities may be prohibitive for providers. A workgroup on this issue will meet immediately after the next ALF meeting.

• **Emergency Generators.** – House Bill 20 introduced by Delegate Costa during the 2005 General Assembly Session would have required the assisted living programs licensed to serve 50 or more individuals to have an emergency power generator on premises that meets specified criteria and provides lighting and supports certain systems. In Maryland, nursing homes with 50 or more beds are required to have an emergency power generator as well as a disaster plan; and those with 49 or fewer beds have the option to install an emergency generator or to provide a written evacuation/relocation plan for patients that is approved by the Department. Nursing homes are also required to have signed agreements between the nursing facility and the facility that agrees to accept the patients. The Department believes that assisted living programs, which provide care to nursing home eligible individuals, should be held to this requirement.

Some local jurisdictions reported to the Department during Hurricane Isabelle that they had to allocate resources to provide emergency power to some assisted living programs. The Department acknowledges that the financial burden that would be placed on assisted living programs to install emergency power generators to support the wattage requirements of the systems called for in House Bill 20. Of the 1,575 licensed assisted living facilities in Maryland, 98 facilities would be subject to this requirement. The Department conducted an informal survey of those programs during the Legislative Session and found that 21 of the 98 programs did not have any type of emergency generator.

The Department proposes that generators be required for ALPs licensed to serve 50 or more individuals and that an exception for this requirement be given to those programs that can safely transfer residents via an enclosed corridor. In addition, ALPs that can demonstrate financial hardship that would adversely affect the program’s viability can apply for a waiver for this requirement on a year-to-year basis. There was no dissension noted to this proposal.
• **Notification.** - Also contemplated in House Bill 1425 from the 2005 General Assembly Session was whether ALPs should be required to register with their local health departments, law enforcement agencies, and local fire departments. Currently COMAR 10.07.14.06(A)(4)(h) requires that a prospective ALP shall provide notification to the local health department and local area on aging of its request for licensure. The Department proposes that a new section should be added to require ALPs to notify the local fire department once they have become licensed. There was no dissension noted to this proposal.

• **Automated External Defibrillators (AEDs).** – House Bill 21 from the 2005 General Assembly Session, would have required nursing homes and assisted living facilities, with the exception of those facilities (1) licensed for nine or fewer beds; (2) participates in the Certified Adult Residential Environment Program administered by the Department of Human Resources (DHR); or (3) has a defibrillator on-site, to have and maintain an automated external defibrillator (AED) and have a trained operator on-site 24-hours each day. It would have also allowed an assisted living program facility and a nursing facility to participate in the Maryland Institute of Emergency Medical Services Systems’ AED program. Therefore, the bill would have applied to 347 of the 1,575 licensed assisted living facilities in Maryland.

In its fiscal analysis, the Department of Legislative Services noted that the average cost range for an AED is somewhere between $800 for a refurbished unit to more than $4,000 for a new unit. In addition, employee training would be required. The effectiveness of an AED program in a facility is based upon immediate access to a unit and intervention in the event of an arrest by a trained operator, therefore, assisted living facilities may need to purchase more than one unit. These costs may be a financial burden for some medium sized facilities. It is also uncertain how a facility’s use of an AED may interact with a resident’s advanced directive or its potential impact on end-of-life care. The Department proposes that the use of AEDs should be voluntary and should be disclosed to residents in the ALPs admission agreement. There was no dissension noted to this proposal.

V. **2005 Interim Meeting Schedule**

The Department is planning to tentatively hold ALF meetings on September 21, 2005, in Auditorium of the Maryland Psychiatric Research Center on the campus of Spring Grove Hospital Center in Catonsville, Maryland from 10:00 AM to 12:00 noon and October 19, 2005 from 10:00 AM to 12:00 noon, location to be determined.

VII. **Adjourn**

There being no further business before the ALF, the meeting was adjourned at 12:00 noon.