North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Adam Sholar
Legislative Counsel
Director of Government Affairs

April 1, 2014

SENT VIA ELECTRONIC MAIL

The Honorable Ralph Hise, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina Senate
Room 1026, Legislative Building
Raleigh, NC 27601-2808

The Honorable Mark Hollo, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
NC House of Representatives
Room 639, Legislative Office Building
Raleigh, NC 27603-5925

The Honorable Justin Burr, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
NC House of Representatives
Room 307A, Legislative Office Building
Raleigh, NC 27603-5925

Dear Senator Hise and Representatives Burr and Hollo:

Pursuant to the provisions of Session Law 2013-360, Section 12G.1(b), the Department of Health and Human Service is submitting a report on laws pertaining to staff ratios and other staffing requirements of special care units. The Department's Division of Health Service Regulation (DHSR) brought together a diverse group of stakeholders to review these laws and the attached report reflects the findings of this group.

If you have any questions or need additional information regarding this report, please contact Ms. Cheryl Ouimet, DHSR Chief Operating Officer at (919)-855-3757 or at Cheryl.Ouimet@dhhs.nc.gov.

Sincerely,

Adam Sholar

cc: Mark Payne Susan Jacobs

Drexdal Pratt	Theresa Matula
Sarah Riser	Joyce Jones
Kristi Huff	Pam Kilpatrick
Pat Porter	Rod Davis
Brandon Greife	reports@ncleg.net

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April 1, 2014

SENT VIA ELECTRONIC MAIL

Mark Trogdon, Director
Fiscal Research Division
North Carolina General Assembly
Legislative Office Building, Room 619
Raleigh, NC 27603-5925

Dear Director Trogdon:

Pursuant to the provisions of Session Law 2013-360, Section 12G.1(b), the Department of Health and Human Service is submitting a report on laws pertaining to staff ratios and other staffing requirements of special care units. The Department's Division of Health Service Regulation (DHSR) brought together a diverse group of stakeholders to review these laws and the attached report reflects the findings of this group.

If you have any questions or need additional information regarding this report, please contact Ms. Cheryl Ouimet, DHSR Chief Operating Officer at (919)-855-3757 or at Cheryl.Ouimet@dhhs.nc.gov.

Sincerely,

Adam Sholar

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Mark Payne	Susan Jacobs
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Kristi Huff	Pam Kilpatrick
Pat Porter	Rod Davis
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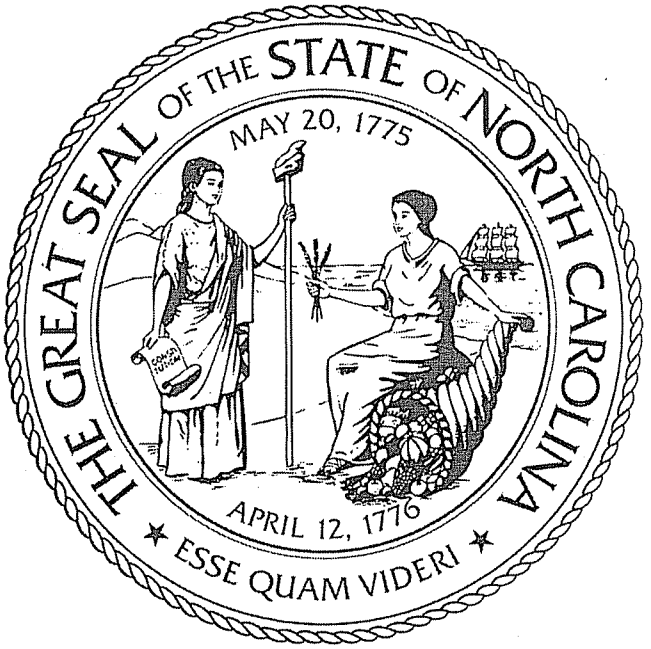
REPORT ON THE LAWS PERTAINING TO STAFF RATIOS AND OTHER STAFFING REQUIREMENTS OF SPECIAL CARE UNITS

PURSUANT TO SESSION LAW 2013-360, SECTION 12G.1.(b)



STATE OF NORTH CAROLINA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

APRIL 1, 2014

Special Care Unit – Staffing Ratio Report

Introduction – Purpose of the Study

In response to Session Law 2013-360 the Department of Health and Human Services (DHHS), Division of Health Service Regulation was charged with reviewing the laws pertaining to staff ratios and other staffing requirements of special care units, and for preparing a report for submission to the General Assembly by April 1, 2014. The specific language from Appropriations Act of 2013 is listed below.

> "Section 12G.1(b) By no later than April 1, 2014, the Department shall review the laws pertaining to staff ratios and other staffing requirements of special care units and report the results of its review to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division. The report shall compare special care unit staff ratios and staffing requirements in North Carolina to those of other states, including those states that border North Carolina. The report shall contain all the specific information:
> (1) The rationale and justification for establishing the existing special care unit staff ratios and staffing requirements.
> (2) Recommendations for changes to existing staff ratios and staff requirements based on findings of the Department's review."

Review Process

The Division of Health Service Regulation (DHSR) brought together a diverse group of stakeholders to participate on a Special Care Unit (SCU) Staffing Study Group. The Study Group was facilitated by DHSR senior leadership and Adult Care Licensure Section staff. The composition of the study group included representatives from other DHHS agencies (Division of Medical Assistance, the Office of the Controller, Division of Aging and Adult Services), County DSS Adult Services, Long Term Care Provider Associations, SCU service providers, and researchers in the field of dementia care. The list of study group participants is referenced in *Attachment A*.

The SCU Study Group began meeting in November 2013 and continued its work with its members sharing expertise and perspectives on at least a monthly basis through January 2014. The study group gathered information about the history and development of the current SCU staffing requirements, and the staffing requirements for dementia care units in other states. Based upon the review of this information, as well as the practical knowledge of providers, regulators, advocates and researchers, recommendations were developed on behalf of DHHS for submission to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

Rationale and Justification for Existing SCU Staffing Requirements

The rules related to the current staffing requirements for Special Care Units for Alzheimer and Related Disorders are found in the North Carolina Administrative Code (10A NCAC 13F .1308), and were adopted in 1999 along with the other special care unit rules in Section .1300 of 10A NCAC 13F.

10A NCAC 13F .1308 - SPECIAL CARE UNIT STAFFING

(a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.

(b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents.

(c) In units of 16 or more residents and any units that are freestanding facilities, there shall be a care coordinator as required in Paragraph (b) of this Rule in addition to the staff required in Paragraph (a) of this Rule.

History Note: Authority G.S. 131D-2; 131D-4.5; 131D-4.6; 131D-7; 143B-165; S.L. 1999-0334;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000.

These special care unit rules were adopted in 1999 after deliberation and recommendation by a DHHS Implementation Work Group after legislation. The 1999 document titled, "DHHS Implementation Work Groups and Related Provisions in the State Budget" listed the following charge to the Division of Facility Services (now the Division of Health Service Regulation):

"Special Care Services in Adult Care Homes (DFS)
Products/Deliverables: Revised initial & renewal license application forms; revised license; disclosure statement; revised section in Adult Home Specialist Procedures Manual; definitions of "mental health disability" and "other special needs, disease, or condition, as determined by the Medical Care Commission"; training curriculum; training schedule & notices; and training sessions.
End Users: Consumers, adult care homes (all types); & DSS Adult Home Specialists.
Implementation Work Group: DFS Group Care Licensure Section, DOA, DMH/DD/SAS, consumer advocates, Adult Foster Care Association, provider trade associations."

The minutes of the DHHS Implementation Work Group meetings on special care services in adult care homes are not available, so the source of information regarding staffing ratios as recommended and promulgated at that time comes from recollections of members of that committee and a few documents that were discovered by Division of Health Service Regulation staff. DHSR staff who served on the work group, in conversations with other former members of the work group, recalled that various resources from studies and expertise of researchers in the area of Alzheimer's and dementia care were available during the course of these meetings. These researchers and experts included: Lisa P. Gwyther, MSW,

LCSW, currently Associate Professor, Department of Psychiatry and Behavioral Sciences; Director, Duke Family Support Program; Director, Duke Employee Elder Care Consultation Program; Education Director, Bryan Alzheimer's Disease Research Center; Dr. Phillip Sloane of UNC with expertise in special care unit design features; and Alice Watkins who was the Director of the Eastern Chapter of the NC Alzheimer's Association.

One source of information that was identified as being used in discussions on staffing ratios is the North Carolina Adult Care Home Time Study. The results of this study, dated December, 1997, were based on research sponsored by the Division of Facility Services (now Division of Health Service Regulation) and the Division of Medical Assistance of the North Carolina Department of Health and Human Services, and prepared in report form by Myers Research Institute of the Menorah Park Center for the Aging and the Program on Aging and Long-Term Care of the Research Triangle Institute. A chart included in the time study report, entitled Exhibit 5-2: Projected Distribution of Resident Care Times by ADL and Cognitive Ability Levels (*Attachment B*), was used by the work group as a guide for possible special care unit staffing ratios.

As stated in rule, the minimum staff-resident ratio for first and second shifts is 1:8 plus one hour of staff time for each additional resident which equates to one hour of staff time per resident per those two shifts. For third shift the required minimum ratio is 1:10 plus .8 hours of staff time per each additional resident which equates to .8 hours of staff time per resident on this shift. Exhibit 5.2 from the Adult Care Home Time Study showed the estimated care minutes per day by number of Activities of Daily Living (ADL) and their degree of cognitive impairment. The work group members recalled that the discussion and development of these rules were based on the needs of the individuals with Alzheimer's disease and other related conditions. The reimbursement of SCU services was not part of the work group's charge nor did it enter into dialogue about Special Care Unit staffing ratios in the late 1990's.

Another source of information for review during the development of SCU rules in 1999, was a survey of various states' licensure rules regarding staffing in dementia special care units. Those survey results are not available, but one member of the 1999 implementation work group recalled only one state, Colorado, among those surveyed having specific staffing ratios for special care units for residents with Alzheimer's or other forms of dementia. Other states required staffing based on the needs of the residents.

A significant historical document in regards to staffing ratios was the proposed temporary rule 10 NCAC 42D .1908 Special Care Unit Staffing (*Attachment C*) that appeared on the DHHS website in September, 1999, for public comment along with other proposed temporary rules to implement the legislation. It shows changes from an earlier draft of the rule with proposed staff-to-resident ratios of 1:8 on 1st and 2nd shifts and 1:10 on 3rd shift, to ratios of 1:10 and 1:12. Following public comment, public hearing and the Medical Care Commission's review, the staffing rule was temporarily adopted and later permanently adopted by the Rules Review Commission requiring the 1:8 and 1:10 staffing ratios that have remained in rule since that time.

As noted above, the SCU staffing rules were adopted in 1999 well before Special Care Units were eligible to receive public funding for these services. Although recent events have focused on reimbursement mechanisms and rates for SCUs, the current staffing rules were not developed in response to or calculated based on the cost of care in SCUs. The public funding for SCU's came into existence in 2005. The SCU rates were based on a December 2004 "Report of the Findings and Recommendations of the Adult Care Home Cost Modeling Committee."

Staffing Requirements in Other States

S.L. 2013-360 mandated that comparison information on staffing requirements be obtained from other states, including the states that border North Carolina. DHSR Adult Care Licensure staff polled other states on Dementia Special Care Facility/Unit Staffing by sending a survey to the Association of Health Survey Agencies for distribution to all states. The survey asked four (4) questions:

1) Does your state have Assisted Living (AL) facilities or units within AL facilities licensed or designated exclusively for Alzheimer's/dementia?
2) Does your state have staff to resident ratios in these facilities or units and, if so, what are those ratios?
3) Does your state staff these facilities or units based on sufficiency to meet needs of residents (no ratios specified)?
4) Does your state staff these facilities or units using staffing arrangements other than #2 and #3 above?

Survey Responses

Twenty-seven of the fifty states responded to the survey, including the states that border North Carolina. The states responding to the survey included: Alabama, Arizona, Colorado, Connecticut, Florida, Georgia, Hawaii, Iowa, Idaho, Illinois, Indiana, Kentucky, Maryland, Missouri, Montana, New Hampshire, New Jersey, New Mexico, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, and Wisconsin.

Twenty-three of the twenty-seven states reported having facilities or units licensed or designated as Alzheimer's/dementia special care units. Two of the twenty-three states (Alabama and Colorado) with licensed or designated special care units reported having staffing ratios. The staff to resident ratio is 1:6 for SCUs in Colorado. The staffing ratios for Alabama are listed below with a rule citation from the Alabama's administrative code of the Department of Public Health, Bureau of Health Provider Standards. Of note, neither of these two states with required staffing ratios provide Medicaid funding for dementia special care unit care and services. The other states with licensed or designated special care units reported having no specific staffing ratios, but require sufficient staff to meet the needs of the residents. The table in Attachment D displays the results of the survey.

The comparison of staffing ratios across states should be taken in context with other factors such as a state's definition of assisted living and licensing categories, public funding access, and nursing home eligibility requirements. Although information from other states is important to consider, the

comparison not perfect due to the significance of public funding put in place in North Carolina to allow access to all individuals needing this specialized service environment.

Alabama Citation of Staffing Requirements

420-5-20-.04 Personnel and Training.

(1) General. A specialty care assisted living facility shall have at least two staff members on duty twenty-four hours a day, seven days a week. No specialty care assisted living facility shall have fewer staff on duty than specified in Table A below. Even if this minimum staffing ratio is met, the governing authority of a specialty care assisted living facility shall have sufficient *additional* staff on duty to meet the care needs of all residents twenty-four hours a day, seven days a week. If a facility's resident population has care needs that exceed those which should reasonably be expected to be provided by the number of staff on duty, then the facility does not meet this governing authority requirement.

Staff Number	7 AM - 3 PM	3 PM - 11 PM	11 PM - 7 AM
2	1 -16 Residents	1 - 16 Residents	1 - 16 Residents
3	17 - 24 Residents	17 - 36 Residents	17 - 48 Residents
4	25 - 32 Resident	37 - 48 Residents	49 - 64 Residents
5	33 - 40 Residents	49 - 60 Residents	65 - 80 Residents
6	41 - 48 Residents	61 - 72 Residents	81 - 96 Residents
7	49 - 56 Residents	73 - 84 Residents	97 - 112 Residents
8	57 - 64 Residents	85 - 96 Residents	113 - 128 Residents
9	65 - 72 Residents	97 - 108 Residents	129 - 144 Residents
10	73 - 80 Residents	109 - 120 Residents	145 - 160 Residents
11	81 - 88 Residents	120 - 132 Residents	161 - 176 Residents
1 Additional Staff	For each 8 residents, or any fraction thereof, by which the census exceeds 88.	For each 12 residents, or any fraction thereof, by which the census exceeds 132	For each 16 residents, or any fraction thereof, by which the census exceeds 176

Special Care Unit Providers' Concerns

Although providers support the current special care unit program model, including staffing ratios, there remains concern about the affordability of the model in light of impending rate reductions for personal care services. Currently, Medicaid beneficiaries who are residents of Special Care Units may be eligible for up to 80 hours of personal care services. Session Law 2013-360 enables Medicaid beneficiaries to be eligible for up to an additional 50 hours of Personal Care Services (PCS) if deemed necessary via an independent assessment. NC DHHS is awaiting the approval of Centers for Medicare and Medicaid Service (CMS) for a State Plan Amendment based on that law. The approval of this State Plan Amendment by CMS will increase the number of PCS hours available to beneficiaries who need them, but will also decrease the hourly reimbursement rate for Personal Care Services. In addition, Session law 2013-360, Section 12H.18.(b), requires NC DHHS to pay three percent (3%) less for personal care services rendered to Medicaid and NC Health Choice recipients in adult care homes as well as other healthcare providers beginning in January 2014 in conjunction with a later shared savings plan.

The reimbursement rate for residents served in SCUs is outside the scope of this report, however, the provider community has expressed their concern that a possible reduced PCS rate and the impact of the shared savings plan may create financial challenges for providers and impact on the services available to individuals with Alzheimer's and other related conditions in assisted living facilities.
The providers say the impact may result in:

1. Limiting Medicaid beneficiaries access to Special Care Units,
2. Reducing the number of special care unit beds if providers close these units; and
3. Impacting on the quality of care and safety of dementia residents served in adult care homes.
   - Under current NC adult care home licensure regulations, providers could give up their SCU license, continue to operate and not be required to adhere to SCU regulations as long as they do not advertise as a SCU to the public.
   - Providers may choose to serve older, frailer residents in non-SCU adult care home settings with younger residents possibly creating an environment where individuals with dementia would be more vulnerable in these settings with fewer regulatory safeguards to guide dementia care.

Providers are committed to serving the dementia population and express their heartfelt desire to continue to ensure the health and safety of this vulnerable population, believing that a special care unit is a viable program model but only if it is accompanied by a viable fiscal model to support the program.

Recommendations for Staffing Requirements in SCU

Recommendation #1: The staff ratio requirements for special care units that are in current rules - (North Carolina Administrative Code (10A NCAC 13F .1308) should remain unchanged. The study group, after much dialogue, believes that the staff ratios in current rule reflect the minimum number of staff needed to provide adequate supervision and care of the dementia population served in Special Care Units.

Recommendation #2: Review other special care unit rules cited in 10A NCAC 13F.1300 to identify opportunities that could potentially reduce redundancy and offer cost savings related to the proportion of staff time counted in staff ratios. For example, if the State Plan Amendment (SPA) 13-009 is approved by CMS, the new personal care services requirement for a comprehensive care plan could eliminate the need for quarterly profiles of SCU residents as currently required in rules. Additionally, an examination of the roles and responsibilities of staff assigned to work on special care units (care coordinators, activity coordinators) may identify if a portion of these staff members' time could be counted toward the staffing ratios; however, these staff would still need to meet the orientation and training requirements as specified in 10A NCAC 13F.1309.

Recommendation #3: Consider an updated cost study to the 2004 Cost Modeling Study for Adult Care Homes to evaluate the reimbursement rates and explore other possible public funding mechanisms for special care units.

Attachment A – Special Care Unit Staffing Study Group Participant List

Douglas Barrick, NC DHHS
Policy Coordinator, Adult Care Licensure Section
NC Division of Health Service Regulation

Judy Click, JEC Healthcare Management, Inc.
NC Association of Long Term Care Facilities (NCALTCF) Representative

Paul Cole, Branch Head
Office of the Controller

Curtis I. Crouch, NC DHHS
Section Chief, Cost Accounting/Financial Reporting
Office of the Controller

Mary Ann Drummond, Vice President of Operations
Carillon Assisted Living

Lisa P. Gwyther, MS, LCSW
Associate Professor, Department of Psychiatry and Behavioral Sciences
Director, Duke Family Support Program
Director, Duke Employee Elder care Consultation Program
Education Director, Bryan Alzheimer's Disease Research Center

Leslie Hall, Senior Care, Inc.
North Carolina Assisted Living Association (NCALA) representative

Susan Kesler Sibbett
Office of the Controller

Libby Kinsey, NC DHHS
Program Development Coordinator, Adult Care Licensure Section
NC Division of Health Service Regulation

Frances Messer, Executive Director
North Carolina Assisted Living Association (NCALA)

Tenesha Moore, NC DHHS
Ombudsman Program Specialist
Division of Aging and Adult Services

Karen Moriarty, CEO
Carillon Assisted Living

Talbatha Myatt, NC DHHS
Program Manager, Division of Medical Assistance

Cheryl Ouimet, MSW, NC DHHS
Chief Operating Officer, Division of Health Service Regulation

Cathy C. Rouse, MSW, Adult Home Specialist
Cumberland County Department of Social Services

Barbara Ryan, NC DHHS
Section Chief, Adult Care Licensure
Division of Health Service Regulation

Sandy Spillman, Salem Senior Living, Inc.
NC Association of Long Term Care Facilities (NCALTCF) Representative

Tom Stahlschmidt, Regional Director of Operations, Meridian Senior Living
NC Association of Long Term Care Facilities (NCALTCF) Representative

Candace Stancil, NC DHHS
Nurse Consultant, Division of Medical Assistance

Alice W. Watkins, Executive Director
Alzheimer's North Carolina Inc.

Sharon Wilder, NC DHHS
State Long Term Care Ombudsman
Division of Aging and Adult Services

Dean Wilson, Therapeutic Alternatives
NC Association of Long Term Care Facilities (NCALTCF) Representative

Lou Wilson, Director of Government Relations
NC Association of Long Term Care Facilities (NCALTCF)

impairment and received help in all five ADLs. This same process was also applied to each of the 17 other resident categories.

EXHIBIT 5.2: PROJECTED DISTRIBUTION OF RESIDENT CARE TIMES BY ADL AND COGNITIVE ABILITY LEVELS IN THE STATE SAMPLE

Number of ADLs in Which Receiving Help & Cognitive Impairment Level		Percent of Statewide Sample	Estimated Direct Care Minutes per Day
O ADLs:	Little or No Cognitive Impairment	15.2%	31.2
0 ADLs:	Moderate Cognitive Impairment	11.5%	51.9
0 ADLs:	Severe Cognitive Impairment	12.0%	65.4
1 ADL:	Little or No Cognitive Impairment	6.7%	30.4
1 ADL:	Moderate Cognitive Impairment	9.7%	47.6
1 ADL:	Severe Cognitive Impairment	16.0%	56.1
2 ADLs:	Moderate Cognitive Impairment	1.7%	56.1
2 ADLs:	Little or No Cognitive Impairment	3.4%	67.4
2 ADLs:	Severe Cognitive Impairment	6.6%	75.6
3 ADLs:	Little or No Cognitive Impairment	1.2%	43.9
3 ADLs:	Moderate Cognitive Impairment	1.6%	70.7
3 ADLs:	Severe Cognitive Impairment	4.1%	83.0
4 ADLs:	Little or No Cognitive Impairment	0.5%	94.0
4 ADLs:	Moderate Cognitive Impairment	2.4%	98.5
4 ADLs:	Severe Cognitive Impairment	4.4%	98.5
5 ADLs:	Little or No Cognitive Impairment	0.1%	58.4
5 ADLs:	Moderate Cognitive Impairment	1.5%	109.4
5 ADLs:	Severe Cognitive Impairment	1.5%	121.5

These figures were then used to calculate an average care time for the State sample as a whole. The estimated average care time in the State sample was 58.1 minutes per day. This estimated average care time for the State, based on the 1993 sample's characteristics, was roughly five minutes per day (8.5%) lower than the average care time observed in the 1997 time study sample.

Attachment C

TPW

SEP 7 1999

North Carolina
Department of Health and Human Services
101 Blair Drive • Post Office Box 29526 • Raleigh, North Carolina 27626-0526
(919) 733-4534 • Courier 56-20-00

September 1, 1999

James B. Hunt Jr., Governor

H. David Bruton, M.D., Secretary

Dear Reader:

Over 100 agencies, organizations, and individuals submitted comments about the proposed temporary rules that will govern implementation of the initiatives included in SB-10 and related provisions in the state budget. We have given careful consideration to each of the comments. Some of the proposed rules have been revised based on these comments while others have not changed.

The enclosed proposed temporary rules will be considered for adoption at the public hearings. The rules are organized in the same order and format as the first set distributed on July 30, 1999. Changes in the rules are denoted in two ways: (1) new or revised language is bolded; (2) deleted language is struck through with a black line so that you can still see what is changed about the rule. Rules with neither one of these markings did not change. Additionally, the pages have been numbered for easier reference.

The revised rules can also be found on the DHHS website. The website address is www.dhhs.state.nc.us. To view the rules, click on "Special Initiatives" and go to the section entitled "Long Term Care Safety". Instructions for returning comments via the Internet can be found there.

Another Opportunity for Input

You have additional opportunities to submit written comments on these proposed temporary rules – (1) prior to the public hearings; and (2) at the public hearings. Comments submitted prior to and at the hearings will be considered in adoption of the rules. **If you submit written comments prior to the public hearings, they must be received by end of day September 13, 1999** and should be mailed to:

John Tanner
NC Division of Social Services
325 N. Salisbury Street
2405 Mail Service Center
Raleigh, NC 27699-2405

~~(d) Dementia causes dependency which progresses over time and requires increased health care.~~

~~(f) Family involvement and support is a vital element in resident care and well-being.~~

~~(g) Confusion, restlessness and agitation in late afternoon or evening, restlessness at night and wandering during the day or night are common so that staff should have a variety of activities and distractions available to manage residents who exhibit these behaviors.~~

~~(h) Consistency and familiarity in environment and staffing need to be maximized because confusion and disorientation worsen in changing situations.~~

.1908 SPECIAL CARE UNIT STAFFING

(a) ~~Direct care and supervisory~~ Staff ~~and~~ shall be present in the unit at all times in sufficient number to meet the needs of the residents, but at no time shall there be less than one ~~personal care aide~~ staff person, **who meets the orientation and training requirements in Rule .1901 of this Subchapter,** for every ~~eight~~ ten residents on first and second shifts ~~one personal care aide~~ and for every ~~ten~~ twelve residents on third shift. ~~and a supervisor on each shift.~~

(b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. **The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 19 or fewer residents.**

(c) In units of 20 or more residents and any units that are freestanding facilities, there shall be a care coordinator as required in Paragraph (b) of this rule in addition to the staff required in Paragraph (a) of this rule.

~~(e) Staffing shall be consistent so that rotation of staff on and off the unit is avoided except for emergency situations or to alleviate staff burnout.~~

.1909 SPECIAL CARE UNIT STAFF ORIENTATION AND TRAINING

The facility shall assure that special care unit staff receive at least the following orientation and training:

(1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement.

(2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents.

(3) Within six months of employment, ~~direct care~~ staff **responsible for personal care and supervision within the unit** shall complete 20 hours of training specific to the population being served **in addition to the training and competency requirements in Rule .1410 of this Subchapter and the six hours of orientation required by this rule.**

Appendix D
Results of Survey of States Regarding Alzheimer's/Dementia Units

	State	Staffing Ratios	Medicaid (Specific to ALZ)	Admission/Discharge Criteria other than Diagnosis & Meeting Needs	Comments
1	Alabama	Yes	No	Yes	Physical Self-Maintenance Scale Score no greater than 23
2	Arizona	No	Yes	Yes	1915(c) waiver for Level II requiring at least 1 nurse on staff; cannot be bed bound
3	Colorado	Yes	No	No	
4	Connecticut	No	Yes	No	Demonstration projected only for limited # of beds
5	Florida	No	No		
6	Georgia	No	No	No	
7	Hawaii *				
8	Idaho	No	No	No	Home & Community based waiver but not specific to ALZ
9	Illinois	No	No		Pilots Only
10	Indiana	No	No	No	Medicaid waiver but not specific to ALZ
11	Iowa *				
12	Kentucky	No	No	Yes	Must be mobile or have use of cane, walker or wheelchair; facilities certified, not licensed
13	Maryland	No			
14	Missouri	No	No		Medicaid Advanced PC based on needs
15	Montana *				
16	New Hampshire *				
17	New Jersey	No	No	No	
18	New Mexico	No	No		
19	Pennsylvania	No	No	No	
20	Rhode Island	No	No	No	Waiver for certain residents
21	South Carolina	No	No	No	
22	South Dakota				
23	Tennessee	No	No	Yes	Program called Choices; no physical or chemical restraints
24	Utah	No	No	No	
25	Virginia	No	Yes	Yes	Alz. memory care waiver; NH criteria, state auxiliary grant eligible ($1,000), 55+
26	West Virginia	No	No	No	
27	Wisconsin	No	No		Home & Community based waiver for all eligible residents

* No ALZ or Dementia Care Units