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Testimony Re: BZA Case # 19751 (Application of MED Developers, LLC)

Professional History:

I am Dr. Nathan Billig, a geriatric psychiatrist with over 40 years of experience in the field. I have taught residents, medical students, and fellows in geriatric psychiatry, and treated patients at Georgetown University, rising to level of Professor. I am a physician (M.D.-1966) and a certified psychiatrist with geriatric sub-specialty training. I am the author of two books and over 25 articles on aspects of psychiatry. I have presented, both nationally and internationally, in the field of geriatric psychiatry. I am now retired from practice and retain the position of Clinical Professor in the Department of Psychiatry at Georgetown.

As part of my work as a geriatric psychiatrist, I have been a consultant to several nursing home groups with memory care units or the equivalent. I consulted to the original Sunrise Assisted Living management team, formally and informally, from the beginning of their efforts 30+years ago until their establishment of a multi-facility corporation. I was a consultant to the Hebrew Home of Greater Washington, participating in clinical and research efforts, and supervised fellows in training there. I was on the Advisory Committee of Aegis Senior Care, Seattle, WA from its inception, and helped to develop its clinical programs. I am familiar with the Manor Care Arden Courts Memory Care facilities, in the Washington, DC area, and have referred patients there over the years.

I have no financial interests in any long term care facilities, nor do I receive any remuneration from any.

The Field of Memory Care:

Memory or Dementia Care has developed as a specialized field in the last 30 years from its origins in nursing home care and assisted living. It arose out of the realization that patients with moderate to severe dementia needed and benefited from specialized care that neither nursing home nor typical assisted living facilities fulfilled. That care is not merely custodial, but rather seeks to provide a program to retain and enhance residual functioning of residents, with the aim of prolonging maximal cognitive ability, so they can enjoy a more successful quality of life for

as long as possible. Dealing compassionately and constructively with the behavioral symptoms of dementia is a major task of the care staff.

Memory care facilities require trained nurses, nursing assistants, recreational and activity specialists, consulting physicians of various specialties and allied health professionals. The patients residing in a memory care unit have moderate to profound cognitive impairments and vary greatly from exhibiting calm and reserved behavioral patterns to very agitated, even psychotic behaviors, at times. Managing operators and staff of such facilities must be trained and experienced to deal with the range, and unpredictability of illness and disability of the residents, as well as the care aspects that are specifically designed to retain and enhance cognitive functioning. They must design their facilities to maximize function and deal with the specific needs of significantly demented residents.

Specific Plans for the Memory Care Facility in Question:

Physical facility:

The specific physical design of a memory (dementia) care facility is essential to the care program for the residents involved. Over the past 25 years or more, the internal design that has evolved as most effective, safe and caring is that of several "houses" or "neighborhoods," on one floor, within the facility. Each would be made up of several bedrooms in close proximity to a recreational "living room," activity area and a dining area, simulating, as much as possible, a cozy, familiar home environment, rather than a more restrictive dormitory or typical nursing home plan. An open, accessible nursing station area, not a "nook," should be integral to this space, so that residents can freely seek care or attention when needed, and nursing staff can interact with and observe the residents to optimize care and maintain maximum security. Having the "neighborhoods" loosely connected on one floor, with hallway paths in-between, allows residents safe paths for exploration, socialization and exercise within the facility. **The planned facility being discussed in this case does not appear to have any of the most desirable design features of a dementia care unit, but rather seems to be a rather tight and restrictive space plan, on each of three floors, and dictated by the available space rather than the needs of a proposed facility with a very specific purpose.**

Residents should not have to be gathered into an elevator or stairway on a regular basis to go to a dining room or activity space in other parts of the facility on a distant floor, as is the plan in this facility. Since demented patients do best when the environment and surrounding personnel are constant , this forced mobility will intensify confusion, anxiety, agitation and fall risks, and lead to mealtimes (and other activities) being unnecessary stimuli for upset, rather than a time for calm group interaction and nourishment. Having a gymnasium or fitness center on a floor other than the living floor is also not ideal, for similar reasons.

Since most moderately to severely demented patients usually have some degree of agitation, and benefit significantly from being able to be able to walk or pace ad lib in a safe environment, a secure, attractive walking path, both indoor, as mentioned above, and outdoor is recommended in a facility, as close as possible to the living space. Often these are of "figure of eight" design, in an attractive, quiet garden setting, and have a length of at least 1/8 - 1/4 of a mile. A greenhouse or garden plot, as a regular activity space, is a venue that is often integrated into the resident programming and provides a calming alternative space. **These basic physical attributes of a memory care facility also do not appear present in the proposed design, either indoors or out.**

Family members and close friends of the residents should be encouraged to visit the facility regularly, and even participate in the program. Many family members of residents spend several or more hours per day visiting in the building. Contact with familiar people enhances retention and enhancement of memory and ameliorates agitation. Therefore, adequate, accessible and unrestricted parking should be available on-site for the coming and going of guests of residents, as well as indoor and outdoor spaces for visiting, and a provision for the purchase or availability of meals by visitors. The parking in the neighborhood of the proposed building is largely restricted and therefore not available to most of the visitors to the facility.

Since residents of memory care centers are almost all elderly, they will be vulnerable to medical emergencies and may necessitate emergency transfer to a hospital via ambulance. The plan of this facility indicates that all transfers such as this, deliveries, and movement from the small parking area will occur through an alley at the rear of the property. This does not appear to be practical, adequate, nor safe.

The site of the proposed facility does not allow for essential recreational or visitation space, has little dining expansion space, has poor access for emergency vehicles, nor does it appear to have adequate parking and other amenities for guests.

Staffing:

Optimally, staffing should include one resident care staff member (usually certified nursing assistants) per five residents during day and evening shifts, and one staff member per every ten residents at night. A trained staff nurse should be present in the facility 24 hours per day. It is desirable to have care staff be full time employees rather than per diem or agency temporary employees, so that residents and family members can form trusting, positive relationships with known caregivers over time. There is a need for emergency staff back-up plans, as it can be expected that crises will occur and additional staff will be necessary. In general, staffing patterns should encourage time spent leading activities and engaging with residents and family members and not merely having to attend to surveillance, safety issues, paper work, etc.

Often family members desire to hire supplementary private duty nursing aides for particularly upset residents, for parts of the day, or even the entire waking period. Provision for their being integrated into the facility environment is essential to ongoing care. Similarly, some of the residents will benefit from hospice or other specialized, non-invasive, medical care, and it is desirable that they be able to maintain the constancy of the facility living situation while that care is delivered, rather than be forced to move to another facility.

The employment of a variety of trained activity and recreational staff members is essential to a well functioning memory care unit. These staff might lead art, music, poetry, language and reminiscence programs within the daily schedule. These activities, and appropriate others, are usually programmed throughout the day and early evening in a schedule that is considerably more intensive than in a typical assisted living environment.

In the plans that I have seen for this proposed facility there are no specific details of appropriate care staffing levels and no provision for additional care situations which inevitably arise in the population being treated.

Summary:

There is no information to indicate that the proposed operators of the 2619-2623 Wisconsin Avenue project have had training or experience specifically in the management of memory or dementia care facilities. While they cite assisted living experience within their management team, memory care requires additional and different skills. In addition, the proposed operators of this facility cite the DC Assisted Living Standards as ones that they would observe. Those standards are non-specific with regard to staffing and facility design, more geared to unimpaired or mildly impaired residents. They do not take into account the needs of residents who are moderately to severely ill with dementia and its associated complicated disabilities. The facility is planned to be built on a small, inadequate lot on a busy street, and therefore cannot include the necessary outdoor activity spaces, sufficient parking areas, easy access in emergency situations, and comforts that are usually a part of a well-functioning dementia care center. The internal design, as planned, appears cramped, on each of three floors, and is not ideal for the functioning of a well-managed memory care unit. Staffing patterns are not well-documented nor specified by area of expertise, and there is no indication that the proposed operators have thoughtfully planned for the depth and variety of specifically trained staff that is essential for such a residential facility.

In my work with patients and families, over the past four decades, I have found that their selection of a facility for a demented loved one is based on design, staffing, comfort, experience of the operator and staff, safety, programming, and respect for family concerns and the resident's needs in a state of significant disability. My assessment of the plan for this facility is that it appears lacking in all areas.

In summary, I see the proposed plan, as outlined in the application for a zoning exception, as unsuitable as a memory care facility.

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