DHHS Public Hearing Proposed Residential Care and Assisted Housing Rules

4-1-25

Good afternoon. Thank you for providing this opportunity for us to share our thoughts on LD 979 and how this complete rule revision will impact the assisted housing programs in the state of Maine.

My name is Beth Boutot and I am NOT in support of this rule as written.

I have been a registered nurse since 1995. Since 2006, I have been working in the post-acute care setting. Recently, during the 'Covid' years, I taught CNA, CRMA and PSS courses under extremely difficult circumstances. I am currently employed by First Atlantic Healthcare in a documentation integrity role, working with our facilities to accurately and completely document the care that we are providing, both in the long term care and assisted housing settings. These rules will have a direct negative impact on all of our Assisted Housing/Residential care facilities in that they will require movement from a social to a medical model of care; require an increase in staffing without a workforce to support it; and they represent yet another mandate without a funding source.

The current rules are older, and I can agree that they should be revised and simplified. My opinion is that DHHS is using these rules to change our current social model of assisted housing into a medical model. However, we already have a medical model of care, found in the Long Term Care and Skilled Nursing Facilities. These facilities are closing at an unprecedented rate in Maine, creating large gaps in service availability across the northern and coastal regions of our great state. It's not because the population is getting younger and the service isn't needed. It's because reimbursement, specifically from Mainecare has not kept pace with the cost of operating a long term care facility.

Pushing the Assisted Housing model into a medical model will exacerbate this problem.

Taken alone this proposed rule change may not compellingly convince someone of its role in pushing assisted housing from a social to a medical model however, there are three tangible items have led me to this conclusion. DHHS is simultaneously re-writing:

1. the Assisted Housing Rules which we are discussing today (LD 979)
2. the MDS-AH used for reimbursement has been revised and rewritten copying much of the MDS used for skilled nursing facilities—no rulemaking or permissions required and
3. The Rules for State Board of Nursing: Ch 2, Sect 380, Chapter 6 governing the delegation of nursing tasks to Unlicensed Assistive Personnel have also been rewritten and are being considered by this legislature.

Why is this pertinent? Unlicensed Assistive Personnel (UAPs) are the care staff in Assisted Living. In the Board of Nursing rule revision, 02-380 Chapter 6, the new rule states:

> *"The registered professional nurse is responsible for the nature and quality of all nursing care that a patient receives."*

and 02-380 Chapter 6 Section 2.1.B.(5) states,

> *"The registered professional nurse must be **readily** available to the unlicensed assistive personnel performing the delegated nursing activity or task, either in-person, by telephone, or through another form of telecommunication. "*

This language related to the registered nurse being available at all times was taken out of the Assisted Housing regulations, but it remains in the Board of Nursing (BON) rules. I don't know of any RN that wants to be on call 24/7 not to mention the cost to assisted living providers to have an RN always readily available.

The MDS-AH manual links long-term care with the assisted housing sector. Chapter 1.1 on page 6:

> *Given the growing demand for long-term care and the significance of the assisted housing sector, there is a need for a greater understanding of the types of clients being served, the quality of care they receive, and the ability to adequately reimburse providers for the care and services required to meet these needs.*

This new MDS form and manual are designed to mimic the MDS 3.0 which is used in long term care and skilled nursing facilities. The language of 'assessment' is throughout the document, implying the need for a RN to be involved in each resident's 'assessment'. It also adds data elements that imply increased acuity and ignores some of the common care needs in the AH setting. Additionally this

new MDS form will be required to be submitted electronically—likely causing significant financial hardship for many smaller facilities. Especially with the regulatory changes related to informational security. The cost of the required software will be in the thousands per facility.

The state of Maine is experiencing a shortage of nurses—these rule changes will require more RN time and increase the difficulty of finding RN coverage as required. The state of Maine has a shortage of all types of caregivers—certified, licensed and unlicensed. The state of Maine has an ABUNDANCE of older or disabled adults who need care and services—either in their own home or in a facility. As you have likely already heard today, every facility already has open positions.

Lastly, if the plan is to retain the social model, I would ask: Why does the proposed staffing model that is being phased in look like that of long term care? I would come back to—have we accurately defined the 'problem' that the regulatory changes are trying to 'fix'?

I've worked to help find people who want to provide care for others, people who want to make a difference. We all want people who are willing to work hard with compassion and competency in a difficult environment, however they are very hard to find. I've had recent first-hand experience trying to recruit people to take a **free** CNA, CRMA or PSS class with very little success.

My role now is to help to ensure that the record of the excellent, compassionate care, is reduced to a 'piece of paper'. Documentation is necessary, but takes time away from the residents we are meant to be serving.

These new rules increase the administrative burden by increasing the documentation requirements and the complexity of the documentation. Here are just a few examples:

- Closure policies and plans must be developed upon opening. We might ask — are so many failing that a plan to close must be developed upon opening?

- Residents have the freedom of choice of provider, however the provider documentation requirements for a resident in assisted housing are very different than office visit requirements. Facility staff must jump through hoops to obtain the required documentation from community providers—if it even exists
- The facility must document their available services and their ability to meet the needs of each resident.
    - This includes potential nursing needs of the resident. However, the RN may not delegate those nursing duties to UAP unless allowed in Chapters 5 & 6 of the Board of Nursing rules. Without RN availability 24/7, this could lead to a decrease in available services. Causing an additional backlog of residents with specific needs left in acute care.
    - Increased detail in job descriptions with corresponding written policies and procedures
    - More detailed documentation of the training provided (by a RN) as well as specific details related to what must be included in that training
    - A RN must be readily available to the UAP either in-person, by phone or through another form of telecommunication for ANY delegated tasks—per the Board of Nursing Rules
- <u>More detailed documentation related to:</u>
    - <u>Admissions;</u>
    - <u>Annual physical exam;</u>
    - <u>Incident reports;</u>
    - <u>Medication errors;</u>
    - <u>Care refusals—</u>with documented efforts of education (requires a RN)
    - And review of the resident's record for care needs
- MDS/Resident Assessment Instrument—the re-write has happened. It has significantly increased the complexity with 'assessment' verbiage throughout the instructions for the tool. It is very difficult to find a UAP currently able to correctly complete or code the current "simpler" form. The state will readily say that they have difficulty obtaining accurate data with the current form. Why increase the complexity unless the ultimate plan is to require a licensed nurse to complete it?

    - The new instrument is based on the MDS 3.0 used for SNF and LTC facilities in the US, the verbiage within the training guide reflects this focus.
    - The State only hires RNs to review this assisted housing MDS coding—yet continues to claim that anyone can be trained to complete the MDS-AH.
    - The new questions reflects the opportunity to provide care that is currently considered skilled level of care such as tube feedings, significant wound management, respiratory management, etc.
    - Are we looking at changing the payment model for Assisted housing to mimic the long term care/skilled payment model?
- Facilities, or someone in the facility, will need to track the amount of time each employee spends providing direct care vs. ancillary services such as housekeeping. The intent is good—but as a registered nurse, I often take out the trash. Why separate this now? What happened to the social model using universal workers?
- Discharge documentation requirements mimic those of long term care or hospitals—reflecting a medical model of care and requiring skills beyond that of the staff typically found in the AH setting.
    - Documented evidence that the facility cannot meet the needs of the resident as the program is fundamentally designed
    - Additionally it only reflects a transition of care to a 'new' provider, however some of our residents do return 'home'.
    - Emergency transfers now require the facility to assist with finding appropriate placement
- Proposed protocols around risk assessments, medication management, incidents, reportable items and investigatory items are expanded and mimic the medical model. Many of these require assessments beyond the scope of a non-licensed care-giver.

I am 100% certain that if the rules are implemented as written, multiple facilities will close—limiting access to care for our family and neighbors.

I don't believe that is your goal. In that light, I would respectfully ask that this emergency rulemaking be paused and an effort be made at collaboration so that we have a chance to get this right.

We want the same thing—for the system to work as designed so that our elders and those with disabilities are provided at a minimum something for care options.

Thank you.