Regulating Assisted Living: The Proper Paradigm

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Assisted living regulation: What’s at stake?

- Preserving or undermining the fundamental values and resident focus of AL.
- This issue has been at the heart of AL regulation debate since its inception.

What does the history (short) of AL tell us about where we are?

- Ten year growth pattern.
- Broad range of AL types and regulatory practices.
- Increased public sector support (Medicaid waiver)
- Negative media (some bad outcomes in a sea of success).
- Growth plateau—time to assess, adjust and plan (2000-2010).

What does the research show?

A. The influence of autonomy, control and privacy (necessary conditions for dignity) on perceived quality of life in long-term care and implications for AL regulation and funding. AL may be a more propitious setting for achieving these outcomes than in-home care for some. Research in Florida (Salmon & Polivka)

What does the research show? (cont'd)

B. Many AL residents are highly impaired (3+ ADL deficiencies/cognitive impairment. In Florida this group is about 20% of AL population—facts on the ground. Quality of care outcomes (ADLs and pain and comfort) in AL. Research in Oregon (Kane, 2001). Same as nursing home outcomes controlling for initial status.

What does the research show? (cont'd)

C. Resident and staff assessments of AL (high privacy, high service or both facilities—40% of all ALFs (Hawes, 20001). Generally very positive.

- Residents were treated with respect, affection and dignity.
- Concern about staffing level and turnover.
- 26% who needed help with toilet reported unattended for assistance.
- 90% thought they could stay in ALF as long as they wanted, but most were uninformed about policies on retention and discharge.
- Staff appear satisfied with working conditions, but need to know more about dementia and normal aging.

What does the research show? (cont'd)

D. Reason for discharge from high privacy, high service or both AL (Hawes, 2000) #1.

- On annual basis, 8% move to NHs, 4% to another ALF, and 81% remain; 78% moved because they needed more care. A decline in cognitive status was only resident variable that significantly affected likelihood of entering a nursing home.
- Only 12% of those who moved indicated dissatisfaction with care.

What does the research show? (cont'd)

E. Reason for discharge #2.

- Residents in facilities with a *fulltime* RN involved in direct care were half as likely to move to a nursing home. When different formulations of staffing/service variables were used (any RN staffing, RN hours per resident, aide staffing, arranging for nursing care), the relationship between services and outcomes was not significant.
- It appears that these alternative staffing arrangements, or just better staffed facilities, are no substitute for a fulltime RN who does direct care.

Implications of what we know for assisted living regulation

- Desire for alternatives to NHs and aging in place should not be frustrated by excessive regulation.
- The preservation/enhancement of the fundamental values of AL (autonomy, privacy, dignity) should be the first priority in the development of AL regulations. AL as the principle setting for achieving these outcomes.

Implications (cont'd)

- Regulations should be designed to maximize the demonstrated capacity of AL to serve seriously impaired persons and allow aging in place, if specified conditions are met (i.e., clear consumer preferences, availability of necessary services). Providers, however, should be free to decide the level of care they are willing to accommodate.
- States as natural laboratories for the emergence of AL regulation that achieve an effective balance between freedom and safety, quality-of-life and quality-of-care outcomes. Avoid "rush to judgment" that could destroy what we most want to preserve.

Implications (cont'd)

- Serious consideration, however, should be given to Hawes et al. findings concerning the negative impact of cognitive decline in assisted living residents and the apparent positive impact of RN care on preventing movement to a nursing home or facilitating aging in place.
- The provision of sound dementia care and skilled nursing care are essential components of any efforts to maximize the aging-in-place potential of assisted living.

Regulation-related approaches

Given these research findings and their policy implication, I would suggest the following regulation-related approaches:

- For the most part, I think we should continue to take a wait-and-see approach to assisted living regulation. We need to learn more abut the effects of the different regulatory schemes across the states, the impact of Medicaid waiver funding on the demographics of assisted living, etc.
- There are some areas, however, where initiatives are needed and some where we should be prepared to stand our ground.

Public Disclosure

- Assisted Living Federation of America (ALFA) and other organizations have already moved to develop model programs for fully informing (potential) residents and their families about what facilities offer, how much they cost and how costs change in response to changes in resident need and other issues identified by the GAO as full disclosure problems in assisted living.
- This is an issue that probably needs to be clarified by state regulators, especially in the area of dementia care. Residents and their families should not be surprised by provider decisions.

Admission/Retention Criteria

- In order to maximize consumer choice, admission and retention criteria should be as inclusive and flexible as possible and staffing should be sufficient to meet the needs of individual residents.
- Restrictive criteria would keep many frail elderly out of assisted living and the quality-of-life conditions they want and force them into nursing homes as could uniform staffing standards by making assisted living less affordable.
- Staffing should be based on assessed resident needs.
- Providers should be free to determine the level of care they are willing to provide, hence the level of resident impairment/need they can accommodate (the fulltime RN issue).

Negotiated Risk

- Negotiated risk contracts, if clear, non-coercive conditions are met, should be permitted on an expansive basis in assisted living.
- The ALFA book and the draft guidelines on this topic are very helpful guides to the use of risk contracts which will continue to evolve through law and regulation over the next ten years and become an increasingly important vehicle for consumer choice and direction and aging in place.

Dementia Care

- The industry should develop a set of model guidelines for dementia care which could be used by states to develop regulatory standards designed to ensure an acceptable level of care for residents with dementia. Initially, these standards should be applied only to providers who claim to provide specialty services.
- There are a number of unresolved controversies (separation of resident, locked units, etc.) in this area and standards should be developed and implemented very carefully and in close collaboration with the industry.

Privacy/Single Residency

- I support physical plant/environmental designing regulations designed to create as homelike a living environment as possible, to provide privacy and enhance autonomy.
- We know from research by Kane, Hawes and others and from our own experience that assisted living residents and potential residents place a *very* high priority on privacy as a quality-of-life value. Most fundamentally, this means a strong preference for private rooms and bathrooms and, to a lesser but still very significant extent, kitchenettes.
- The assisted living experience in Oregon, which requires these privacy provisions and where costs are within the industry norm, would seem to indicate that privacy is affordable.

Employee Training

- The industry tendency to have employees play multiple roles is generally positive in that it can help dilute the stifling effects of hierarchy and avoid the alienation and detachment of command and control structures and help maintain staff morale, creativity and commitment.
- This tendency toward "universal worker" roles can also help contain staff costs.
- It also creates a greater need for cross-training, both pre-and-in-services training, especially for workers in facilities serving more physically and cognitively impaired residents.

Quality-of-Life Outcomes

- In lieu of standard, institutionally oriented structure and process quality-of-care regulatory criteria, advocates, providers and policymakers should press for resident-oriented quality-of-life outcomes measures based on the fundamental values of assisted living—autonomy, privacy, dignity and the experience of a fuller life, however impaired one may be.
- This approach to performance accountability would prioritize systematic consumer feedback on such variables as enjoyment, meaningful activity, quality of relationships, spiritual well-being, autonomy, privacy and dignity as well as the resident's sense of security and physical comfort (Kane, 2001).

Certificate of Need

- I see no need for a certificate-of-need approach to containing the growth of assisted living at this point.
- Assisted living is overbuilt in some areas now, but market forces and the growth of the Medicaid waiver funded sector (and other sources of public funding) are likely to handle this problem over the next five years.
- Non-nursing staff should be allowed to assist in administering medications.

Medication Management

- Properly supervised non-nursing staff should be allowed to assist in administering medications (nurse delegation)

Resident Assessment

- I do not think we are ready for a standard uniform resident assessment and case planning instrument in assisted living á la MDS.
- Maine's initiative in this area is interesting and will prove helpful in the future. But, we need more research and development and debate about the tradeoffs before requiring a single instrument.
- This is another area where states are a natural laboratory and we need to learn much more about the comparative results and give time for the emergence of a consensus.

Resident Assessment (Technology)

- Technology can help in the assessment, care planning and monitoring process. ALF specific software that is user friendly and non-medical model in design can help streamline operations, calculate staffing based on current resident population and facilitate quality/insurance/risk management by identifying at risk residents and ensuring follow up.

Additional Strategies

•In addition to quality assurance in assisted living, I think there are two other strategies that can be used that are more consumer (resident) oriented than conventional nursing home regulatory schemes.

- Case management/care advocate and publicly supported residents.
- Consumer direction—"portable" funding.
- Room and board/housing funding issue.

Conclusion

- A sound foundation for future success.

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This presentation can be found at http://www.fpeca.usf.edu