DEDICATED MEMORY CARE UNITS IN OHIO'S LONG-TERM SERVICES SETTINGS: STRUCTURE AND PRACTICES

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EXECUTIVE SUMMARY

Providing care for persons with dementia is an important task of our system of long-term services and supports (LTSS). Many of our long-term services settings, such as nursing homes and residential care facilities (e.g., assisted living), have created special and innovative strategies for meeting the complex needs of these individuals and their families. One of these strategies is to create dedicated units that specialize in caring for residents with dementia and memory issues. These units are referred to by a variety of names, including "dementia special care units" and "memory care units."

Despite the prevalence of residents with dementia in long-term services settings, there are no national requirements or regulations for MCUs. Ohio has some regulations that are relevant to MCUs, though they are largely directed to general requirements about residents with cognitive impairment. In 2016, Ohio House Bill 470 called upon the Directors of the Ohio Departments of Health and Aging to gather input from nursing home, residential care facility, consumer, and provider stakeholders across the state to create recommendations for "standards and procedures for the operation of memory care units."[1] Recently, legislation has been proposed for a second task force focused specifically on improving dementia care within Ohio, including assessment of dementia-related population trends, service needs, and policies.[2] An important aspect of improving care for individuals with dementia is to understand special care units that are specifically devoted to caring for residents with memory loss.

This report, based on data from the 2017 Biennial Survey of Ohio Long-Term Care Facilities, provides information about the current state of MCUs in Ohio's nursing homes or skilled nursing facilities (SNFs) and residential care facilities (RCFs). As Ohio considers policies for MCUs, an understanding of the current industry structure and practices provides an important background.

Highlights from our findings are provided below.

- Nearly one-third of SNFs and four in ten RCFs have an MCU. Facilities with MCUs are more likely to be of proprietary ownership and one in five MCUs are located in a continuing care retirement community.
- Facilities generally devote about 30% of their facility to the MCU if they have one. MCUs are fairly small; about 30 beds in SNFs, 28 in RCFs.
- The vast majority—about 95%—of MCU residents have a dementia or dementia-related diagnosis, although about 20% of SNF residents have a diagnosis of severe mental illness, often in addition to their dementia diagnosis.
- SNF residents in MCUs exhibit more behavioral and psychosocial symptoms of dementia (BPSDs) than RCF MCU residents. The most prevalent BPSDs are being verbally or physically abusive; the proportion of MCU residents exhibiting these behaviors is about twice as high in SNFs as in RCFs.

- Slightly over half of SNFs and about six in ten RCFs with an MCU have a dedicated unit manager.
- Resident-to-staff ratios in the MCUs at 10 a.m. on a typical day average six residents to one worker in SNFs, and seven in RCFs. There is more variation in resident-to-staff ratios in RCFs than SNFs.
- The vast majority—over 90%—of facilities require special dementia training for staff before working on the MCU.
- A higher proportion of direct care workers receive special dementia training in RCFs than in SNFs. Since dementia training is required of all federally certified SNFs, it is possible that special training for the MCU staff is less prevalent than in RCFs where the general requirement is not present.
- Six in ten SNFs use an assessment beyond the MDS for the residents in their MCU; about 90% of RCFs conduct initial and regular assessments for MCU residents.
- About half of SNFs and RCFs admit individuals without an established dementia diagnosis to their MCU.
- Eight in ten SNFs and nine in ten RCFs provide memory care in a locked unit.
- A vast majority (88% of SNFs; 93% of RCFs) of facilities provide activities in the unit that are matched to residents' cognitive, sensory, and physical capabilities.
- Physicians are more often engaged with monitoring of behavioral symptoms in SNFs than in RCFs. Almost 95% of SNFs have physician monitoring monthly or more often, compared to about 75% of RCFs.
- Physicians are also more engaged with monitoring psychotropic medications in SNFs than in RCFs. About 90% of SNFs have physician monitoring monthly or more frequently, compared to not quite 70% in RCFs.

Memory care in Ohio's SNFs and RCFs is provided via a wide range of practices with some observed differences between the type of residents, the type of care, and care practices in these two types of facilities. There is also a great deal of variation within each facility type. Without national standards or regulations, it has become the purview of states to determine what might be most appropriate for memory care settings and what certifications or standards would be meaningful to the families and friends caring for some of our most vulnerable citizens. This look at the current state of this industry in Ohio provides a starting point for these considerations.

INTRODUCTION

Providing care for persons with dementia is an important task for our system of long-term services and supports (LTSS). Many of our long-term services settings, such as nursing homes (SNFs) and residential care facilities (RCFs) (e.g., assisted living residences), have created special and innovative strategies for meeting the complex needs of these individuals and their families. One of these strategies is to create dedicated units that specialize in caring for residents with dementia and memory issues. These units are referred to by a variety of names, including "dementia special care units" and "memory care units."

BACKGROUND ON MEMORY CARE UNITS

Dementia, of which the most common type is Alzheimer's, not only impairs a person's short-term and long-term memory, but also impairs other brain functions. This can affect attention, personality, impulse control, ability to plan, motor and verbal abilities, and previously-automatic routines of self-care (e.g., brushing teeth).[3] While dementia affects each person differently, symptoms tend to worsen over time. The combination of cognitive loss coupled with behavior changes, such as wandering, often put persons with dementia at risk of harm, requiring more care and monitoring for many individuals than can be provided at home by family and friends. In fact, the cognitive impairment associated with dementia is among the strongest predictors of eventual nursing home placement.[4]

Today, it is estimated that nearly 50% of SNF residents and between 40-50% of RCF residents have dementia, with some estimates putting the rate for SNFs at nearly 70% when including those with very mild cognitive impairment.[5, 6, 7] Recent Ohio results found that 40% of SNF and 30% of RCF residents exhibited moderate to severe cognitive impairment.[8]

In response to the large number of residents with dementia and the complex care they require, many of the nation's long-term care facilities have created MCUs. MCUs generally house small numbers of residents with dementia or memory loss, and often have higher staff-to-resident ratios with staff receiving specific dementia-focused training.[9, 10, 11, 12]

National recommended standards for memory care units

National standards have been recommended for MCUs, including indoor and outdoor walking paths, activity spaces within the unit, private resident rooms, homelike décor, residential kitchens, open floor plans, and outdoor gardens.[13] Additionally, well-managed MCUs should seek to avoid pharmacological interventions, such as the use of antipsychotic medications, whenever possible.[14] This can be done by incorporating door

or resident monitors to maintain resident safety, and including interventions to manage dementia symptoms such as music therapy, bright-light therapy, physical and recreational activities, and provision of a reduced-stimulation environment.[15, 16, 17] Environmental design in MCUs often includes elements that allow residents with memory care needs to better navigate and feel more comfortable within the unit, such as increased visual contrast around doorways, meaningful markers for wayfinding, and common spaces to socialize (e.g., living/dining rooms).[18, 19]

Moreover, many leading organizations advocate that the dementia care provided in long-term services needs to be person-centered. Since 2012, the Centers for Medicare and Medicaid Services' (CMS) ongoing quality initiative *National Partnership to Improve Dementia Care in Nursing Homes* has emphasized how person-centered dementia care can lead to significant benefits, namely reducing behavioral symptoms, falls, and the use of antipsychotic medications.[20, 21, 22, 23]

The tenets of person-centered care are also echoed by other organizations. The *Alzheimer's Association Dementia Care Best Practice Recommendations* specifies eight areas of practice recommendations that are grounded in person-centered care, including: (1) detection and diagnosis, (2) assessment and care planning, (3) medical management, (4) information, education, and support, (5) ongoing care, (6) staffing, (7) therapeutic environment and safety, and (8) transitions and coordination of services. Similarly, the Joint Commission's (2014) report for memory care accreditation underscores many of these key components: care coordination, staff knowledge and competency, activity programming based on abilities, behavior management, and a safe and supportive physical environment. In combination, these reports highlight the importance of interdisciplinary collaboration including non-physician care providers, education and support for residents, families, and staff, non-pharmacological approaches, and individualized activities as best practices.[24, 25]

MEMORY CARE UNIT REGULATIONS

Recently, a few states have studied and adopted policies outlining what is expected when a SNF or RCF markets the provision of dementia or memory care. Currently, 16 states require licensing or certification of MCUs within RCFs, 17 states require agency review, and all 50 states have some dementia care provision in their RCF rules.[26] Two states, Mississippi and West Virginia, appear to regulate MCUs in SNF; however, an updated detailed review of state codes in SNFs is currently unavailable and could lead to new information.[27]

There is currently no "gold" standard for regulating MCUs; there is significant variability in which aspects of MCUs are regulated across states.

There is currently no "gold" standard for regulating MCUs; there is significant variability in which aspects of MCUs are regulated across states. A recent review of RCF regulations found that these regulations address, in order of commonality: administrator training, consumer disclosure, building design, staffing levels and types, and pre-admission screening.[28] Apart from these common regulatory areas, some states also include rules about staff orientation and training, resident care planning, nutrition assessment, behavior and medication management, and the frequency, types, and management of therapeutic activities.[29, 30]

The most commonly addressed aspect of MCU regulation is administrator training. Forty-nine states address this topic through certification or licensure, training hours, and/or continuing education requirements. Ten states specifically require RCFs to have an administrator for an MCU.[31] But dementia-specific training for MCU administrators in RCFs is largely unspecified and much is incorporated under the general rules.

The second-most prevalent aspect of MCU regulation is consumer disclosure, seen in 33 states. Disclosure regulations require that residents and family members are informed about various aspects of the MCU. Depending on the state, disclosure requirements may include information about the MCU mission, services, cost, staff type and training, and procedures.[32] This is important for making sure consumers are knowledgeable about the services and care provided in the MCU, given its secured, typically segregated environment.

The third most common area of MCU regulation applies to building design, also referred to as the physical environment. These requirements are included in 29 states' regulations for RCF MCUs. Typically, these rules encompass egress (e.g., locked entrance/exit doors/unit), outdoor space (e.g., walking paths), and resident unit features (e.g., personalization of resident rooms).[33] Mississippi and West Virginia physical environment rules for MCUs include the requirement for a multipurpose room, security measures and egress policies, high visual contrasts for doorways and doorplates, a nurse's station or secure area for medication, and outdoor space with a walking path.[34, 35]

States may also regulate the staff types and levels of staff who work in MCUs. In total, 17 states' RCF MCU regulations include information about either *staffing level* or *type of staff* who should be employed in the unit. Of these, 14 states involve some specification of staff other than direct care workers who must be employed, which include the following types of professionals: social workers, licensed nurses, and administrators. Only seven states specify any minimum staffing levels in RCF MCUs. Illinois, Mississippi, North Carolina, Pennsylvania, and West Virginia specify staffing levels for

direct care workers. Two other states, Texas and Virginia, note that an activities director must work a minimum of 20 hours a week dedicated to the unit.

Finally, 14 states require RCFs to conduct pre-admission screenings to determine that the MCU is an appropriate setting for the resident. Some states require a physician's diagnosis of dementia in order to be admitted to an MCU, while other states require a physician's order, or require a resident to have certain scores on evidence-based cognitive assessment tools.

OHIO'S CURRENT SPECIAL CARE UNIT REGULATIONS

Ohio's Administrative Code (OAC) for SNFs and RCFs includes some provisions that are relevant to MCUs although they are often directed to general requirements about residents with cognitive impairment. The most recent revisions to the OAC was in 2018.

Currently in SNFs, OAC defines "specialty care" as "advertising the [nursing] home provides specialty care, represents to the department or the public that it provides specialty care, or admits ten or more individuals with common specialized care needs. Specialty care includes, but is not limited to, dementia care, behavioral care, mental health care or hospice care." The OAC also has a general requirement that nurse aides have at least twelve hours of training each year and this training shall address the needs of residents as determined by their care plans. Additional training is required if a SNF provides "specialty care," although the amount and type is not specified.[36] Outside of these provisions, the OAC is rather limited in scope as it relates to MCUs in SNFs.

In contrast, the OAC currently has more rules related to RCF special care units and treating individuals with dementia. An RCF can have a "special care unit" which is dedicated to providing care to residents with diagnoses that may include "late-stage cognitive impairment with significant ongoing daily living assistance needs, cognitive impairments with increased emotional needs or presenting behaviors that cause problems for the resident or other residents, or both; or, serious mental illness."[37]

For residents that are admitted to special care units, including MCUs, Ohio requires disclosure of information to prospective residents regarding the RCF's policies on care. Information that must be provided prior to admission includes: a mission statement for the unit, admission and screening criteria, transfer and discharge procedures, weekly staffing plans and how they differ from the rest of the facility, an explanation of increased supervision provided, a description of the specialized activities, extra costs, specialized staff training, the process for assessing and providing services, a description of the physical environment and design features that support the functioning of residents, the involvement and support of families, and any other "services and procedures that are over and above those provided in the remainder of the facility".[38] In addition, prior to admission to a special care unit, RCFs are required to have a

physician or other licensed healthcare professional make a determination that the admission to a unit is needed if the resident's freedom of movement is restricted.[39]

Ohio has no specific MCU regulations for staff training except as applied generally to caring for residents with cognitive impairment. Persons who plan activities for residents with cognitive impairment must have training in appropriate activities for these residents.[40] Additionally, among direct care workers that do not hold a medical license (e.g., registered nurses), various levels of training are required based on whether the RCF admits residents with cognitive impairment, serious mental illness, or both. For example, if an RCF only admits residents with cognitive impairment without serious mental illness, training includes "Two hours of initial training in the care of such residents within fourteen days of the first day of work; and four hours of continuing education in the care of such residents annually." These continuing education hours may count towards other continuing education requirements.[41]

OHIO'S LEGISLATIVE MEMORY CARE INITIATIVES

With the prevalence of dementia expected to increase in the coming decades, there is a clear impetus to create a specific standard of care for residents with dementia in Ohio's LTSS settings. As indicated above, regulations in RCFs are generally directed to all types of specialty care rather than specifying requirements for MCUs, and SNF regulations for specialty care are nearly non-existent. Recently, House Bill 470 called upon the Directors of the Ohio Departments of Health and Aging to gather input from long-term services stakeholders across the state to create recommendations for the "standards and procedures for the operation of memory care units."[42] These industry stakeholders included psychologists, social workers, and other mental health care providers with specializations in dementia; administrators and managers of Ohio SNFs and RCFs; and researchers in the fields of dementia and aging. Legislation (SB24) has been passed for a second task force focused specifically on improving dementia care in Ohio, including assessment of dementia-related population trends, service needs, and policies.[43] This task force would outline recommendations on improving dementia care, ameliorating the financial impact of dementia, and securing adequate health care providers to meet dementia care needs.

With the prevalence of dementia expected to increase in the coming decades, there is a clear impetus to create a standard of care for residents with dementia in Ohio's LTSS.

Ohio House Bill 732 was introduced in 2018 during the 132nd General Assembly to address the issue of staff training. That bill called for eight hours of evidence-based training for direct care staff and four hours for indirect care staff in facilities that market or promote special dementia programs or units. Training topics were included along with additional training criteria. That bill was referred to committee but has not come to a vote.[44]

In 2019, House Bill 265 was introduced to create a dementia care certificate. This bill allows for an individual certification in dementia care based on a program of training to be developed by the Ohio Department of Aging (ODA). Training topics specified in the bill are the same as those included in House Bill 732, but training would be administered by ODA rather than individual facilities.[45] Individuals would be certified in dementia care rather than certifying or licensing a facility to provide such care.

Also in 2019, Senate Bill 24 was introduced and passed to establish the Alzheimer's Disease and Related Dementias Task Force. This group will examine the needs of individuals with dementia, the services available for those individuals, and the ability of Ohio providers and facilities to meet current and future needs.[46]

METHODS

This report, based on data from the 2017 Biennial Survey of Ohio Long-Term Care Facilities, provides information about the current state of MCUs in Ohio's SNFs and RCFs. As Ohio considers policies for MCUs, an understanding of the current industry structure and practices provides an important background.

The Biennial Survey of Ohio Long-Term Care Facilities is a survey conducted every other year in order to understand the state of Ohio's long-term care facilities. A survey is sent to every licensed SNF and RCF in the state that is open during the target year. Data from the 2017 Biennial Survey of Ohio Long-Term Care Facilities are utilized for this report. The survey was generally completed by the administrator of the facility (95% for SNFs and 91% for RCFs), though input is often provided by other staff, including the Director of Nursing and business office staff. The response rates for the survey are 91.2% for SNFs and 88.4% for RCFs.[47] For this report, the sample was restricted to those facilities that answered questions needed to determine whether they had an MCU or whether their entire facility was dedicated to memory care. In addition, SNFs were only included if they could be merged with data from the Certification and Survey Provider Enhanced Reporting (CASPER) system and were certified for Medicare or Medicaid. This resulted in a sample of 901 SNFs and 604 RCFs.

RESULTS

Memory care unit structure and payment

Many Ohio long-term care facilities have specialized MCUs (Table 1). Nearly one-third of SNFs and 38.6% of RCFs have an MCU. Facilities with MCUs are more likely to be proprietary, with the percentage being similar to the state average among all facilities. Around one out of five MCUs are located in a continuing care retirement community.

SNFs and RCFs devote about 30% of the facility's beds to the MCU; about 30 beds in SNFs, 28 in RCFs. Occupancy rates in MCUs are similar to rates in the facility as a whole. The occupancy rate in MCUs at SNFs is 87.3% compared to an overall occupancy rate of 81% for the average SNF in Ohio. For RCFs, MCUs have an average occupancy rate of 84.1% compared to an overall occupancy rate of 85.3.[48]

One aspect of MCU structure that differs between SNFs and RCFs is the type of rooms housed in the unit. SNFs have more semi-private than private rooms, while RCFs have very few semi-private rooms in the MCU. In fact, one in three MCU rooms in SNFs are private, compared to almost nine in ten (86%) in RCFs. This may be a reflection of payer-mix. Medicaid rates are lower than private-pay rates and do not include the cost of a private room. In SNFs, about three-quarters of MCU residents are paid for by Medicaid. In contrast, the average MCU in an RCF has 8.3% of their residents paid for by Medicaid via the Assisted Living Waiver Program or MyCare. In fact, fewer than one-quarter of MCUs in RCFs report any residents paid for by Medicaid.

Across all rooms and rates, SNFs are more expensive than RCFs. The average private-pay single room in an SNF was $266 per day and $191 in RCFs in 2017. SNF rates are similar for both the MCU and other rooms. However, a high proportion of MCU residents rely on Medicaid and that rate ($192) is considerably lower than the private-pay rate. RCFs rely primarily on private-pay residents with more than nine in ten residents paying privately. The Medicaid rate for RCFs through the Assisted Living Waiver Program ($96) is below the private-pay rate.

Table 1. Structure of Ohio Memory Care Units		
	SNFs	**RCFs**
Facilities with a Memory Care Unit		
Has a memory care unit (#)	298	233
Proportion of facilities with a memory care unit (%)	33.1	38.6
Proprietary facility (%)	74.2	76.0
Part of a continuing care retirement community (%)	18.1	21.5
Description of Memory Care Units		
Beds in facility devoted to unit (%)	28.1	32.1
Occupancy rate (%)	87.3	84.1
Number of rooms in unit	20.3	26.3
Number of private rooms in unit	7.9	22.3
Number of semi-private rooms in unit	12.4	3.4
Number of other rooms in unit	N/A	0.6
Percentage of private rooms in unit (%)*	34.3	85.9
Payer-Mix of Memory Care Units		
Medicaid residents (%)	74.6	8.3
Private-pay residents (%)	25.4	91.3
Other payment residents (%)		0.4
Average Daily Rates#		
Private room in memory care unit ($)	266	191
Semi-private room in memory care unit ($)	240	191
Private room in facility for private-pay resident ($)	272	153
Semi-private room in facility for private-pay resident ($)	239	162
Medicaid reimbursement rate ($)	192	96

Note. Sample sizes vary for each question.

* Includes only facilities that reported a number for both private- and semi-private rooms.

Rates for memory care units are not specific to payer. The rates reported for private-pay and Medicaid are restricted to facilities that reported a rate for their memory care unit. Rates can vary due to some facilities not having certain type of rooms.

Location of memory care units in Ohio

Offering memory care in special units may be a strategy for facilities to meet a specialized need in their area, or to remain competitive with other nearby facilities. To examine whether certain locations were more likely to offer MCUs than others, the number of SNFs and RCFs that have an MCU in each county was calculated and mapped in Figures 1 and 2.

MCUs in RCFs are found in fewer counties than MCUs in SNFs. Forty counties do not have an RCF with an MCU, (including the six counties that do not have any RCFs)

compared to only 15 counties that do not have a SNF with an MCU. Counties that have no MCUs (shown in light green) tend to be located in the more rural parts of the state, either in the Appalachian region or along the Indiana border. Nine counties do not have any MCUs, either in a SNF or RCF, four of these same counties also do not have any RCFs. There are a few rural counties that have two or more facilities with MCUs (indicated in dark blue), but in general, counties that have a larger number of facilities with MCUs are more urban or near urban centers.

Figure 1. Number of SNFs with MCUs by County

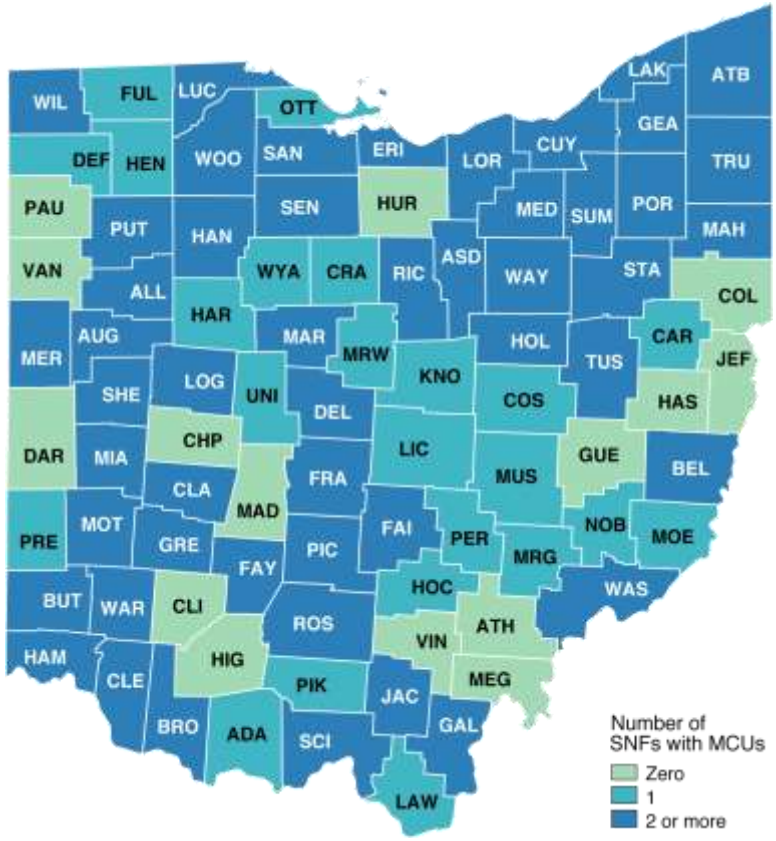
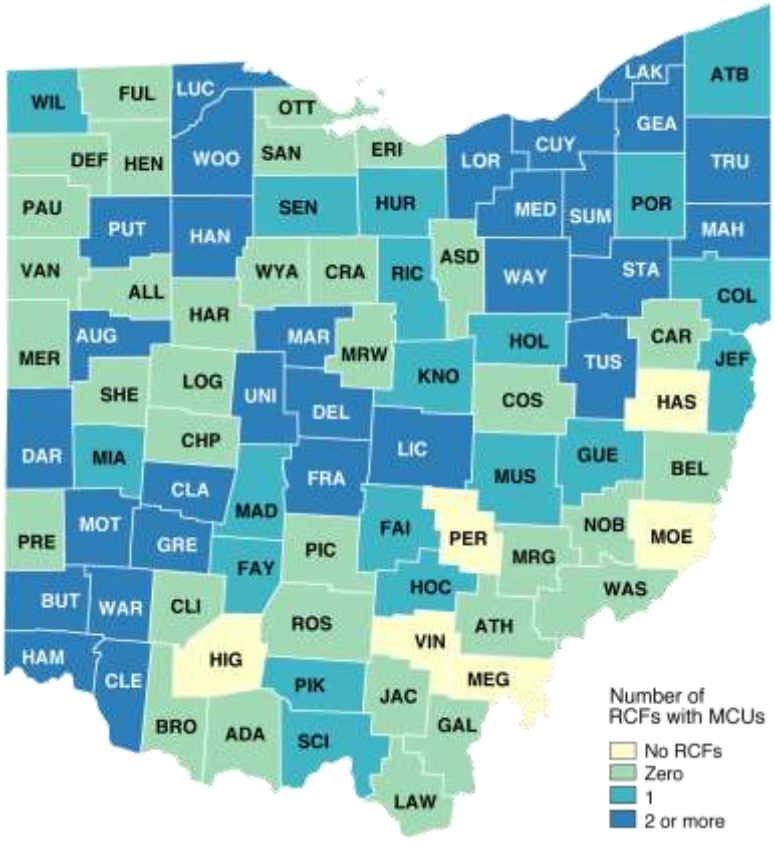


Figure 2. Number of RCFs with MCUs by County



To further understand which counties have MCUs, the total number of MCUs for both SNFs and RCFs were calculated. Thirteen counties have 10 or more MCUs and six have more than 25. The top 10 counties in terms of the total number of MCUs are shown in Table 2. The distribution of MCUs between SNFs and RCFs shows a wide variation among counties, with Cuyahoga having an equal number of MCUs in SNFs and RCFs compared to Franklin and Summit counties; both have twice as many MCUs in RCFs as in SNFs. More research is needed to understand the determining factors used by SNFs and RCFs to invest in an MCU.

Table 2. Top 10 Counties in Total Memory Care Units

County	SNF MCUs	RCF MCUs	Total
Cuyahoga	31	31	62
Hamilton	32	18	50
Franklin	13	27	40
Montgomery	20	16	36
Stark	13	12	25
Summit	8	17	25
Mahoning	11	8	19
Butler	8	10	18
Lorain	10	6	16
Lake	7	6	13

Characteristics of residents in memory care units

Facilities were asked to report the total number of residents in their MCU, as well as the particular diagnoses, behaviors, or treatments associated with dementia care. As shown in Table 3, the percentage of residents with dementia is similar for both SNFs and RCFs. However, MCU residents in SNFs are more likely to have behaviors and treatments associated with more advanced dementia. For example, MCU residents in SNFs are more likely than those in RCFs to have severe mental illness and exhibit behavioral or psychosocial symptoms of dementia (BPSD) such as verbally or physically abusive behaviors, hallucinations, or delusions. Despite having a lower percentage of residents with BPSD, the proportion of residents with antipsychotic, antidepressant, or other psychotropic medications is higher in RCFs. This lower use of antipsychotic and other psychotropic medications among SNFs could be due to CMS' initiatives to reduce the use of these drugs in nursing homes and the public reporting of quality measures related to these drugs on CMS' Nursing Home Compare website.

Table 3. Characteristics of Residents in Ohio Memory Care Units		
	Percentage of Residents	
	SNFs	RCFs
Diagnosis: Dementia or dementia-related	94.4	94.7
Diagnosis: Severe mental illness	19.16	2.9
Behavioral symptoms: Hallucinations/delusions	18.6	12.6
Behavioral symptoms: Verbally abusive	16.4	7.6
Behavioral symptoms: Physically abusive	11.6	4.9
Behavioral symptoms: Repetitive walking behavior	20.7	17.1
Treatment: Using antipsychotic medications	26.4	28.5
Treatment: Using antidepressant medication	28.0	40.0
Treatment: Using other psychotropic medications	28.3	29.6
Treatment: Physically restrained	2.0	0.0

Note. The SNF and RCF samples are restricted to facilities that have a dedicated memory care unit.

An independent source of data, the Minimum Data Set (MDS) was used to validate the findings from the self-reported survey data reported in Table 3. Specifically, the first quarterly or annual assessment for all unique long-stay (100+ days) residents aged 65+ in Ohio's SNFs was identified. Unfortunately, the MDS does not identify whether a resident is residing in an MCU. Therefore, we examined how many of these residents were diagnosed with dementia and examined the characteristics of residents with dementia based on whether they resided in a SNF with or without an MCU. Table 4 provides a comparison of all SNF residents, and residents in a SNF with and without an MCU.

Six in ten (62%) of all long-stay residents in SNFs have a diagnosis of dementia. This indicates that almost every SNF in Ohio is providing dementia care, whether the facility has a specialized unit or not.

Overall, six in ten (62%) of all long-stay residents in SNFs have a diagnosis of dementia. This indicates that almost every SNF in Ohio is providing dementia care, whether the facility has a specialized unit or not. More Ohioans reside in SNFs without an MCU (55%), though SNFs with an MCU have a higher proportion of residents with dementia compared to SNF's without an MCU (68% vs. 58%). Moreover, SNFs with MCUs tend to have residents with more advanced symptoms of dementia, such as behavioral symptoms, hallucinations, delusions, and rejecting care. One of the largest differences between SNFs with and without MCUs is wandering, which is more prevalent in SNFs with MCUs (14% vs. 9%).

Table 4. Characteristics of Long-Stay Residents Aged 65+ with Dementia in Ohio			
		Memory Care Unit in SNF	
	All SNFs	No	Yes
Total number of long-stay residents	45,492	25,296	20,196
Diagnosed with dementia	28,327 (62.3%)	14,664 (58.0%)	13,663 (67.6%)
Characteristics of Residents with Dementia (%)			
Hallucinations	3.3	3.1	3.6
Delusions	11.5	10.0	12.8
Physical behavioral symptoms	7.0	6.1	8.1
Verbal behavioral symptoms	11.7	10.4	13.1
Other behavioral symptoms	10.4	8.9	12.0
Behavioral symptoms impact resident or others	0.9	0.9	1.0
Rejecting care	12.5	11.0	14.1
Wandering	11.3	8.7	14.0

Note. The sample is restricted to unique long-stay residents (100+ days length of stay) aged 65+ identified in the 2017 Minimum Data Set (MDS) that resided in a Medicare or Medicaid certified SNF.

Memory care unit managers and staffing practices

Rejecting care, wandering, and other behavioral symptoms, as well as the need for cueing and other assistance with activities of daily living, increases as dementia progresses.[49] In the past, many of these issues were managed with antipsychotics. However, use of antipsychotics in SNFs has declined in response to CMS' *National Partnership to Improve Dementia Care in Nursing Homes* and facilities are expected to adopt non-pharmacological practices to manage dementia symptoms.[50] These practices require significant investment in staff time and training, and may require staff in MCUs to provide more assistance than in other areas of the facility.[51] Staff assigned to MCUs often apply for this assignment and are selected because of their special interest in serving this group of residents.

West Virginia's MCU regulations, which apply to both RCFs and SNFs, require a designated unit coordinator with a license as a health-related professional.[52] Five states have specified staffing level requirements for direct care workers in RCF MCUs. Two of these states, North Carolina and Illinois, use staffing ratios that dictate the maximum number of residents per staff member (i.e., resident-to-staff ratio). North Carolina allows each direct care worker to care for up to eight residents while Illinois allows for up to 10 residents. Three states (including West Virginia) require a minimum number of direct

care staffing hours per resident each day. These requirements range from a low of two hours per resident day in Pennsylvania to three hours per resident day in Mississippi.[53] Mississippi regulations for MCUs in SNFs also require that at least two staff members be present on the unit at all times.[54]

To understand how Ohio's MCUs are managed and staffed, Table 5 examines whether the MCU had a dedicated coordinator or manager solely assigned to the unit, the credential of that individual, and information on the direct care staff of the MCU.

The majority of Ohio facilities have a full-time dedicated manager, though they are more common in RCFs than in SNFs (59% vs. 51%). Most dedicated managers are a licensed nurse (i.e., registered nurse [RN] or licensed practical nurse [LPN]), though SNFs are more likely than RCFs to employ an RN as a dedicated manager. Very few facilities use social workers or licensed nursing home administrators as MCU managers. The most common response in the "other" category includes individuals that received special training or certificates in providing memory care.

When staff know the residents for whom they care, understanding behavior and communication becomes easier and non-pharmacologic approaches can be better tailored to individual residents.

In Ohio, RCFs have higher resident-to-staff ratios (i.e., fewer staff per resident) than SNFs across all shifts. In addition, RCFs have the greatest variation in resident-to-staff ratios across shifts. For example, the average MCU in an RCF has 6.8 residents per staff member in the morning, compared to 10.7 at night (4 a.m.). In contrast, the average morning shift (10 a.m.) in SNFs has a 6.2 resident-to-staff ratio, compared to an 8.7 resident-to-staff ratio at night. Where the variation in staffing is probably most striking is in the variation across facilities. While resident-to-staff ratios among SNFs and RCFs are similar among the best staffed facilities (10th percentile), the lowest staffed facilities (90th percentile) have very high resident-to-staff ratios in RCFs (9.7 at 10 a.m. to 15.5 at 4 a.m.). These ratios do not meet the resident-to-staff ratios required at RCFs in other states that have staffing regulations.

Consistent assignment of staff to the unit and the resident was also analyzed. Consistent assignment of staff is considered an important aspect of person-centered care and ideally means that the same staff member provides care to the same residents almost every time they are on duty.[55] When staff know the residents for whom they care, understanding behavior and communication becomes easier and non-pharmacologic approaches can be better tailored to individual residents. As shown in Table 5, in both settings, nine in ten direct care staff are consistently assigned to work in the MCU. About six in ten direct care staff (58% in SNFs and 66% in RCFs) are consistently assigned to the same residents.

Table 5. Managers and Staffing in Ohio Memory Care Units		
	SNFs	**RCFs**
Unit has dedicated manager (%)	51.1	58.9
Dedicated Manager Credentials* (%)		
Registered Nurse	38.3	19.6
Licensed Practical Nurse	47.4	50.4
Licensed Social Worker/Independent Social Worker	7.1	1.5
State-Tested Nurse Aide	9.2	7.5
Licensed Nursing Home Administrator	5.0	3.0
Other	20.6	30.1
Resident-to-Staff Ratio#		
At 10 a.m.	6.2 [4.0, 8.4]	6.8 [3.5, 9.7]
At 7 p.m.	6.7 [4.0, 9.0]	7.7 [4.0, 11.0]
At 4 a.m.	8.7 [5.7, 12.0]	10.7 [5.7, 15.5]
Consistent Assignment of Direct Care Staff (%)		
To unit	87.9	94.0
To resident	58.1	65.7

Note. The SNF and RCF samples are restricted to facilities that have a dedicated memory care unit.
* Facilities could indicate more than one type of manager and rates may add up to more than 100%.
# The staffing ratios reported are the mean and the [10th, 90th] percentiles. Staff includes RNs/LPNs/STNAs.

Training of memory care unit staff

Many MCU residents exhibit verbally or physically abusive behaviors that require special staff skills to address. The use of non-pharmacological practices for behavioral symptoms, development and support of appropriate environments and modifications, and understanding dementia symptoms and disease progression are only a few of the areas where MCU staff can benefit from special training. Both a thorough and comprehensive training program for new staff, and ongoing training for continuing staff, are integral to worker success in the MCU and to the satisfaction and well-being of those who live there.[56]

Both a thorough and comprehensive training program for new staff, and ongoing training for continuing staff, are integral to worker success in the MCU and to the satisfaction and well-being of those who live there.

Currently, West Virginia's state regulations for all MCUs call for 15 hours of training before providing hands-on care under supervision and another 15 hours before working unsupervised in the unit, followed by eight hours of annual training.[57] Mississippi SNFs require staff orientation for new employees in the MCU guided by an orientation manual, as well as quarterly in-service training on at least three dementia-related topics. However, no minimum hourly

requirements are specified.[58] Section 6121 of the Affordable Care Act also requires CMS to verify that aides receive training on preventing abuse and dementia care,[59] however, federal regulations do not specify the amount of training time required.[60]To that end, CMS has developed *Hand-in-Hand*, an instructor-led five-hour program or a self-paced program for aides that requires about 24 hours to complete.

In Ohio, current regulations for SNFs specify that training "shall be sufficient to ensure the continuing competence of nurse aides…and shall include training for nurse aides providing nursing and nursing-related services to residents with cognitive impairment. The in-service education for nurse aides working in specialty units shall address the assessed needs of the residents in the unit."[61] SNFs that provide "specialty care" require nurse aides to receive "sufficient" additional hours of training each year to ensure competency and to meet the individual needs of residents."[62] RCF regulations specify that facilities that admit residents with late-stage cognitive impairment must provide "two hours of training in the care of such residents within 14 days of the first day of work."[63]

Table 6 shows the special dementia training Ohio SNFs and RCFs provide to their state-tested nurse aides (STNAs) and direct care workers. Nine in ten (92%) SNFs and almost all (99%) RCFs require special training before working in the MCU and almost all SNFs and 100% of RCFs provide special training within the first 14 days of a new staff member working in the unit. Most MCUs also require annual continuing education and training; these rates are higher in RCFs than in SNFs (98% vs. 85%). When training is provided before working in the unit, the average amount of training is 7.7 hours in SNFs and 11.3 hours in RCFs. When provided within the first 14 days of working in the unit, training in SNFs is 10 hours and 12.6 hours for RCFs. Using West Virginia's requirement of 30 hours of training as a comparison, only 10% of Ohio MCUs in SNFs and 12.3% of MCUs in RCFs meet this standard within the first 14 days of working in the unit. Similar patterns of training and hours were also reported for RNs and LPNs in these units.

Table 6 also reports the areas of dementia care in which STNAs and direct care workers in MCUs are trained. For all areas, RCFs were more likely to provide training to their direct care workers than SNFs were to their STNAs. Due to the federal requirement for abuse prevention training, it is not surprising that this tops the list of training topics. Facilities that did not indicate providing this education may do so in the larger facility context rather than as part of the curriculum for specialized dementia training. Interestingly, the data shows that some of the non-pharmacologic approaches to managing BPSD, such as personalized approaches, are included in training much more frequently in RCFs where psychotropic medication use is also higher.

Table 6. Training of Staff in Ohio Memory Care Units		
	SNFs	**RCFs**
	STNAs	**Direct Care Workers**
Require Training of Memory Care Staff (%)		
Before working on unit	92.5	98.6
Within first 14 days of working on unit	96.9	100.0
Annual continuing education and training	84.7	97.7
Hours of Training (If Required) *		
Training provided before working on unit	7.7	11.3
Total training within first 14 days of working on unit	9.7	12.6
At least 30 hours of total training within first 14 days of working on unit (%)	10.0	12.3
Training Includes (%)		
Abuse prevention	84.6	91.9
Communication techniques for residents with dementia	83.2	92.3
Symptoms of dementia and its progression	82.6	91.9
How unmet needs are expressed through behaviors	77.9	91.4
Personalized approaches for behavioral expressions	75.8	90.6
Supporting residents through cues or landmarks	66.8	83.7
How to respond to potential symptoms of delirium	62.8	66.5
How to use environment measures to promote comfort:		
Sounds	70.8	83.3
Lighting	68.5	82.8
Room temperature	62.4	81.1

Note. The SNF and RCF samples are restricted to facilities that have a dedicated memory care unit.
STNA = State-tested nurse aides
* For this analysis, all facilities with 30 hours of training or more are treated as if they only provide 30 hours of training.

Care practices and policies

Resident assessment

Before a resident is admitted to the (usually) more costly and restrictive environment of the MCU, it is important to determine whether they are likely to benefit from the type of service and care provided there.

Before a resident is admitted to the (usually) more costly and restrictive environment of the MCU, it is important to determine whether they are likely to benefit from the type of service and care provided there. There is a consensus among practice recommendations that a pre-admission assessment along with ongoing assessments are a requirement to create an effective, person-centered care plan, monitor change and progression of the disease, ensure that resident values and preferences are obtained and honored, and determine that the MCU is an appropriate setting for the resident.[64, 65, 66, 67] Gaugler, et al. suggest that the assessment included in the MDS, a regular assessment required of all SNF residents, is not thorough enough to adequately guide dementia care and should be supplemented with an additional dementia-specific assessment.[68] In addition, The Joint Commission Accreditation Standards for Memory Care specify the use of evidence-based cognitive and functional assessment tools.[69] Fourteen states require RCFs to conduct a prospective resident assessment prior to admission.[70]

In Ohio, only three in five SNFs conduct an additional assessment beyond the required MDS. Among the SNFs conducting additional assessments, most assess residents on an initial and regular basis and make efforts to include resident preferences and involve the family when possible. Seven in ten (69%) of SNFs doing additional assessments use an established evidence-based assessment tool to assess cognitive change.

In contrast to SNFs, there is no standard assessment required of Ohio RCF residents. Current Ohio RCF regulations require initial and periodic assessments of preferences, medical diagnoses, psychological and intellectual disability and a health history that includes cognitive functioning.[71] Table 7 shows the assessment practices of RCFs for their MCU residents. Most RCFs reported (> 80%) assessing residents on an initial and regular basis, incorporating resident preferences and family involvement. Three in five RCFs use an evidence-based assessment tool for changes in cognition.

Table 7. Assessment of Residents on Memory Care Units in RCF

RCF Assessment of Residents	% of MCUs
Assessment includes resident preferences	88.8
Residents are assessed initially and on regular basis	89.7
Families are involved in assessments	82.4
Uses evidence-based assessment tool for changes in cognition	64.0
Other assessment practices used	8.2

Note. RCF sample is restricted to facilities that have a dedicated memory care unit.

Admission policies

Along with a pre-admission assessment, it is important to determine whether an MCU is the appropriate location for a prospective resident. Therefore, there are a number of recommendations and regulations related to admitting new residents to an MCU, such as requiring a physician's diagnosis of dementia in West Virginia's MCUs, or requiring a physician's order to be admitted to an MCU as required in South Dakota's RCFs.[72] Other states allow pre-admission review to be conducted by other professionals; Mississippi specifies that either a nurse practitioner or physician can perform the pre-admission review in SNF MCUs.[73] Wyoming does not allow facilities to admit or retain a resident who has certain scores on an evidence-based cognitive assessment tool (i.e., score of more than 20 or less than 10 on the Mini-Mental State Examination).[74]

Ohio regulations for RCFs specify that residency on a special care unit, such as an MCU, must meet each resident's individual needs and preferences, must be reviewed as part of each periodic assessment, and is not based solely on a resident diagnosis. A resident can choose to reside in the MCU if their spouse is a resident, or if the only room in the facility is in the MCU. These residents must be able to enter and exit the unit by choice and without assistance.[75] Moreover, before transferring or admitting a resident to an MCU that restricts freedom of movement, RCF regulations specify that a physician or other licensed healthcare professional must make a determination that the special care unit is needed.[76] In contrast, there are currently no regulations related to admission to an MCU in SNFs.

As shown in Table 8, RCFs are much more likely than SNFs to require a physician recommendation for admission to the MCU (83% vs. 54%). About half of these MCUs will admit individuals without an established dementia diagnosis. When a potential MCU resident does not have a dementia diagnosis, nine in ten facilities rely on a physician recommendation, though about three-quarters of facilities will admit residents based on a family or guardian concern.

Table 8. Admission Policies in Memory Care Units

Admission Policies (%)	SNFs	RCFs
Require physician recommendation	53.7	83.0
Admit individuals without established dementia diagnosis	50.2	45.1
Criteria to Admit Without Dementia Diagnosis (%)		
Physician recommendation	87.7	94.1
Family member or guardian concern or request	72.5	74.5
Performance on cognitive assessments or tests	69.6	65.7
Social worker or psychologist recommendation	63.0	42.2
Certified nurse practitioner recommendation	48.6	63.7
Other	19.6	10.8

Notes. The SNF and RCF samples are restricted to facilities that have a dedicated memory care unit.

Memory care unit features, activities, and care practices

The features, activities, and care practices in MCUs play an important part in supporting high-quality care for residents with dementia. The Alzheimer's Association suggests that the physical environment can be supportive of the residents' needs while also maintaining their safety.[77] One of the largest concerns regarding residents with dementia is elopement, or wandering outside of a safe area. To minimize behavioral issues, the Association recommends that MCUs should have features associated with a homelike and pleasant environment. The opportunity to personalize one's space and the display of personal objects outside one's room can assist in wayfinding and making the unit feel like home. Beyond the physical environment, it is recommended that MCUs support opportunities for meaningful engagement with others in order to maximize their abilities.[78] As recommended by The Joint Commission, memory care activities should match a resident's capabilities, involve small groups with similar cognitive levels, allow for flexibility based on the resident's sleep cycle, and promote creative expression.[79] Ohio RCF regulations call for the person who plans activities for residents with late-stage cognitive impairment to have "training in appropriate activities for such residents."[80] This is not specific to residents in a special care unit.

Table 9 describes some of the features, activities, and care practices commonly found in Ohio's MCUs. Nearly 90% of MCUs have written procedures related to the event of elopement. To reduce the risk of elopement, RCFs are more likely than SNFs to use locked units (92% vs. 81%), while SNFs are more likely to use elopement alarms (71% vs. 65%). RCFs are also more likely to use some of the other physical features and practices associated with the Alzheimer's Association recommendations for MCUs than SNFs. RCFs are more likely to have dementia-related resources and tools to plan programming and services (90% vs. 78%), display objects in personal areas to reflect an individual's past (88% vs. 76%), and have visual cues and landmarks to assist in wayfinding (81% vs. 60%). RCFs are also more likely to have a secure outdoor area. We also asked whether higher staffing was a feature of the MCU. RCFs are more likely than SNFs to report they use higher staffing levels in the MCU than the rest of the facility. While RCFs are more likely to use more staff relative to the rest of the facility, they still have resident-to-staff ratios higher than SNF MCUs (See Table 5). Finally, while the vast majority of facilities have activities consistent with The Joint Commission recommendations, RCFs are more likely to offer these activities than SNFs.[81]

Table 9. Features and Activities in Ohio Memory Care Units		
	SNFs	**RCFs**
Elopement Related Features in Memory care Units (%)		
Written procedures in event of elopement	87.6	94.9
Locked unit	81.2	91.9
Elopement alarms	71.1	64.8
Room/unit alarms	36.9	45.5
Other Features of Memory Care Units (%)		
Dementia-related resources and tools to plan programming and services	77.5	91.0
Display objects in personal areas to reflect individual's past	75.5	88.0
Visual cues and landmarks to assist in wayfinding	59.7	80.7
Secured outdoor area	63.8	85.0
High staffing level in unit	56.4	82.0
Activities in Memory Care Units (%)		
Activities matched to cognitive, sensory, and physical capabilities	88.3	92.7
Small groups with similar cognitive levels	85.6	91.0
Allow for flexibility based on sleep and wake cycle of individual	79.9	85.0
Promote creative artistic expression	71.1	86.3

Note. The SNF and RCF samples are restricted to facilities that have a dedicated memory care unit.

Medical management

Physician involvement in the MCU is important for monitoring disease progression, comorbidities that may be occurring, and any medications that are being provided to the resident. While non-pharmacological approaches to BPSD are preferred, monitoring the effects of psychotropic medications is essential when they are prescribed.[82, 83, 84] West Virginia specifies that registered nurses must monitor residents taking psychotropic medications monthly and that physician monitoring and reassessment to address dose reduction be conducted at least every six months.[85] In addition, West Virginia requires daily monitoring of residents taking psychotropic or behavior-modifying medications; staff are required to report changes in condition to the resident's physician. The Joint Commission Accreditation Standards for Dementia require a medical director in the facility who both monitors the use of psychotropic medications and the need for their continuation. They do not specify the frequency of such monitoring.[86] Currently, Ohio's RCF regulations for facilities that have residents with late-stage cognitive impairment require a staff or consulting physician, but do not require any specific activities for their monitoring or guidance.

Physician involvement in the MCU is important for monitoring disease progression, comorbidities that may be occurring, and any medications that are being provided to the resident.

Tables 10 and 11 provide information about the frequency of physician monitoring in Ohio's MCUs. Physician monitoring of behavioral symptoms is done monthly or more often in 93% of SNFs compared to 74% of RCFs. Fifteen percent of RCFs report monitoring of behavioral symptoms every six months or less or no monitoring at all. Because 12% of residents in RCF MCUs have hallucinations or delusions, 8% are verbally abusive, and 5% have physically abusive behaviors (See Table 4), such limited monitoring could be a practice and regulatory concern.

This same pattern among SNFs and RCFs is found for physician monitoring of antipsychotic use. Over 90% of SNFs monitor antipsychotic use at least on a monthly basis compared to 69% of RCFs. Fifteen percent of RCFs monitor semi-annually or less often or have no monitoring. Given that over a quarter of MCU residents are prescribed antipsychotics and/or other psychotropic medications (See Table 4) this again is an area for practice and regulatory review.

Table 10. Frequency of Physician Monitoring of Behavioral Symptoms

	SNFs (%)	RCFs (%)
At least weekly	50.7	34.9
Monthly	42.7	39.5
Quarterly	4.8	11.0
Semi-annually	0.0	2.3
Yearly	0.0	3.2
No monitoring by physicians	1.8	9.2

Note. The SNF and RCF samples are restricted to facilities that have a dedicated memory care unit.

Table 11. Frequency of Physician Monitoring of Psychotropic Medications

	SNFs (%)	RCFs (%)
At least weekly	33.6	22.8
Monthly	57.2	45.7
Quarterly	8.1	16.9
Semi-annually	1.1	3.7
Yearly	0.0	4.6
No monitoring done by physicians	0.0	6.4

Note. The SNF and RCF samples are restricted to facilities that have a dedicated memory care unit.

CONCLUSION

Caring for family members and friends with dementia is a significant challenge, and as a result many Ohioans have turned to Ohio's SNFs and RCFs. In 2017, over half of all long-stay residents in Ohio's SNFs had a diagnosis of dementia, and while less precise, our RCF estimates suggest a 30% rate. Many of these residents live in facilities that do not have specialized MCUs, but nearly three in ten SNFs and two in five RCFs have a dedicated MCU.

A number of experts and national organizations have provided guidance on standards and preferred practices for dementia care in general and for MCUs in particular. Memory care in Ohio's residential long-term care settings encompasses an array of environments with a broad range of structures and practices. As the population continues to age and the number of older people with dementia increases, it is critical to understand what special services Ohio's MCUs provide, at what cost, the areas that need improvement, and the impending needs of the population.

As the population continues to age and the number of older people with dementia increases, it is critical to understand what special services Ohio's MCUs provide, at what cost, the areas that need improvement, and the impending needs of the population.

In general, Ohio's MCUs reflect national trends of concentrating on relatively small numbers of residents; both SNFs and RCFs devote an average of 30% of their facility's beds to the MCU. While MCUs in Ohio facilities are similar in this dimension, one area where there is a difference is payer-mix. The majority of residents in MCUs in SNFs are paid for by Medicaid, while MCUs in RCFs are primarily focused on private-pay residents. Further study to understand why Medicaid pays for a small share of MCU residents in RCFs may be warranted, but could be due to Medicaid reimbursement for RCFs under the Assisted Living Waiver Program being low ($91 per day) relative to the rate private-pay residents are willing to pay.

Another area where SNFs and RCFs are similar is the majority of Ohio facilities that have a full-time dedicated manager. Because of the unique care needs of residents with dementia, having a manager dedicated to the unit may help the MCU better respond to the needs of residents, provide more support to the MCU staff, and give the unit an expert and advocate when securing resources within the facility. There is more involvement of licensed health professionals in the SNF MCUs than in RCFs, with a higher proportion of unit managers who are nurses and more frequent involvement of physicians in monitoring medications and behavioral symptoms.

Staffing is an important determinant of quality in all residential care settings. For this reason, various states have regulations related to the training and staffing levels of workers providing direct care to residents. There are many areas where the majority of Ohio's MCUs provide care in ways that meet or approach the staffing recommendations of experts. For example, nearly all Ohio facilities provide staff training before working on

the MCU, and most require annual continuing education and training. But this is not a standard met by every facility. Even where training is offered, the number of hours of training varies by facility and setting. SNFs tend to have fewer hours of training, but this may reflect federal regulations that already mandate all STNAs in SNFs undergo some training; this is not true of direct care workers in RCFs. On average, the number of hours of training provided by Ohio facilities is far less than the 30 hours of training that other states have specified for staff in MCUs. More importantly, using data from 2017 we find that when training is provided, the number of hours is significantly higher than the two hours of initial training on residents with late-stage cognitive impairment required in the RCF regulations.[87] This could indicate that training level hours will decrease in the future.

Some states have implemented MCU-specific minimum staffing levels to assure staffing levels are adequate to care for residents in MCUs. In Ohio, the staffing levels in RCFs tend to be lower than SNFs, with these differences potentially justified by residents in RCFs having fewer behavioral symptoms than SNF residents. There is also significant variation in staffing, with the lowest-staffed RCFs not meeting staffing levels required in other states that have such regulations. Implementation of minimum staffing levels in MCUs can reduce some of this variation across facilities by increasing staff in the lowest-staffed homes, but also needs to be balanced against potential negative consequences, such as higher-staffed facilities reducing staffing levels to the minimum standard.[88]

Another area for staffing improvement involves consistent assignment of staff to residents. About one-third of RCFs and nearly half of SNFs have the opportunity to strengthen relationships and improve behavioral management through consistent assignment of staff to residents.

The features and physical environment of the MCU are other important aspects of memory care. Specialized activities and a greater likelihood of amenities such as secured outdoor areas and environmental cues for wayfinding are more frequently found in RCFs than in SNFs, while SNFs are less likely to rely on locked units than RCFs. Descriptions of these features are required in prospective resident disclosures; this may be an impetus to create certain amenities as part of a marketing plan.

Admission criteria and additional assessment of residents in MCUs is essential in assuring that the MCU is the appropriate setting and that residents are receiving the care they need. Admission criteria range widely, with nearly three-quarters of facilities admitting residents to the unit on the basis of family member or guardian concern. A physician recommendation is required in the majority of facilities, but not all. The requirement for a healthcare professional to make a recommendation for admission in RCFs may help with the prevalence of physician recommendations. Improvements can also be made in assessment practices. Experts suggest that the MDS is not

comprehensive enough to guide an MCU care plan, but two in five SNFs do not provide an assessment beyond the MDS. Despite regulations to the contrary, at the time of our survey in RCFs, about 10% of facilities do not provide initial and ongoing assessments.

Another area for attention, particularly in RCFs, is physician monitoring of behavioral issues and psychotropic medications. Residents in both SNFs and RCFs are found to exhibit challenging behaviors such as being verbally or physically abusive. While RCF residents are more likely to be prescribed psychotropic medications, RCFs provide monitoring of medications less often, with nearly one-third of RCFs having only yearly or no monitoring. Although RCFs admitting residents with late-stage cognitive impairments are required to have a physician on staff or as a consultant, there is no requirement as to the frequency with which their services should be provided.

Based on the findings of this report, there is not a clear pattern of practices suggesting that a SNF or RCF would be the best placement for a particular type of resident needing memory care. Furthermore, there is no clear pattern of care suggesting that most MCUs are providing care that is substantially different than what is provided in a facility without an MCU. While RCFs do have some regulations for special care units, they are often vague, such as stipulating two hours of training without any guidance as to topics or content.

As Ohio considers specific regulations regarding environment, staffing, or practice standards for MCUs, the first step should involve better information to consumers about MCUs. Currently there are few, if any, resources available for consumers to inform themselves about best practices for memory care and MCUs. Providing consumers with this information would give them a resource to guide what they should look for in an MCU and better equip them to ask informed questions of facility staff to determine if an MCU is the right choice. The mandatory disclosure of a particular RCFs MCU practices in specific areas such as staffing levels, hours of staff training, physician monitoring, or activities offered, provides consumers with comparative information to match an individual's needs with services and amenities found in different settings. However, without a similar requirement for SNFs a valid comparison of all care alternatives cannot be made.

Recent Ohio legislation illustrates an initial emphasis on staff training as a foundation for dementia care. Through House Bill 732, Ohio introduced legislation related to hours of staff training, specified topics, and consumer disclosure of such. The vast majority of facilities with MCUs do appear to meet the standard of eight hours of training specified in House Bill 732, but the legislation has not yet come to a vote.[89] Action in this area would ensure that all workers in MCUs have a consistent base of knowledge to provide the specialized care that residents with dementia require. It would also ensure that workers who are asked to work with physically or verbally abusive residents would have the skills needed to do so. Eight hours of training might be viewed as a minimum;

additional hours of training as required by other states would be a welcome addition to this legislation.

Even more recently, House Bill 268 calls for the creation of a certificate in dementia care to be awarded to individuals who complete a program of training to be developed by the Ohio Department of Aging. This credential allows for different training criteria depending on the type of health care professional being trained, and disallows the use of other titles related to dementia certification or practice.[90] Establishment of a certification for individuals based on a statewide program of training would allow facilities to inform consumers about the specific qualifications of their staff, and for consumers to know that consistent training had been provided, regardless of the facility. Similar to the advantages of requiring training by facilities, individually certified workers in MCUs would have the skills needed to provide effective dementia care. Specific to this legislation, however, they would also have a credential that goes with them regardless of employer and could potentially translate to better pay or work opportunities. However, this bill puts the cost and responsibility on individuals rather than facilities, which may affect the uptake of such a program.

Another area where regulation would provide clear standards is sufficient staffing. Our results showed some of the widest variation among facilities regarding resident-to-staff ratios and also some wide variation between SNFs and RCFs as groups. While both federal and state regulations have remained silent on requiring specific resident-to-staff ratios in general, the marketing of dementia programs and units should come with some specific guarantees. Having enough trained staff to meet resident needs is a foundation on which other MCU practices can be built.

There is room for improvement in providing memory care in many of Ohio's SNFs and RCFs. Recent legislative initiatives suggest that strategies to begin these changes have begun and continue to be under development. This report provides background information to assist in determining where additional improvements might best begin.

ENDNOTES

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