Summer 2017

LeadingAge California

engage™

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LeadingAge California

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Founded in 1961, LeadingAge California is the state's leading advocate for quality, not-for-profit senior living and care. The association's advocacy, educational programs and public relations help its members best serve the needs of more than 100,000 of the state's older adults. LeadingAge California represents more than 600 nonprofit providers of senior living and care – including affordable housing, continuing care retirement communities, assisted living, skilled-nursing, and home and community- based care.

Mission

It is the mission of LeadingAge California to advance housing, care and services for older adults.

Vision

To be the champion for older adults.

Shared Values

The values shared by LeadingAge California members include:

- Long term commitment to the security of older adults
- Mission driven
- Mutual support and assistance among members
- Respect of all peoples
- Commitment to socioeconomic and multicultural diversity
- Advocate for not-for-profit status
- Consumer focused
- Dignity and quality of life for older adults
- Community-based

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A Note From The Editor

Contemplating the Resident of the Future

In this issue, we look into trends and innovations to meet the evolving needs of the next generation of seniors accessing both campus-based and home-based services. We called on experts in the field to get a feel for what changes are already underway and what is on the horizon. The consensus appears to be true to the old adage that "the only constant is change."

Our feature article comes from Dr. Robyn Stone, a noted researcher and leading international authority on aging and long-term care policy. Dr. Stone articulates the unique challenges facing the future resident and how providers can begin now to work to meet them.

Karen Adams, vice president of planning with GSI Research and Consulting, shares her perspectives on the evolving needs of residents since the time she began her career in the field in the 1970s. Her work in market research and competitive analysis provides deep insights into the mind of the consumer.

In this issue's Dear Brenda column, Brenda Klütz examines the notion of person-centered care and the way it is applied in the regulatory environment. The changes in regulatory lingo signals a movement afoot in the way government programs view participants in their programs.

In a sign of changing times, we tasked attorney Tomek Koszylko with Hanson Bridgett LLP to provide guidance on medical and recreational marijuana in California senior living communities. Mr. Koszylko provides the "do's and don'ts" from the legal perspective now that California has legalized recreational use.

LeadingAge California member ACC Care Center is highlighted in this issue for their work on developing technology to meet the demands of the future resident, including innovative lighting techniques that both save energy and promote resident health.

I hope you enjoy this issue of *Engage*. Our Fall issue will focus on tackling the problem of ageism and its destructive pervasiveness in American life. Our Director of Digital Media, Robin Douglas, spoke with author Ashton Applewhite who penned "This Chair Rocks: A Manifesto Against Ageism" for a one-on-one interview. You will not want to miss their conversation!

Eric Dowdy
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From The CEO

What is the Goal?

I was challenged in a meeting recently to think differently – not to talk about the 'resident of the future' but rather to consider the 'older adult of the future.' Yet, in a separate meeting, participants didn't want to be called an older adult. I'm not even sure what I want to be called. I'm not offended by the terms: senior, elderly, older adult, aging person, spry – yet I know each of these terms may not feel quite right to everyone, and may challenge us to categorize when categorization isn't necessary or intended. So, I asked a few friends what they wanted to be called, and they asked me – what is the goal? If it's a senior discount, I want to be a senior; if it's about my age, I'm older than I used be so I am an older adult; if it's about the level of activity, I want to be acknowledged for what I am doing, not amazement that I'm still capable of doing something – like hiking, running, riding a bike, or going shopping – and that I can add value to the conversation, whether it be fitness, politics, current events, a recent article online, or a strategic discussion. This last point hit home. It's recognizing our abilities to their fullest as we age that may make the most difference, and not 'amazement' that we can still do 'it.'

" If it's a senior discount, I want to be a senior; if it's about my age, I'm older than I used be so I am an older adult; if it's about the level of activity..."

My mom, pushing 99, still wants to be valued as politically savvy and thoughtful, engaging in intense discussion about current events. When I think of her, I don't think about her being old, even though she is by most standards. I think about what she still does and how she contributes.

Robyn Stone's beautifully written feature article articulates that tomorrow's elderly population will differ from today's older adults. Likewise, other contributors challenge us to consider the future and how we will adapt to their needs. As we consider her article, amongst the other articles in this issue, we must also think differently, adapt, and each ask – what is our organization's goal as we approach these new older adults?

– Jeannee P. Martin
President & CEO

Have you Heard?

LeadingAge's Save HUD 202 rally was highlighted in a *Washington Post* article, titled "LeadingAge leads protest against proposed cuts in affordable housing for elderly people."

PEP Housing was featured in an article in the *Petaluma Argus Courier* titled, "PEP Housing chosen for Petaluma affordable project" in June.

Eskaton Village Carmichael celebrated their 25th anniversary in May.

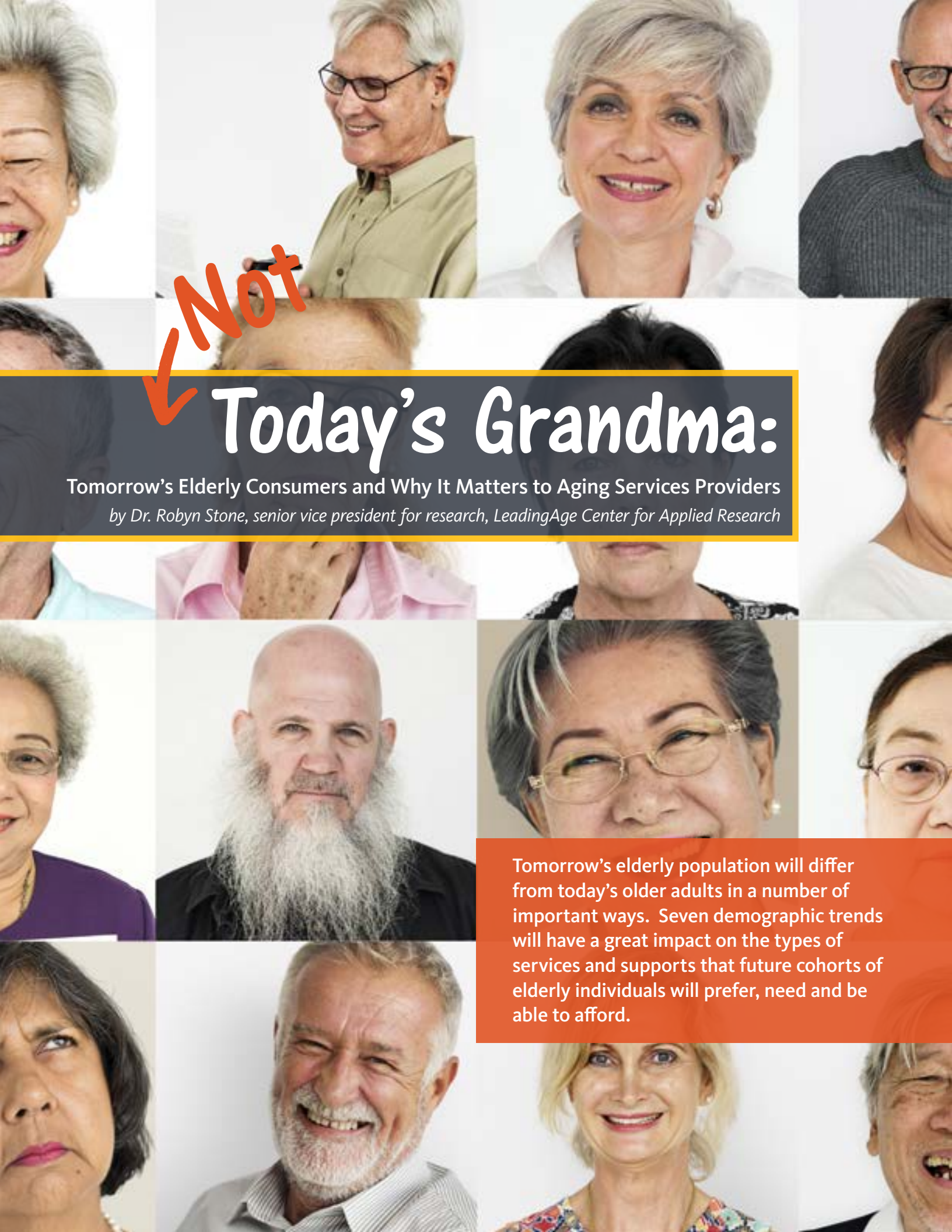
Eskaton Care Center Fair Oaks resident and artist Pauline Voss, 90, received a Lifetime Achievement award for Artistic Creation, presented by KVIE.

Vicenti, Lloyd and Stutzman joined with CliftonLarsonAllen (CLA) in June.

The Terraces at Los Altos celebrated in June the completion of a $100 million multi-phase project designed to provide current residents with more options and amenities.

Northern California Presbyterian Homes and Services' (NCPHS) Janet Howley, vice president of Community Services & Housing, retired in June.

O'Connor Woods was named Best Retirement Community in *San Joaquin Magazine*.



Not

Today's Grandma:

Tomorrow's Elderly Consumers and Why It Matters to Aging Services Providers

by Dr. Robyn Stone, senior vice president for research, LeadingAge Center for Applied Research

Tomorrow's elderly population will differ from today's older adults in a number of important ways. Seven demographic trends will have a great impact on the types of services and supports that future cohorts of elderly individuals will prefer, need and be able to afford.

Growth of the Elderly Population with Chronic Illnesses and Disability

The longevity revolution has allowed many individuals to live longer over the past few decades. Those living to age 65 have a three in five chance of living to at least 90. At the same time, the tremendous increase in the number of older adults, particularly those aged 85 and older, translates into a large volume of individuals who will be living out their last years with multiple chronic illnesses and significant functional decline. Conditions such as diabetes, hypertension and depression, furthermore, represent significant causes of increased disability among middle-aged adults that will carry into their later years, and increasing numbers of nonwhite minorities surviving to old age also will contribute to higher disability rates among the young-old. With no cure in sight for Alzheimer's disease and one out of three individuals living to age 85 expected to have some form of dementia, the size of the elderly population with significant cognitive impairment is likely to grow exponentially over the next two to three decades.

Increase in Racial and Ethnic Diversity among the Elderly Population

The older population will become more racially and ethnically diverse over the next few decades. In 2011, slightly less than four out of five older adults were white, non-Hispanic; by 2030, this percentage is projected to decrease to 71.2 percent and will continue its decline to 58.5 percent by 2050. Of the projected 72.8 million older Americans in 2030, 20.2 million will be members of minority groups, more than double the current number of minority elderly. The greatest increase will be in the Hispanic population, rising from seven percent to almost one in five older adults by 2050. Health disparities between whites and non-white minorities during the life course have important implications for continued disparities in old age and differences in the demand for and ability to pay for services by race and ethnicity.

Decline in Family Caregiver Availability

A number of demographic trends, including increased rates of childlessness, divorce among baby boomers and increased labor force participation among middle-aged and older women, are projected to negatively affect the supply of family caregivers over the next few decades – just as demand for services and supports is expected to increase. One important measure of caregiver availability is the caregiver support ratio, based on the number of people in the most common caregiving age range – 45 to 64 – divided by the number of older people most at risk of needing services – those 80 years and older. Researchers are predicting a large decline in this ratio as boomers transition from caregivers themselves into old age between 2010 and 2030. The population aged 45 to 64 is projected to increase by only one percent in this time period; the 80-plus population is projected to increase by 79 percent. In all states, the projected ratio will decline between 2010 and 2030 and 16 states are projected to experience declines of 50 percent or more in the caregiver ratio by 2030. Between 2030 and 2050, the caregiver support ratio is expected to decline further, from 4.1 to 2.9 as boomers complete the transition to the 80-plus, high-risk category.

Decline in the Economic Status of the Elderly Population

In 1968, one-fourth of all persons aged 65 or older were living in poverty; by the early 1970s, the poverty rate among older persons had dropped by 10 percentage points. Since 1980, poverty has continued to decline among older adults and has remained at about 10 percent, even during the recent recession. Poverty among the older population, however, varies considerably by race, ethnicity and gender. While 7 percent of non-Hispanic whites ages 65 and older live in poverty, this figure rises to 23 percent among blacks and 17 percent among Hispanics. Women aged 65 and older have much higher levels of poverty than men in every racial and ethnic group, especially among those who live alone. Researchers and analysts have begun to raise serious concerns about the future of the overall elderly population's financial status and ability to pay for services. Many argue that it is highly unlikely that the baby boomers will enjoy the income and wealth for a given set of demographic characteristics as favorable as those enjoyed by the

pre-boomers. There is already evidence that the former group has lower demographically-adjusted incomes and wealth than the latter group. The boomers also have little time to make up for severe economic shortfalls that occurred during the 2008 recession. A growing number of baby boomers and young retirees are still carrying mortgages and are heavily house-burdened because of high property taxes and other housing-related expenses.

Uncertain Pipeline for Aging Services Workforce

Even if elderly individuals had sufficient resources to purchase care, the question about the future availability of qualified, competent individuals to provide such services is uncertain. The female labor force participation rate for those aged 25 to 54 – the women most likely to provide hands-on care – has declined by 1.4 percentage points between 2002 and 2012 and is expected to decline another 0.7 percent by 2022. For those aged 35 to 44 – representing a large proportion of the potential formal workforce – the decline is even greater (1.6 percent between 2002 and 2012, and another 1.5 points over the following decade). While projecting further into the future is not possible, it is clear that the labor force potentially available to provide formal services and at least supplement informal care is shrinking just as the demand is on the rise. This problem is exacerbated by the aging of the nursing workforce – the staff most likely to provide services to chronically ill and disabled older adults.

As these individuals retire, a shrinking pipeline will present a serious challenge to aging services providers who depend on a quality workforce to serve elderly residents and home care clients. While technology may help improve the efficiency of the workforce, there is great uncertainty about the ability of robots and other forms of artificial intelligence to replace humans, at least in the foreseeable future.

Preferences for Aging in Place and Community-based Options

Several decades of findings from surveys of baby boomers indicate that most individuals prefer to remain in their own homes for as long as possible. Polls indicate that 42 percent believe that people deteriorate after nursing home placement. Only 4 percent say that they would prefer a nursing home if they needed long-term care, 17 percent would choose assisted living, 53 percent would prefer care in the home, and 21 percent would move in with family. Many of those willing to move out of their homes want to remain in their community where they have lived for years.

Older adults of the future will be more highly educated than the current generation and will choose to either receive a range of services and supports in their own homes or to move to a residential option in that same community or one in close proximity.

Implications for Aging Services Providers

These trends portend a future very different from the current aging services landscape. Aging services providers across the spectrum of settings need to recognize that they are likely to encounter increasing demand for services and supports from an old-old population, a large proportion of whom will have significant functional decline and dementia and will undoubtedly prefer new types of residential options or home-based service packages delivered around a naturally occurring retirement community. At the same time, the projected decline in the economic status of the elderly population and the increase in the non-white older adult subgroup suggests that a growing number of individuals will need affordable residential and home-based options.

Technology is the wild card; no one would have predicted the ubiquitous use of smart phones just a decade ago. And the implications of advances in biotechnology and nanotechnology and artificial intelligence remain to be seen.

One thing, however, is certain. The aging of the population and its increased diversity provide unique opportunities for aging services providers to create new, innovative, affordable community-based services and supports that will meet the demands and preferences for decades to come.

SCENE

1 The LeadingAge California staff celebrated President and CEO Jeannee Parker Martin's first anniversary in June.

2 The 7th Annual Affordable Senior Housing Resident Advocacy Day was held on June 7 in Sacramento. Over 200 residents, administrators and service coordinators assembled at the Capitol to meet with legislators and advocate for increased funding for affordable senior housing.

3 Continuing their 55th anniversary celebration, residents at RHF's Congregational Tower lead the pledge of allegiance before singing "Let Me Call You Sweetheart" to RHF president and CEO, Dr. Laverne Joseph.

4 Rep. Maxine Waters (D-CA) addresses the crowd at LeadingAge's Save HUD202 rally in Washington D.C.

5 Eskaton staff at the social event on the second day of the 2017 Annual Conference and Exposition, May 1-3 in Monterey, Calif.

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ACC Care Center:

Technology Outreach to Meet Demands of the Future Resident

Residents at ACC Care Center have increasing technology demands, and staff have responded with opportunities including Skype, state-of-the-art medical monitoring equipment such as an EKG machine, Bi-Pap and Bladder Scanner which all help reduce hospital re-admissions. The most newsworthy effort to increase technology for improved quality and service to their residents came in hues of blue, amber and white LED lighting.

Numerous studies have been conducted analyzing the role that light plays in suppressing melatonin release as a part of the sleep-wake cycle. Last year, ACC Care Center recognized the opportunity to increase resident care quality, so they accepted the opportunity to pilot a future technology program with Sacramento Municipal Utility District (SMUD). As part of this progressive program, they worked together on installation of intelligent lighting solutions that helped regulate resident sleep patterns, reduced negative behaviors, and minimized shared-room disruptions.

Implementation areas included: Resident bedrooms where LED headboard circadian lighting was installed, LED lighting under the beds with motion control, fixtures including handrails and toilet with dimmed lighting at night, and reduced lighting in the nurses' station and hallway.

ACC Care Center Tunable LED Lighting

According to an article posted on Torchstar.us on Sept. 23, 2016 titled, "ACC Care Center Installs Tunable LED Lighting for Gateway demo as a trial," before installation, the sleep patterns of residents, the senior group staying in the care center in particular, were easily disturbed due to the effect of aging and ailments such as Alzheimer's disease. According to the study of three residents, after installation it was discovered that agitated behaviors of residents such as crying or yelling have declined – one resident even started to reduce their intake of psychotropic and sleep medications. Moreover, the number of recorded patients falling and other accidental injuries have also decreased in one corridor after tunable LED lighting was installed. This corridor has become popular among residents living in other areas for a 'stroll.' These health and safety-related benefits have been attributed to the LED system.

In a project report produced by SMUD on Jul. 8, 2016 they state, "Although the field of circadian lighting research is still relatively new, it is picking up considerable momentum. Information by the Lighting Research Center, the Pacific Northwest National Laboratory and other industry leads, combined with tremendous advances in LED and controls technology, promise exciting new opportunities to improve the quality of life."

For more information on the efforts of ACC to meet the ever-growing needs of their current and future residents, contact Bill Clearwater, Chief Operations Officer, ACC Senior Services: (916) 503-0320 or bclearwater@accsv.org.

Brenda Klütz has 30 years of experience in California state service; with over eight years of working in the Legislature as a consultant on Aging and Long-Term Care issues and 15 years with the Department of Health Services serving as the Assistant Deputy Director and Deputy Director. Currently, she provides LeadingAge California members technical support on issues related to reimbursement, licensing, and regulation interpretation.

Dear BRENDA

Dear Brenda: *The federal and state regulatory emphasis on care has evolved over the years – at first, SNF/NF communities were to view residents as "patients"; then "residents," and now expanding the emphasis to include "person-centered care" or "person-directed care." What are the differences, and is there anything new we need to know from a compliance standpoint?*

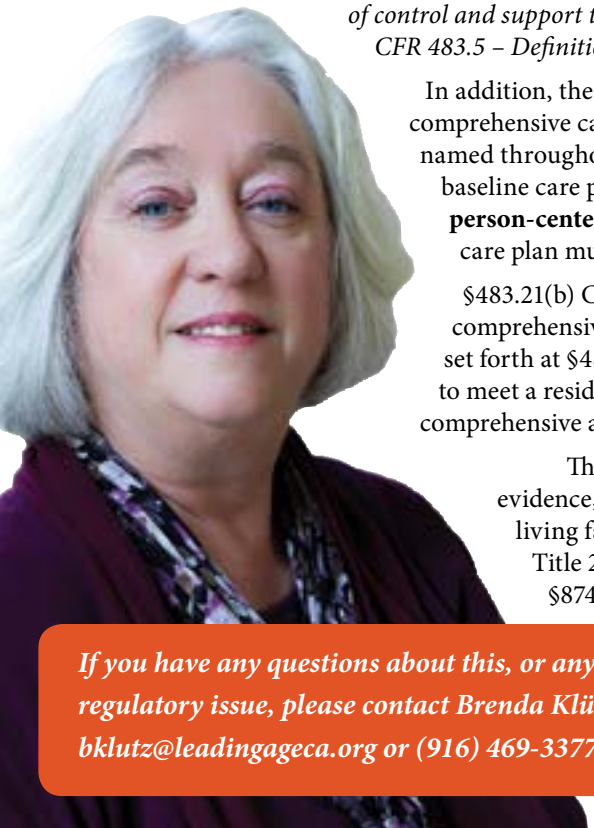
Dear Reader: *The regulatory emphasis and the model of care has changed over the past several decades, as a result of changing resident expectations, an improved understanding of contributors to quality, and the expectations of federal and state regulators that regulatory requirements better measure quality of care and quality of life.*

Not every person wants to make all of the decisions involved in their care – and that is their prerogative. However, there are more and more residents who are used to making their own decisions, insisting on having choices and having their preferences honored. These residents, and future residents, will expect that those opportunities continue, regardless of where they may live. These practices have long been embraced by LeadingAge California member communities.

"'Person-centered care' means that individuals' values and preferences are elicited and, once expressed, guide all aspects of their health care, supporting their realistic health and life goals. Person-centered care is achieved through a dynamic relationship among individuals, others who are important to them, and all relevant providers. This collaboration informs decision-making to the extent that the individual desires."[1]

With the concept of **"person-directed care,"** individuals are more in direct control of decisions about care, their environment, and preferences. Although the regulatory framework has certainly embraced the basic tenets of person-centered care, it is only recently that the regulations clearly use this term. In the most recent amendments to the federal nursing home requirements of participation (ROPs), CMS provides the following definition:

Person-centered care. *For purposes of this subpart, person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives. (42 CFR 483.5 – Definitions)*



In addition, the term is used for the overall care provided to residents and the expectation that the comprehensive care planning be person-centered [the comprehensive person-centered care plan is named throughout the new regulations]: 483.21(a)(1). The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and **person-centered care** of the resident that meet professional standards of quality care. The baseline care plan must – (i) be developed within 48 hours of a resident's admission. [eff. 11/28/17]

§483.21(b) Comprehensive Care Plans (1): The facility must develop and implement a comprehensive **person-centered care** plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The comprehensive care plan must describe the following: Less well known, but still in evidence, are research and interest in transferring person-centered care practices to assisted living facilities. In California, RCFEs require resident participation in decision-making (CCR Title 22, §87467) and resident participation in the pre-admission appraisal (CCR Title 22, §87457).

At the end of the day, person-centered care is most likely what all of us would prefer for ourselves or the people we care about.

If you have any questions about this, or any other regulatory issue, please contact Brenda Klütz at: bklutz@leadingageca.org or (916) 469-3377.

[1] American Geriatrics Society Expert Panel on Person-Centered Care (2016). *Journal of the American Geriatrics Society*, 64, 15-18.

People IN FOCUS

Karen Adams

Vice President of Planning
GSI Research and Consulting

We sat down with Karen Adams, vice president of planning with GSI Research and Consulting, to talk about future trends in senior living, and what providers need to keep in mind as we move towards 2020. *Watch the video interview:* *www.youtube.com/leadingagecalifornia*

Karen, tell us about GSI Research and the work you do.

We do market research and feasibility. We use our data for strategic planning, master planning, and also conduct financial feasibility work.

How do the "hot topics" in the field today compare to when you started in the field in the 1970s?

I think we've seen CCRCs evolve a great deal since then. Since we've established the ability to finance CCRCs we've seen extensive growth over the 1990s and 2000s until the financial crunch. In recent years I think we're gaining an understanding for the demand for autonomy, and the types of amenities in our retirement communities have evolved and will continue to evolve.

As the population of older adults continues to become more diverse and as life expectancy increases, what do you think the resident of the future will look like?

That really depends heavily on what type of product we're talking about. I'm of the belief that with CCRCs or campuses, the resident of the future will continue to age. We've seen the average entry age continue to increase over the years and will continue to see that. In spite of the fact that we say people are more active at older ages, I still think they'll enter not just older but even frailer, because they will wait until they have the need for those services for which they are expected to pay.

I think today people have many more tools to extend their active lives in their broader communities. The result is they will demand to retain that autonomy and use those tools to do so.

I've also been a big believer in trying to think about separating housing from services. When we put services and housing together is when we require people to buy their services to support them. My question is – if we separate housing from services, can we build smaller communities within people's neighborhoods, places that we can't build a 32-acre campus today, that allows people to decrease maintenance, engage in community, but still maintain autonomy from a service package? Then integrate services from the broader community. That's the kind of modeling I think will begin to shift how the resident of the future looks. Taking services from one side and housing from the other side, rather than owning, operating and planning everything.

What should senior living providers keep in mind as we move towards 2020?

A need for change – and change in models. Times have changed so radically, how do we as providers integrate services in many more ways that aren't just brick and mortar? It's about creating networks, creating partnerships, and it's about having the strength as an organization to be able to invest the resources in that. It's about having the creativity and having the will to create resources in that. I am also happy to see some new generation CEOs coming into the field that move much more fluidly in data and technology. I think people's personal technology is going to be such a huge driver, my question these days, is how do we as organizations integrate that personal technology and become either the deliverer of many services or the navigator and coordinator?

Read the full interview on our blog:
www.leadingageca.org/engagehub

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RESIDENT OF THE FUTURE

From the Service Coordinator's Perspective

We chatted with service coordinators Donna Griggs-Murphy, Allen Temple Arms; Mia Almonte, Valley Vista; Suzi Johnson, Volunteers of America; and Margarita Molina-Hinkley, Oak Center Towers, to get their perspectives on how residents' needs and expectations have evolved since they began their careers and how they see their roles changing in the future.

What motivated you to go into this field to work as a service coordinator?

Molina-Hinkley: I have worked with older adults for over 15 years. My culture has taught me to honor and respect our seniors.

What are some of the most rewarding aspects of your work?

Johnson: Seeing residents settle into their own apartments and getting the services they didn't know were there for them, like medical transportation, and St. Vincent's Brown Bag, and allowing them to age in place.

Molina-Hinkley: Seeing I can make a change in residents' lives by caring and advocating for seniors.

Since you started in this field, have you seen a shift in demographics of the residents you serve?

Griggs-Murphy: Yes, we have more residents who have been homeless and need increased case management, residents with more mental health issues, more dementia and Alzheimer's, and substance abuse issues.

As the face of the "typical" resident continues to evolve, their needs and preferences for various services and social opportunities will change as well. Have you seen this change with the average resident over time?

Griggs-Murphy: Yes, it's been dramatic. When I began, I had Bingo and knitting circles. Now, because they are living longer, the residents desire a higher level of engagement – computer technology classes, Artists in Residents, gardening, etc. We try to bring in outside providers that offer a higher level of service.

Almonte: The average resident is living longer and being independent for much longer. We're getting residents in their late 80s and early 90s thriving in our communities. I recently had 82 year-old resident share photos of him zip lining! It's inspirational, motivating and also shows how much the average senior is changing. What we've done in the community setting is try to adapt by providing programming that promotes preventive health, quality living and also community building. We work to provide a community the residents not only take pride in, but actively contribute to as well. It's their home.

What keeps you up at night?

Johnson: Wondering what I could have done differently and whether I did enough. I worry about what happens to certain residents that have less support from family and friends.

If you could make one change to help better suit the needs of your residents, what would it be?

Griggs-Murphy: I would like to see more Supportive Services Models, and housing and healthcare integration to reduce "Frequent Flyers" to emergency rooms and allow seniors to "thrive in place."

Almonte: One change I would like to see over time is to have affordable continuing retirement communities. The average senior doesn't have the financial means to enter a retirement home. I'd love to see affordable senior housing with all levels of care, so residents can continue to age in their homes regardless of income.

How do you see the role of the service coordinator evolving over time?

Griggs-Murphy: Service Coordinators are more engaged in case management, therapies, social work than ever before.

Johnson: Our role seems to change with each resident – they all have different personalities, different needs different health issues, different back grounds and family structures.

Molina-Hinkley: Once, I saw myself helping residents understand their mail. I would spend time helping them fill out forms. Now, if possible, I encourage family members to help with these things and I spend more time trying to engage residents to do for themselves.

Almonte: Depending on the day or the issues we encounter, some days we're the educator or advocator; other days we're community builders or mediators. I see the role of the service coordinator evolving and taking on new roles to adapt to the changes within our society.

Medical Marijuana: *What's a Provider to Do?*

by Tomek J. Koszylko, Hanson Bridgett, LLP

HansonBridgett

It is safe to say that medical marijuana is here to stay. After decades of suspicion or outright demonization, marijuana is increasingly regarded as a legitimate alternative treatment for certain medical conditions. A recent Yahoo/Marist poll found that 83 percent of Americans are in favor of legal medical marijuana use. Additionally, more than half the states in the nation have passed laws legalizing medical marijuana, and in California and several other states, recreational marijuana is legal as well.

As a senior care attorney, I have had many discussions with our clients about resident and family requests to accommodate medical marijuana. Highlighted are some of the more common concerns we have addressed for our senior housing and senior care clients. [1]

Any advice about what we should do right now?

Whether your organization is in favor of medical marijuana, against it, or somewhere in between, the best first step is to implement a written medical marijuana policy sooner rather than later. Requests from current and prospective residents will likely only increase over time, and it is important to have a written policy that clarifies your organization's position and allows your staff to provide thoughtful responses to such requests. Written procedures also help providers uniformly enforce policies and avoid potential discrimination claims.

Can we prohibit all medical marijuana at our community?

For now, yes. Because marijuana in all forms is still illegal under federal law, providers can prohibit medical marijuana use at their communities even though California has legalized it. As long as marijuana remains illegal under federal law, state marijuana laws do not obligate providers to accommodate medical or recreational marijuana use at their communities.

However, providers should think twice about implementing an across-the-board prohibition, since this might simply force the behavior underground. A provider who is not aware that a resident is consuming medical marijuana may have a blind spot in that resident's care plan regarding potential side effects, such as loss of balance, intoxication, and decreased inhibitions, all of which could lead to accidental falls or other injuries. What you don't know can hurt you … and your residents.

Are there scenarios in which we have to prohibit medical marijuana?

Providers that participate in Medicare, Medi-Cal, HUD, and other federal programs must comply with the rules set by those programs. Both CMS and HUD have issued guidance stating that providers may not have policies allowing marijuana use of any kind, including for medical purposes. Therefore, communities with skilled nursing facilities that accept Medicare or Medi-Cal funds cannot allow medical marijuana use in the skilled nursing area. Similarly, affordable housing communities that participate in HUD, and assisted living providers who participate in a Medi-Cal assisted living waiver program, cannot have policies allowing medical marijuana use at those communities under current federal guidelines.

If we allow it, can we limit the types of medical marijuana permitted on campus?

Yes. Depending on what works for your community, you can restrict the forms of medical marijuana you allow on campus. For example, in light of strict no-smoking policies, providers may want to limit medical marijuana to edible and topical products only. Providers may also consider allowing residents to use vaporizer-based medical marijuana products, since vaporizers do not burn the product and produce little lingering odor. Either approach is permissible.

Can we allow residents to smoke medical marijuana in our designated smoking areas?

This situation can be tricky. Other residents may not want to be in the presence of marijuana smoke, and they may feel that their own rights are being

[1] This article should not be taken as legal advice. Please contact your legal counsel if you have questions, or contact us to set up a client consultation

violated if they have to share their smoking space with medical marijuana users. Additionally, state marijuana laws prohibit individuals from smoking marijuana in "public places." From a practical point of view, a provider might want to set up a separate, secluded medical marijuana smoking area that does not impose on other residents.

If we allow it, do we have to have the same policy at every level of care?

Not necessarily. A community may choose to allow medical marijuana for independent living residents who are able to handle their own medications, provided that the marijuana is stored in a locked cabinet in the residents' living quarters. At the same time, the community can choose to prohibit medical marijuana for assisted living and memory care residents who require medication management, to avoid the added risk of centrally storing marijuana for residents.

Can we centrally store medical marijuana for assisted living residents?

Yes, under certain conditions. DSS has advised that it considers medical marijuana to be a medication, not an illegal drug, stating that if a facility "complies with applicable regulations regarding the storage, administration and documentation of such medication, then there is no violation with regard to such possession, storage, and use of marijuana by the patient-resident." Therefore, assuming other licensing obligations are met, DSS will not object to central storage of medical marijuana in an RCFE setting. However, the devil will be in the details. Providers wishing to centrally store marijuana should consult legal counsel to determine what is required to comply with central storage regulations.

Can we prohibit marijuana use by employees?

Absolutely. Providers are free to apply drug-free workplace policies to medical marijuana use at their communities. California courts have not found that employers must accommodate on-the-job medical marijuana use by employees.

I have more questions.

I'm not surprised! This is a fast-moving field, and we hear new questions all the time. Is it time for your organization to adopt or update your marijuana policies? That is a question I encourage all providers to ask themselves.

The New Normal: Trends Re-writing the Future of the Senior Living Resident Experience

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The commonly held perception of a "typical" senior is changing, and the senior living resident experience in turn is being transformed by many forces – including shifting demographics, increased diversity among residents, changes in resident preferences, and evolving stakeholder policies, positions and regulations. As customer expectations rise in health care and other industries, it's imperative that senior living providers understand more than the basic needs of customers; they will need to understand what customer expectations are, how companies across all industries are improving and innovating in experience offerings, and what will be considered the new normal in senior living. This paper from Sodexo offers an overview of key trends affecting the senior living resident experience – accommodating a new generation of customers who are more diverse and more tech-savvy, changes in consumers' retail behaviors, new expectations for amenities and services and changes in the senior living industry's stakeholders.

Download the report at: sodexoinsights.com/research

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2017 Webinars

Executive Leadership Webinar Series: Through 2017

LeadingAge California's 2nd Tuesday Leadership Series: A Robust Dialogue with Thought Leaders is a complimentary webinar series that takes place on the 2nd Tuesday of each month from 11:30 a.m.-12:30 p.m. throughout the year. Exciting thought leaders will discuss current events and topics of interest to executive leaders throughout California. These webinars can be used as a starting point for further discussion with your leadership team on how these issues will impact your respective communities.

MDS Essentials: An Introduction to the MDS 3.0 - a 10-Session Virtual Workshop Series

New resident assessment coordinators with fewer than six months experience and staff interested in the MDS process can take advantage of this new education program. The workshop moves through the Resident Assessment Instrument (RAI) User's Manual, helping staff understand the intent, rationale, and coding requirements of each MDS item set, Care Area Assesments, care plans and scheduling. The program will help the MDS coordinator perform his or her job duties skillfully and with confidence.

Driving 5-Star & RoP Implementation Through a QAPI Approach - Webinar Series: Through 2017

LeadingAge California has partnered with Proactive Medical Review and several other LeadingAge state associations to offer a 13-part webinar series throughout 2017 to assist California nursing homes with implementing the new nursing home Requirements of Participation (RoPs) and with quality improvement.

The series will approach and review the new rules through the lens of QAPI (Quality Assurance and Performance Improvement), with the goal of promoting understanding of the new rules while improving both quality and 5-star performance.

Save the Date! Diversity and Dementia Care Webinar Series, Oct. 12,2017-April 12, 2018

Join us for a series of six webinars that address how to provide care that recognizes values, and is responsive to diversity – in cultural, sexual orientation, family support, and more – among people with dementia. You will learn about key factors to consider in meeting the needs of older adults with dementia – who are not just increasing in number but also in diversity. Taught by Dr. Cordula Dick-Muehlke, this webinar series promises to empower you with the knowledge to achieve person-centered dementia care that effectively responds to under-addressed aspects of diversity in those you serve.

Visit www.leadingageca.org/events for more details and to register!