Dedicated Memory Care Units in Ohio's Long-Term Services Settings: Structure and Practices

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Background & Methods

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 or skilled nursing facilities (SNFs) and residential care facilities (RCFs) (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." Only a few regulations guide the provision of memory care in Ohio and most of them apply to general RCF special care units. This brief describes highlights from a larger report on the current structure and practices of memory care units (MCUs) in Ohio's SNFs and RCFs.[1]

The Biennial Survey of Ohio Long-Term Care Facilities is a survey conducted every other year to understand the state of Ohio's SNFs and RCFs. Data from the 2017 Biennial Survey of Ohio Long-Term Care Facilities--which had response rates of 91.2% for SNFs and 88.4% for RCFs--are used for this study.[2] The MCU analyses were restricted to facilities that answered questions needed to determine whether they had an MCU or whether the 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.

What are the characteristics of Ohio MCUs?

Many Ohio long-term care facilities have specialized MCUs (Table 1). Nearly one-third of SNFs and 38.6% of RCFs have an MCU, with about 30% of the facility's beds devoted to the MCU; about 30 beds in SNFs, 28 in RCFs. 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 RCF MCUs have very few semi-private rooms.

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
Percentage of private rooms in unit (%)*	34.3	85.9
Payer-Mix of Memory Care Units		
Medicaid residents (%)	74.6	8.3

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

Who are the MCU residents?

For all residents in the MCU, facilities report the number that had particular diagnoses, behavioral or psychosocial symptoms of dementia (BPSD), and used medications (Table 2). The vast majority of residents are diagnosed with dementia, with severe mental illness being more common in SNFs. SNFs have a greater percentage of residents with BPSD, yet the proportion of residents with antipsychotic, antidepressant, or other psychotropic medications is higher in RCFs.

Table 2. 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	19.2	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
Medications: Using antipsychotics	26.4	28.5
Medications: Using antidepressants	28.0	40.0
Medications: Using other psychotropic drugs	28.3	29.6

Who works in MCUs?

The prevalence of BPSD, and the need for cueing and assistance with activities of daily living increase as dementia progresses.[3] In the past, many of these issues were managed with antipsychotic medications, but facilities are now expected to adopt non-pharmacological practices to manage dementia symptoms.[4] 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.[5] Table 3 examines whether the MCU had a dedicated coordinator assigned to the unit, the coordinator's credentials, and direct care staffing of the MCU.

Table 3. Managers and Staffing in Ohio Memory Care Units

	SNFs	RCFs
Unit has Dedicated Manager (%)	51.1	58.9
Dedicated Manager Credentials* (%)		
Registered Nurse (RN)	38.3	19.6
Licensed Practical Nurse (LPN)	47.4	50.4
Licensed Social Worker/Independent Social Worker	7.1	1.5
State-Tested Nurse Aide (STNA)	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]

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.

The majority of Ohio MCUs have a full-time dedicated manager that is a registered nurse or licensed practical nurse. RCFs have higher resident-to-staff ratios (i.e., fewer staff per resident) than SNFs across all shifts. The average resident-to-staff ratio in MCUs for the morning (10am), evening (7pm), and night (4am) shifts are 6.8, 7.7, and 10.7 in RCFs, whereas in SNFs the resident-to-staff ratios are 6.2, 6.7, and 8.7 for the same shifts. The variation in staffing is most striking across facilities, where the best staffed MCUs (10th percentile) are similar for RCFs and SNFs, but the ratios in the worse staffed (90th percentile) are significantly higher among RCFs. These resident-to-staff ratios do not meet minimum staffing regulations for MCUs in other states.

What are the features, activities, and practices of MCUs?

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.[6] 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. It is also recommended that MCUs support opportunities for meaningful engagement with others. Finally, physician involvement in the MCU is important for monitoring disease progression, comorbidities that may be occurring, and any medications provided to the resident. While non-pharmacological approaches to BPSD are preferred, monitoring the effects of psychotropic medications is essential when they are used.[7, 8, 9]

Table 4 shows some of the features, activities, and care practices commonly found in Ohio's MCUs. To reduce the risk of elopement, RCFs are more likely 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 follow Alzheimer's Association recommendations for MCUs, such as visual cues and landmarks to assist in wayfinding (81% vs. 60%). Given the prevalence of psychotropic medications in MCUs (See Table 2), over 90% of SNFs monitor antipsychotic use at least on a monthly basis compared to 69% of RCFs, with 6% of RCFs having no monitoring.

Table 4. Features, Activities, and Care Practices in Ohio Memory Care Units

	SNFs %	RCFs %
Elopement Related Features in Memory Care Units		
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		
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
Allow for flexibility based on sleep and wake cycle of individual	79.9	85.0
Frequency of Physician Monitoring of Psychotropic Medications		
At least weekly	33.6	22.8
At least monthly	90.8	68.5
No monitoring done by physicians	0.0	6.4

CONCLUSION

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. Based on the findings of this study, there is not a clear pattern of practices suggesting whether a SNF or RCF is the best placement for an individual with particular needs requiring memory care. In some cases RCFs are more likely to follow recommended practices, while in others, better practice is exhibited in SNFs. 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. While greater oversight and clarification of existing regulations for MCUs in SNFs and RCFs may be warranted, recent legislative initiatives suggest that strategies to make necessary changes have begun and continue to be under development.[10]

ENDNOTES

[1] Straker, J. K., Bowblis, J., Kennedy, K. & Harrington, K. (2019). Dedicated Memory Care Units in Ohio's Long-Term Services Settings: Structure and Practices. Scripps Gerontology Center, Miami University: Oxford, OH.

[2] Applebaum, R., Nelson, M., Straker, J. K., Harrington, K., & Bowblis, J. (2019). *Maybe You Can Go Home Again: Ohio's Strategy to Provide Long-Term Services and Supports for a Growing Older Population*. Scripps Gerontology Center, Miami University, Oxford, OH.

[3] Prizer, L. P., & Zimmerman, S. (2018). Progressive support for activities of daily living for persons living with dementia. *The Gerontologist, 58(S1,* S74-87.

[4] Lucas, J. A., & Bowblis, J. R. (2017). CMS strategies to reduce antipsychotic drug use in nursing home patients with dementia show some progress. *Health Affairs*, *36*(7). https://doi.org/10.1377/hlthaff.2016.1439

[5] Fazio, S., Pace, D., Maslow, K., Zimmerman, S., & Kallmyer, B. (2018). Alzheimer's association dementia care practice recommendations. *The Gerontologist, 58(S1),* S1-S9.

[6] Alzheimer's Association (2009). *Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes. Chicago, IL: Alzheimer's Association.* Retrieved on June 11, 2019 from: https://www.alz.org/national/documents/brochure_DCPRphases1n2.pdf

[7] CMS. (2019b). Enhanced oversight and enforcement of non-improving late adopters. Retrieved on April 1, 2019 from: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-07-NH.pdf

[8] See 4.

[9] Austrom, M. G., Boustani, M., & LaMantia, M. A. (2018). Ongoing medical management to maximize health and well-being for persons living with dementia. *The Gerontologist, 58(S1)*, S48-57.

[10] The Ohio Legislature (2019). Senate Bill 24. Retrieved on October 16, 2019 from: https://www.legislature.ohio.gov/legislation/legislation-summary?id=GA133-SB-24

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