Joint Commission On Demand Introduction to New Assisted Living Community Memory Care Certification Requirements

Recording Date: July 2023

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Welcome and thank you for joining us for this On Demand Pioneers in Quality Webinar, Introduction to New Assisted Living Community Memory Care Certification Requirements.

The content for this webinar was prepared and recorded in June 2023. We encourage health care organizations to share the link to this recording and the slides with their staff and colleagues. There is no limit on how many staff can take advantage of this educational webinar.

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Before we start, we'd like to offer just a few tips about webinar audio. Use your computer speakers or headphones to listen. Feedback or dropped audio are common for streaming video. Refresh your screen if this occurs. You can pause the playback at any time. We have captioned this recording and the slides are designed to follow Americans with Disabilities Act rules.

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The learning objectives for this webinar are: Understand the eligibility for the Assisted Living Community Accreditation and Memory Care Certification. Describe the new Memory Care Certification requirements and the rationale for each. Locate and use available resources.

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These staff and speakers have disclosed that they do not have any conflicts of interest, for example, financial arrangements, affiliations with, or ownership of, organizations that provide grants, consultancies, honoraria travel or other benefits that would impact the presentation of today's webinar content.

Myself [Susan Funk], and Debbie Holzer.

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This presentation features Debbie Holzer, who is a Project Director for Health Care Standards Development in the Department of Standards and Survey Methods at The Joint Commission. In this role, she is responsible for developing standards for Assisted Living Community Accreditation and Memory Care Certification, as well as the rest of the accreditation and certification programs denoted on this slide.

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Thank you so much, Susan. Welcome everyone. I'll be discussing our new Memory Care Program Standards and providing some guidance for compliance.

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So, two years ago, we launched our new Assisted Living Accreditation program, to provide some standardization and oversight for the Assisted Living setting. Since that time, Joint Commission Accreditation has been recognized by nine states in lieu of licensing renewal activities. There are also insurers willing to provide coverage discounts for providers accredited by The Joint Commission.

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During the development of our ALC program, we immediately recognized that many residents living in this setting are diagnosed with or suspected to have a form of Dementia. Approximately 42%, according to the Alzheimer's Association. We also recognize that 58% of Residential Care Facilities offer some form of Dementia care services. So, we conducted some additional research and decided to develop an Assisted Living Community Memory Care Certification option for those Assisted Living Communities that provide above and beyond expertise and specialty care, in this setting. The standards expand upon the existing Assisted Living Standards, focusing more intently on Memory Care services. I'm happy to announce that our new Memory Care Certification Program launches July 1st of this year, 2023.

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As I mentioned, The Joint Commission currently offers Assisted Living Community Accreditation. The program defines Assisted Living as an organization that provides housing, meals and a combination of supervision and personal care services. Our services may include nursing care, Dementia Care, Medication Management, rehabilitation, and Palliative Care. Care can be provided in a number of settings, including free standing communities, near or integrated with skilled nursing homes or hospitals, as components of continuing care retirement communities or life plan communities, or at independent housing complexes.

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In order for an organization to be eligible for Assisted Living Community Accreditation, they must be U.S. based, operational and providing care, satisfy state law or licensing requirements and engage in process improvement activities.

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In addition to be eligible for Assisted Living Accreditation, organizations must meet the minimum requirement of three residents served and at least two active for communities up to 18 beds or five residents served in at least two active for communities with 19 beds or more at time of survey. And in order to qualify for the new add on Memory Care Certification, an organization must be ALC accredited or simultaneously seeking that accreditation with Memory Care Certification and have served a minimum of five residents and two active at time of survey. It is not required that organizations have a separate Memory Care unit. Residents receiving Memory Care services can be integrated within the Assisted Living Community. And the certification is awarded for a three-year period.

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The standards for the Memory Care Program are based on the Alzheimer's Association Dementia Care Practice Recommendations and focus on areas critical to quality safety and the resident experience. The standards were developed in collaboration with the Alzheimer's Association and rigorously vetted, which involves research, drafting standards with our writer, collecting feedback, testing and a final approval process. We also use the information collected from our learning visits that we conducted when developing the Assisted Living Program to inform our research. Since all of the ALCs that we visited did have a Memory Care component we elicited feedback on the standards from Internal Subject Matter Experts. We conducted a public facing and a targeted expert panel field review to get boots on the ground input. And to assist in developing our survey process we conducted a pilot test with a surveyor experienced in Assisted Living and Memory Care at an Assisted Living Community exclusively focused on Memory Care services. And finally, the standards were reviewed and approved by Joint Commission Leadership and the Alzheimer's Association.

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The Joint Commission standards define the performance expectation and the structures or processes that must be in place. And the Elements of Performance, or Eps, are the language that the surveyor will use to evaluate compliance. There is a Memory Care Certification Chapter in the ALC Accreditation Manual that lists all of the Memory Care standards separately. The Memory Care standards are also integrated within the Assisted Living Standards throughout the manual and are denoted by a bolded lead-in header before the requirement, as you see it highlighted here on the slide. There's an example of a standard on the slide from the Provision of Care, Treatment and Services or PC Chapter. PC.02.01.01 is the standard, which requires that organizations provide care, treatment, and services to each resident. EP31 is what the surveyor is going to be assessing for it requires that organizations certified in Memory Care supervise residents based on their individual needs. For the remaining slides, I'll provide an overview of the standards within each chapter. The standards that I'm referencing will be listed at the bottom left of each slide in a yellow highlighted box as demonstrated here.

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The Environment of Care Standards, address the physical environment and the types of things that can impact a resident's quality of life. The goal is to promote independence, ensure physical safety, encourage cognitive stimulation, and prevent exacerbating Dementia symptoms. Standards in the EC Chapter require visual cues or landmarks in the environment to assist residents with wayfinding. Minimizing noises that may overstimulate or cause distress such as alarms or maintenance activities. Minimizing confusing visual stimuli such as harsh shadows, busy fabric patterns, or the lack of color contrast. Access to a safe and secure outdoor space, or, if unavailable, a simulated outdoor space. There is no specific requirement for the size of the space or the amount of seating but should be sufficient for the number of residents that you serve. Paths must be free from obstructions or barriers to allow for walking and exploring. Limiting paging systems to minimize distress. And the organization should provide interest points to encourage visual and tactile stimulation such as fish tanks, colorful tapestry, or textured objects. We're not prescriptive on the types or the number of items because each facility will have their own unique considerations as to available space, resident needs, and budgets.

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Organizations can demonstrate compliance through the physical attributes of the environment and also by discussing their approach to controlling noise and other activities that may contribute to a resident's confusion or distress.

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There is a requirement in the Emergency Management Chapter that requires organizations include the special needs of residents with Dementia into the Emergency Operations Plan. We recognize that disruptions in normal routines, loud sounds, hurried activities may all contribute to confusion or agitation in a resident diagnosed with Dementia. They function optimally when their surroundings are consistent and calm. So, planning in advance how to manage disruptions such as emergency activities is vital to keeping residents safe and their essential care uninterrupted. The plan must include how supervision will be maintained during evacuations, how agitation or anxiety will be managed when the environment or circumstances change, and how staff will maintain access to a resident's medical history, current medication orders, physician information, and family contact information. This is the minimum requirement, but the organization may find other considerations that they wish to include in the plan depending on their individual circumstances. Organizations can demonstrate that these items are included by reviewing their Emergency Operations Plan with the surveyor.

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The Human Resources Standards address staffing and staff training. It's essential that organizations employ a sufficient number of qualified staff and provide orientation and training to ensure staff have that specialty knowledge to care for residents living with Dementia. Nothing is more important to ensure quality and safety than a stable, educated workforce.

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The standards in the Human Resource Chapter require that organizations have a process for recruiting and retaining qualified staff. We know how challenging it can be to acquire staff in an Assisted Living setting and what an impact that can have on quality and safety. So, it's important to know that organizations are investing in this effort. Staff and licensed practitioners must be oriented about psychotropic medications based on their responsibilities. The orientation topics listed on the slide are required. However, the education for each topic should be addressed in a way that is appropriate for the staff receiving the training, whether it's very high-level instruction or much more detailed. And staff and licensed practitioners who provide Dementia care participate in annual training that aligns with best practices in Dementia care and must include Team Building, Therapeutic Environments, Pain Management, Palliative Care, and Transitions in Resident Care. It's important that the education and training is documented and should be available to review in the employee’s folders. Organizations may also have group training and attendance lists to demonstrate compliance. The Human Resource director, management and staff can also speak to recruitment and retention initiatives and activities, and any data collected on recruitment and retention may also help demonstrate the strategies and outcomes of those initiatives.

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Dementia care is very specialized health care service and research is ever evolving. So, it's important that organizations keep their finger on the pulse of Emerging Information as it becomes available. The Information Management Standards require that the organization stay current on Dementia care practices by participating in nationally sponsored activities. Nationally recognized Dementia care leaders or authorities will often sponsor activities through funding, research, and resource allocation. Activities must be from reliable sources like the Alzheimer's Association or the American Medical Directors Association. An examples of activities include webinars, conferences, and task force committee attendance. Organizations can provide employee attendance certifications for conferences and webinars and attendance logs for task force and committee involvement to demonstrate compliance.

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Leadership in an Assisted Living setting is very different from Leadership in other health care settings because there's a lower level of medical care needed in most Assisted Living communities. Meeting the medical needs of residents living with Dementia who may have several age-related comorbidities are complicated by Dementia treatments, memory loss and behavioral symptoms. According to the Alzheimer's Association, medical care for the persons living with Dementia is typically provided by a Family Medicine Physician or Internist who often works with a Neurologist or Psychiatrist to meet the patient's needs. Alzheimer's disease is a progressive disease that requires ongoing medical assessments and care planning.

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For an organization to be recognized as going above and beyond the Assisted Living Requirements and striving for excellence in the area of Memory Care services a higher level of oversight is required. The leadership standards require that there's a medical director or other physician designated to oversee care, treatment, and services. The designee must either have the necessary specialty expertise or identify a qualified Physician with the expertise to direct the Memory Care Program. The Physician assigned directs medical care, creates policies, participates in the provision of staff training, provides recommendations for practitioners who provide care, monitors the performance of medical services considers the impact that public health agencies have on resident care, represents the organization in the community, and monitors psychotropic medications to minimize misuse or overuse.

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Of course, the extent of the Physician's role will depend on many factors, including the roles of other health care team members. For instance, they may only help provide relevant content for policies or training materials and delegate the drafting of those documents to others. Or they may provide signature approval for Practitioner recommendations that the health care team puts together. And they may work closely with the Pharmacist to obtain reports and recommendations for psychotropic medication use. The employee folder of the medical director or assigned physician must contain a job description to demonstrate the role of this physician and their responsibilities. The physician and other staff in the organization can also discuss the physician's involvement in the Memory Care Program, which can also be validated through meeting minutes, policy documents, training materials, and attendance logs, as well as Performance Improvement reports.

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It's further emphasized in the Leadership Chapter that any program certified in Memory Care must stay current with the latest evidence in Dementia care practices. Leadership must evaluate and modify their organization's Dementia care practices based on current evidence, best practices, resident needs, and changes to care, treatment and services. And the program must use clinical practice guidelines and evidence-based practices to guide the provision of care, treatment, and services. This can be nationally recognized guidelines as well as organizational guidelines used to address specific circumstances. Leadership can discuss and present in writing the guidelines or other research they use to inform and modify their program, as well as any policies and procedures used to guide the development of their practices.

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Medications used to manage behavioral symptoms of Dementia are often overprescribed or misused and can pose serious health risks or unintended consequences like falls. The goal should always be non-pharmacological interventions before considering psychotropic medications to treat behavioral symptoms. The Medication Management Chapter requires that an Interdisciplinary Team consisting of a Physician, Pharmacist, Nurse, and others from the health care team as needed, monitor each resident's psychotropic medications. Psychotropic medications are prescribed if there's a medical necessity after non-pharmacological interventions have been used or considered and at the lowest effective therapeutic dose. And the resident and family or legal representative, to the extent possible, must be involved in any decision to prescribe antipsychotic medications. This can be demonstrated by notes in the resident's record and in the resident's plan for care. Interdisciplinary Team meeting minutes may also be used to demonstrate compliance.

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When a resident is admitted on a psychotropic medication, the physician and pharmacist review the clinical indication for the medication, whether it's necessary moving forward, and considerations for dose reduction and any alternative interventions. The organization must monitor the use of PRN or as needed psychotropic medication orders to ensure that they are appropriate and effective and to reduce their use. And the organization must also evaluate compliance with its process for monitoring psychotropic medication use. The organization can present evidence of the physician or pharmacists reviews and their conclusions. Data Monitoring PRN, psychotropic medications and the outcomes and evaluations demonstrating compliance with monitoring. The organization can also present policies and procedures that guide these processes.

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It's important for potential residents and their families to know what type of services they can expect from an organization, what their policies and procedures are for transfers and the scope of their practices so that they can make informed decisions.

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Individuals may be looking for a location where they can age in place and an organization that can accommodate their needs and preferences, including any end-of-life considerations. Many states require that Assisted Living residents receive and sign a disclosure form, and some states require it specifically when the organization offers Dementia care services.

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The standards in the Provision of Care, Treatment and Services Chapter require that organizations provide a disclosure form to all residents with Dementia that include the items listed on this slide. The document must be signed by the resident and responsible party. This document must be accessible to surveyors to validate compliance. Resident assessments should be used as an opportunity to get to know the person living with Dementia and to develop a therapeutic relationship with the resident, not only for clinical decisions. Making a connection with the resident, acknowledging them as a unique individual and learning their goals, life story and needs will strengthen the relationship and facilitate positive, productive interactions with the health care team.

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The standards require that residents without a Dementia diagnosis exhibiting symptoms of Dementia must be evaluated by a Neurologist, Psychiatrist, Geriatrician, or other qualified physician to establish a diagnosis. Assessments must be conducted by qualified practitioners to obtain the necessary clinical information needed to make sound recommendations and plans for care. Residents must be assessed every six months and when there's a change in the resident's condition. The resident's Decision-Making Capacity must be assessed by a qualified licensed practitioner. When there's a change in condition, evidence-based Cognitive and Functional Assessment Tools are used, examples include the Global Deterioration Scale and the Functional Activities Questionnaire. And Quarterly Behavioral Health Assessments must be completed for residents taking psychotropic medication. To clarify, a Licensed Practitioner is an individual who is licensed and qualified to direct or provide care, treatment, and services in accordance with state law and regulation, applicable federal law and regulation and organizational policy. These requirements can be demonstrated through resident chart review and staff credentials and qualifications in their employee files.

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The best sources of information about the resident are the residents themselves and to a large degree, those closest to them. Often times family members have also been caregivers prior to the resident moving into the assisted living, and many also may be decision makers. Therefore, the resident and the family should be involved in assessments to whatever degree possible when assessing the items listed on this slide. These items should be documented in the resident's chart when they're assessed, and the family involvement noted. Resident and family involvement in assessments can also be substantiated through resident or family interviews. In order to meet the residents' goals and assess needs and to coordinate the appropriate care, treatment and services, a Plan for Care must be developed for each resident. Sometimes referred to as a Service Plan in Assisted Living settings. Plans for Care are also a great way to ensure that the Interdisciplinary Team are collaborating to develop interventions and monitor outcomes.

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An Interdisciplinary Team, other staff is appropriate, the resident and the family develop the Plan for Care. The plan must reflect the Resident's Personal Goals, Preferences, Lifelong Interests, Routines for daily activities and Freedom of Choice. When necessary, supervision is considered based on the resident's individual needs. The Interdisciplinary Team must then collaboratively review and revise the plan as appropriate. The Plan for Care should be available in the resident's chart or other location that is readily available for review.

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Assisting a family member transition to a Memory Care program can be uncertain times for families. Providing them with education can help alleviate some of that uncertainty and help them to provide a healthy, meaningful relationship with their loved ones. At a minimum, organizations must provide family education on Dementia progression and related behavioral expressions of unmet needs because the resident’s behavior will change and it is less alarming and confusing if families understand and are prepared. Communication Techniques because the resident’s perceptions may change. And there are things that families can do to adapt their communication to meet the resident’s needs. Personalize Approaches to care for the resident with Dementia because each resident is unique and should never be defined by their diagnosis. And the use of psychotropic medications, including the reasons for use, risks versus benefits and any potential side effects. Family education should be documented and can be kept in the resident's chart or other location. The type of education provided must be clearly defined and meet the criteria in the requirement.

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Residents living with Dementia will have all of the same health care concerns as others with similar conditions, with the added complexity of a Dementia diagnosis. For this reason, it's important to ensure each resident has all of their health care needs addressed. The organization must meet the resident’s health care needs by aligning Physician Visits with the resident’s needs, including at least one physician visit during the first 30 days following move in.

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Communicating any Consultative Reports and Evaluations to the resident's physician. Coordinating the resident's Comorbidities and Dementia care because treatments for other health care conditions can be contraindicated with Dementia treatments or exacerbate Dementia symptoms. And the Interdisciplinary Team and others as needed, must conduct Resident Care Conferences regularly to discuss resident centered goals of care, disease prognosis and advanced care planning. This can be accomplished face to face and through remote technologies. Compliance can be verified through chart review by looking at Physician's notes, Resident Assessments, Consultative Reports and Evaluations, and by Reviewing Resident Counsel Meeting Minutes and Attendance Logs.

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Part of what sets a Memory Care Program apart is the coordination of the resident care. There are many facets to a well-organized, person-centered Memory Care program, and to be successful, there must be individuals with the necessary training and expertise to coordinate important aspects of the program. The standards require that the coordination of resident care must be led by those with expertise and training in Dementia care. Either single individual or multiple people can be assigned. Coordination includes planning activities that are tailored to the residents' needs and interests. Many ALCs have activity coordinators because this is such an important component of health maintenance and psychological well-being. Monitoring Staff Performance regarding communication techniques and resident interactions. Referring back to the importance of building those therapeutic relationships. Fostering an Authentic Learning Environment through coaching and modeling. We know that Dementia care practices are always improving and there needs to be an ongoing Learning Environment. Coordinating internal and external sources for family support needs. Families often carry the heavy burden of caring for and often making decisions for their loved ones. An Alzheimer's disease and other Dementia diagnosis can be challenging to accept and physically and psychologically demanding. So, it's vital to keep in mind the needs of these families and to provide them with the support that they need.

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Communicating the quality and safety needs of the program to leadership. Leadership has a responsibility to ensure the quality and the safety of their program. So, keeping them informed helps them evaluate the current state and engage in impactful performance improvement efforts. And assisting with evaluating Cognitive Devices and Equipment to support resident care and treatment. These assistive items can mean the difference between independence and being restricted by functional limitations.

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The role and responsibilities of these individuals designated as Care Coordinators can be verified by their job description and other position documentation. It's also very important for the assigned coordinators to be part of the survey process because of their intimate knowledge of the program.

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Mealtime and food consumption should be more than just sustenance. It can also promote social, cognitive, and functional activities. This is true of any resident living in an Assisted Living, but especially important for residents living with Dementia because they have declines in these areas that might be consistently addressed at these mealtimes because they happen at regular intervals every single day.

The standards require that organizations engage with residents during mealtime by allowing them to assist in the process according to their abilities and interests. For instance, they can help plan a meal menu or decorate a common space. And in order to promote independence and minimize confusion during mealtime, organizations should serve food in a manner that offers visual contrast between the plate, the food, and the place setting. Limit the amount of food choices at one time not to overwhelm the resident. Provide finger foods if cutlery becomes challenging and provide methods of assistance when needed, such as a cup with a lid and a straw to help maintain that independence. These things can be demonstrated during mealtime service and through interviews with the nutritionist, kitchen staff, and care coordinator. And when appropriate, interviews with the residents and the family members.

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As we all know, human interaction is essential to our well-being. For a resident transitioning to an Assisted Living Community that is unfamiliar to them can be unsettling or isolating. Social and Recreational Activities have so many benefits, including physical and psychological health and well-being. It can provide exercise, cognitive stimulation, human connection through shared interests, and so much more.

The standards require that organizations must offer opportunities for residents to participate in social and recreational activities. Programs must adapt to the ability and the interest of the residents and activities should provide Cognitive stimulation and facilitate or enhance communication. This can include technology-based activities. The organization must offer opportunity for residents to go on outings when it is safe to do so. Programming must include intergenerational activities so that family members can participate.

An organization must also offer daily physical activities such as dance or exercise, which can improve balance and may decrease the need for assistive devices and reduce fall risk. Organizations can demonstrate these activities in real time and may also provide activity calendars to show what options are available to the residents. The Care Coordinator or Activities Director can also discuss their planned and unplanned activities. These activities may also be documented in the resident's chart or Plan of Care. And of course, the residents and families may speak to the activities that they participate in.

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As health care workers, we're here to provide information and advocate for our residents not to make decisions for them. So, it's important that we provide the information that they need to make informed decisions and also provide any support that they need. The standards require that organizations must determine the education needs and abilities of the resident, evaluate the residents understanding of any education or training that they provide, and the support needs of the family. It's important to inform the resident of how they can express any concerns that they have before, during and after care is received. This is especially important with such a vulnerable population. The organization must also provide information to residents, families and caregivers on Brain Health and Cognitive Aging, Disease Stages and Progression, Person-Centered Dementia Care Strategies, Transfer Protocols and End of Life Considerations. And the program must offer support to families by either providing a support group or offering a list of support groups within their community.

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The Alzheimer's Association is a good resource for searching local support groups. This education should be documented along with an evaluation of the residents understanding of any information provided. If the organization offers a support group, it should be documented that the family was informed of the offering and any attendance logged. Or the organization can document that the family received a list of support groups within their community.

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There are times when transfers in care may be necessary. Despite the best efforts of the organization, changes in resident condition may warrant a higher level of care. And it's important that they have a process in place to guide that transition. Continuity of care is so important because transitions can often be physically and emotionally traumatic for this population. And transitions in care are susceptible to communication errors and omissions. Carefully planned hand offs may prevent unnecessary trauma errors and interruptions in care. The organization must document the process for transitioning the responsibility for the resident's care from one clinician, organization, program, or service to another.

The process must include identification of potential causes of behavioral symptoms. Successful Personalized Approaches to care, successful Communication Techniques, the resident's cognitive, sensory, and physical capabilities and Advanced Care Planning. It's important that the receiving health care team know the residents so they can meet their needs and ensure continuity of care. And the organization must discuss the resident’s transfer plan with the family and any relevant practitioners across care settings. The transfer or discharge notes should have this handoff communication within the resident’s chart along with any family communication regarding the transition.

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And finally, the resident's clinical record must have information regarding medical treatment and care and changes in resident's condition to facilitate coordination of care and ensure the team remains informed. It must include the Provision of Medical Treatment and Care. The resident's response to the medical treatment and care. Medical Observations and Recommendations made after the initial medical assessment. Progress Notes recorded by the physician at each visit and any Significant Changes in the resident’s condition, care, treatment, and services as determined by the organization. This is verified by reviewing the resident’s record. That concludes my presentation. Thank you all for what you do for your residents and for striving to deliver excellent safe care. I'll now turn it back to Susan, who will discuss how you can learn more and where to find important resources.

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Thanks, Debbie for presenting the content for this webinar.

For more information about our Memory Care Program, you can visit The Joint Commission's website following the link on the slide.

From that site, you can request to preview the standards, learn more about the application process, and much more.

It is important to note that organizations achieving Memory Care Certification will be recognized on Quality Check®, the website which lists Joint Commission accredited and certified organizations, as well as in the Alzheimer's Association Community Resource Finder, a database of Dementia and aging related resources. Organizations will also be able to display a combined certification logo with both The Joint Commission and the Alzheimer's Association logos as are displayed here on this slide.

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We wanted to provide information about where to access basic information about the Assisted Living Community Program and sign up for updates. First, you can find basic information about the Assisted Living Community Accreditation program by visiting this link: www.jointcommission.org/what-we-offer/accreditation/health-care-settings/assisted-living-community/ Click the button that reads, "Learn the Basics" to find many additional resources about the accreditation program requirements.

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To sign up for E-alerts, visit www.jointcommission.org and click the option at the top navigation for E-alerts.

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Once on the E-alerts page, you can locate options for Programs, Newsletters, Publications, and topics about which you'd like to receive updates.

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To ask questions about the standards, please use the inquiry form located at this address: dssminquiries.jointcommission.org. Joint Commission staff closely monitor this portal.

For questions regarding Pioneers in Quality webinar operations, please submit them via e-mail to pioneersinquality@jointcommission.org .

Regarding pricing and eligibility for the Assisted Living Community Memory Care Certification, please use the form located at the link included on this slide.

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Thank you to Debbie for presenting this content. We hope the information provided today will help to prepare your organization to meet the Assisted Living Memory Care Certification requirements.