It's not a nursing home! The past, present, and future of care delivery in assisted living.

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2023-2024 President, AMDA – The Society for Post-Acute and Long-Term Care Medicine

Objectives

By the end of the presentation, attendees will be able to:

1. Describe the history and current state of Assisted Living (AL)
2. List the benefits and drawbacks of a social vs medical model of AL
3. Define the regulatory framework and distinguish it from that of a skilled nursing facility
4. Describe their professional role in caring for individuals living in AL

History of Assisted Living (AL) in the U.S.

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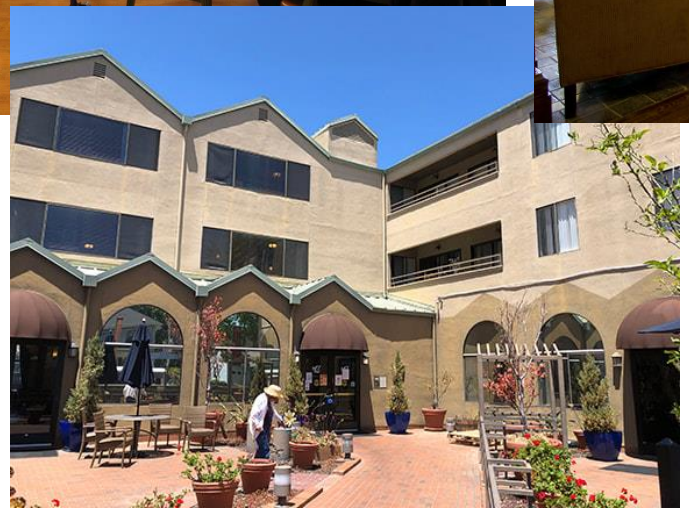

Philosophy of AL: promote autonomy and independence in a residential (not medical) setting, while getting necessary supportive care services

History of Assisted Living (AL) in the U.S.

- National initiative to provide recommendations on care quality formed in 2003

  Assisted Living Workgroup ≅ Center for Excellence in Assisted Living (CEAL) ≅ CEAL@UNC

- CEAL definition of AL: state regulated and monitored residential long-term care option. Provides oversight and services to meet the residents' individualized scheduled needs, based on the residents' assessments and service plans and their unscheduled needs as they arise.

“Stakeholders agree -- and vehemently so -- *that today’s*

assisted living is not as intended in the past,

and must be reimagined for the future.”

Why Reimagine Assisted Living?

- In May 2021, 25 diverse stakeholders participated in two half-day retreats to discuss the status of AL
- They identified key tensions and potential solutions
- Researchers compiled related evidence

The Imperative to Reimagine Assisted Living

JAMDA

journal homepage: www.jamda.com

Special Article

The Imperative to Reimagine Assisted Living

Check for updates

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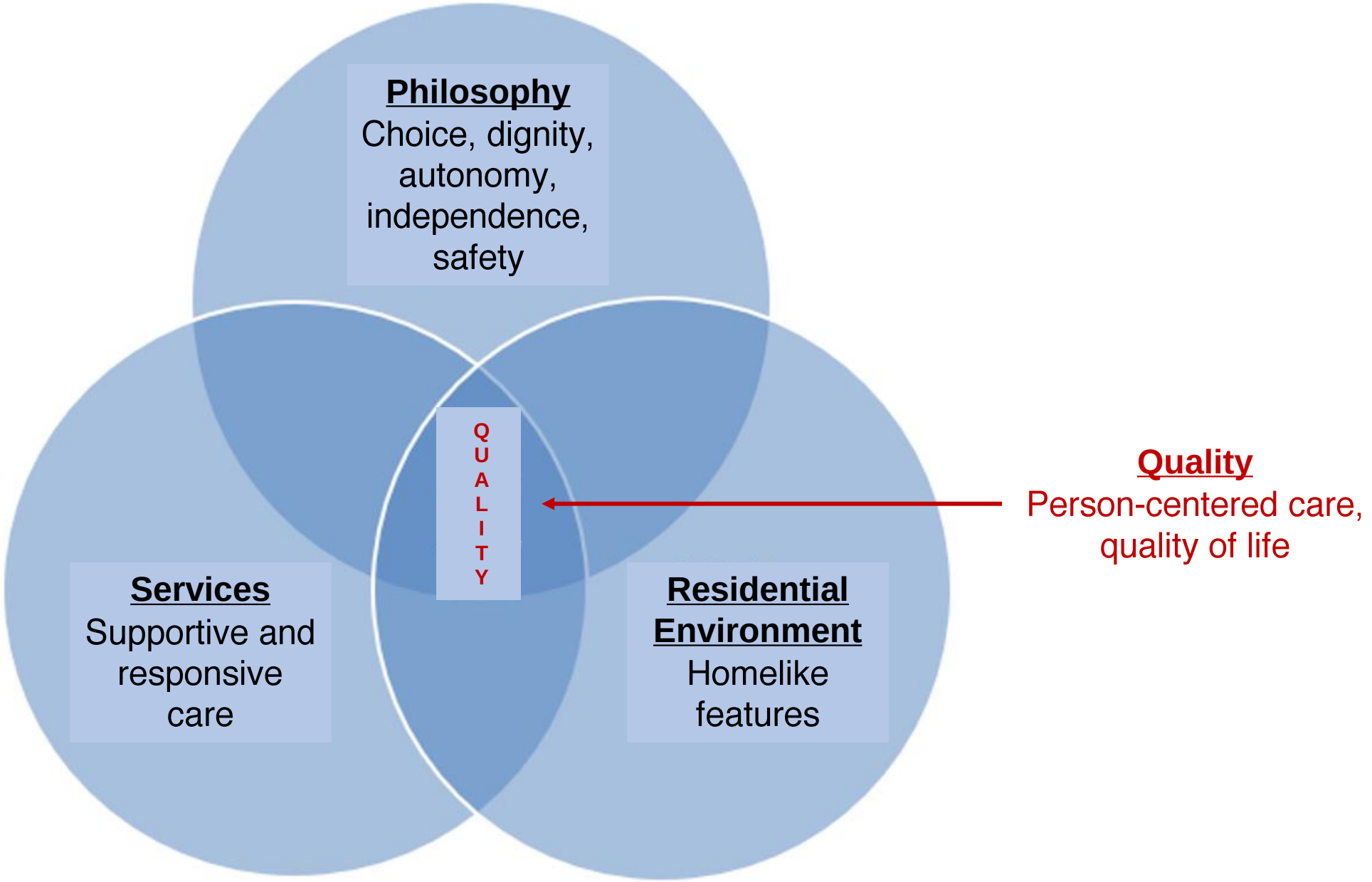
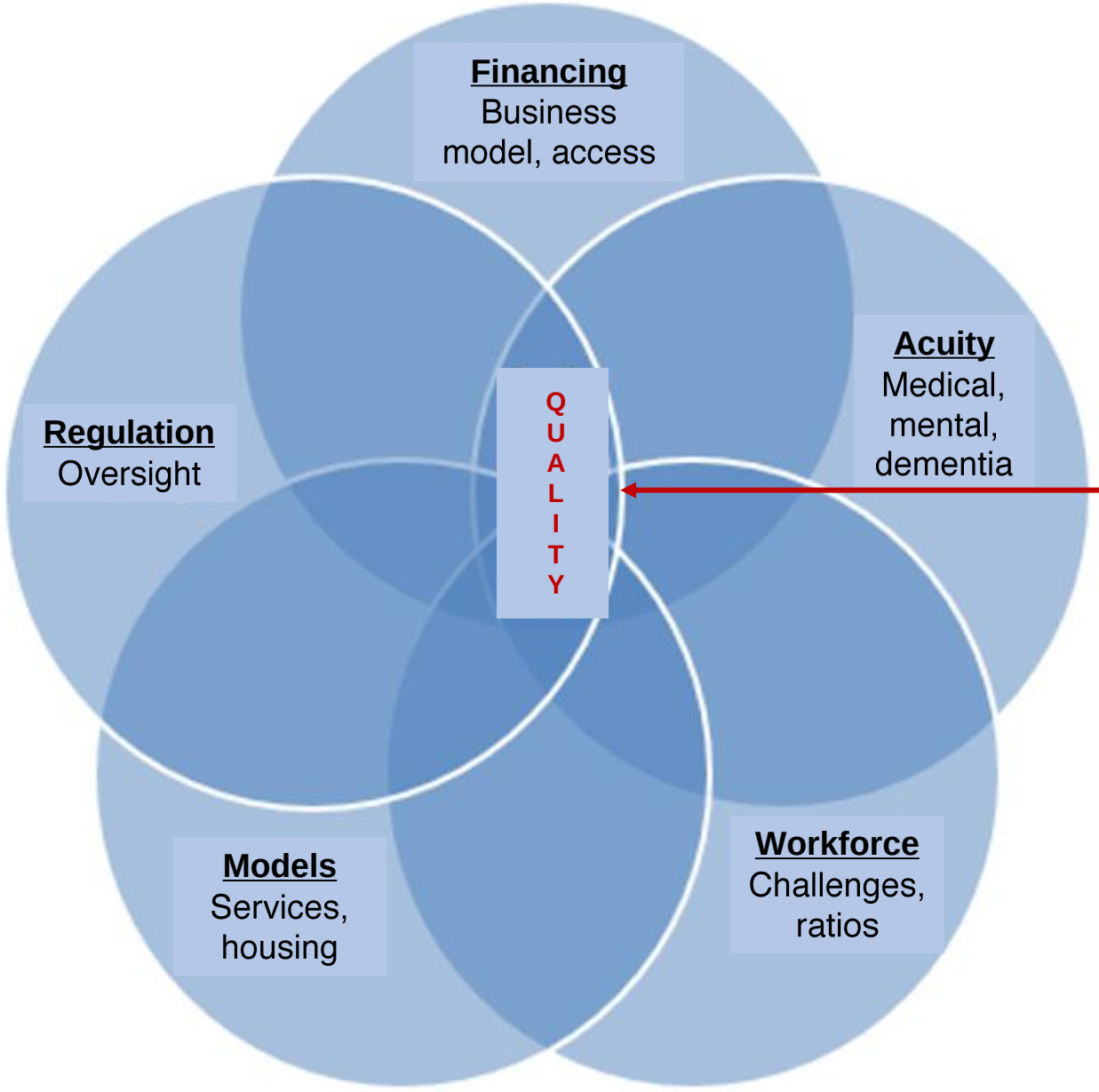
https://www.jamda.com/article/S1525-8610(21)01055-0/fulltext

Initial Key Constructs of Assisted Living



Today's Tensions for Change



Quality
Person-centered care, quality of life

Person-Centeredness

Inherent Tradeoffs in Person-Centered Care and Outcomes

More safety ….
or more autonomy?
More activities …
or more privacy?
More services …
or less cost?
More comfort …
or less sedation?

Person-centeredness is not binary, nor can it be maximized

Tensions and Potential Solutions

1. Models of Care

Models of Care

Tension	Potential Solution
Models reflect what developers offer and states regulate ▪ Institutional, housing and services, service ▪ Privacy, service ▪ Resident characteristics (e.g., dementia, mental illness, function) ▪ Other characteristics Leadership may not be aware of nor embrace these models Communities do not usually market themselves based on these models Consumers are not aware of differences	

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Social versus medical model of care	Put the dichotomy to rest

Tensions and Potential Solutions

2. Regulation

Regulation

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Regulations are flawed/challenging ▪ The regulatory arena is complicated (350 combinations) ▪ Regulations set the floor rather than the ceiling ▪ Some are outdated as new concerns have emerged ▪ Not all reflect the assisted living philosophy (e.g., choice/safety) ▪ Regulations other than those specific to assisted living are relevant to service provision (e.g., Nurse Practice Act) and to promote affordability (e.g., Medicaid waivers)	

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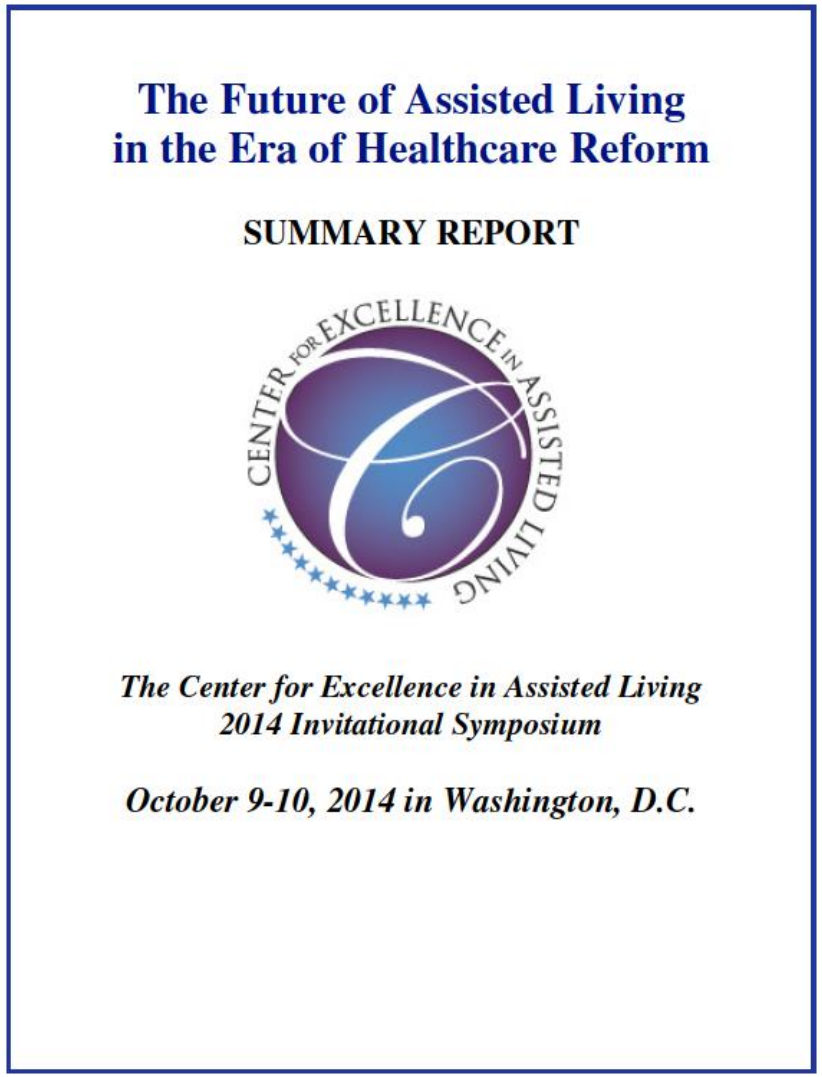
The survey process is disdained	Promote professional approaches to quality improvement ▪ Accreditation

Measurement

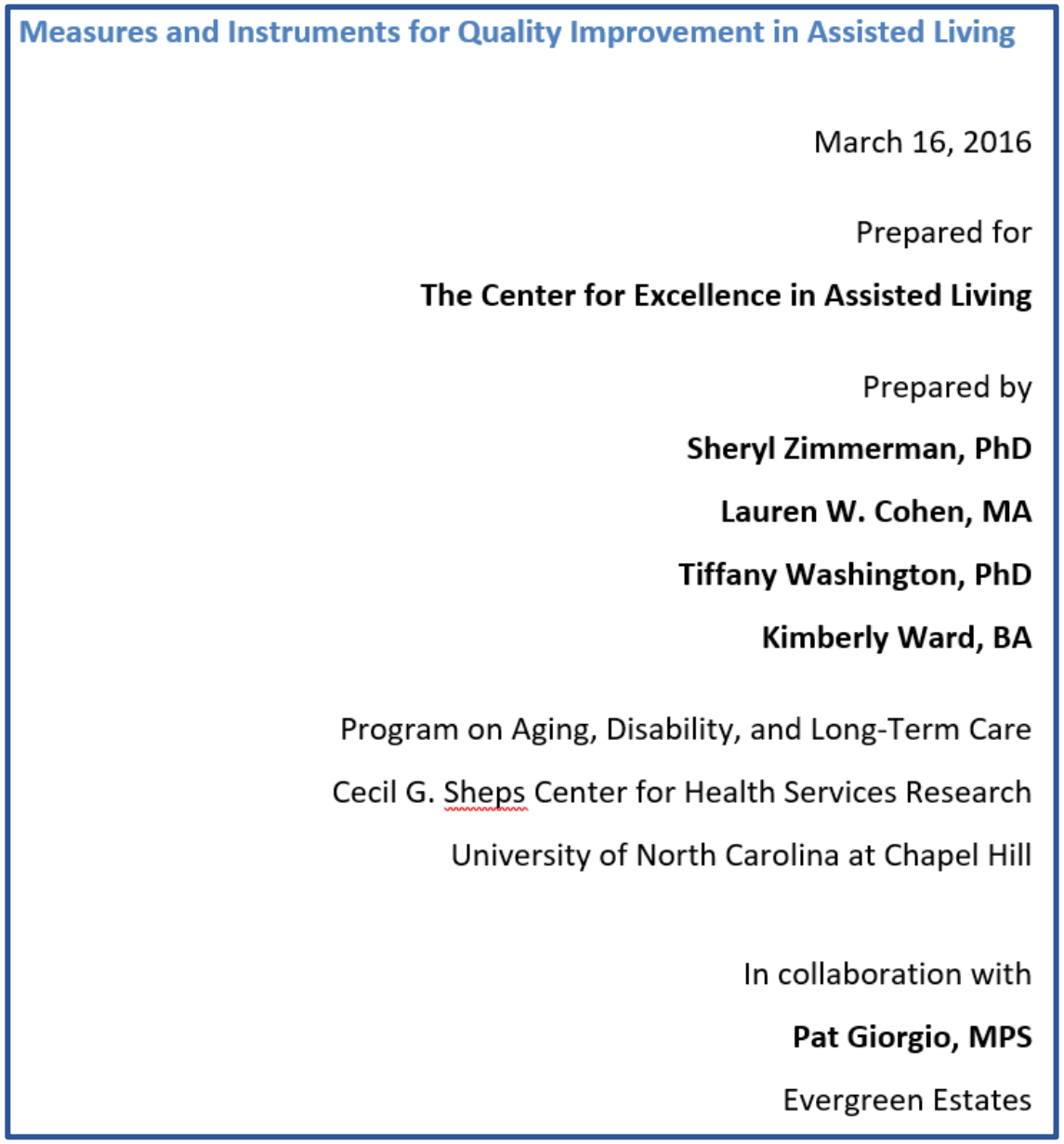


Data Collection, Sharing

- If assisted living does not track and share meaningful data with health care systems, it is in jeopardy of being sidelined
- Assisted living consumers are increasingly demanding quality measures as they evaluate options

https://theceal.org/resources/the-future-of-assisted-living-in-the-era-of-healthcare-reform/

Measurement



Measures and Instruments for Quality Improvement in Assisted Living

March 16, 2016

Prepared for

The Center for Excellence in Assisted Living

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Cecil G. Sheps Center for Health Services Research

University of North Carolina at Chapel Hill

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Domain	Number of Recommended Tools
Person-centered care	6
Medication management	10
Care coordination/transitions	17
Resident/patient outcomes	35
Workforce	28

Center for Excellence in Assisted Living
http://www.theceal.org/

University of North Carolina at Chapel Hill
http://www.shepscenter.unc.edu/

Tensions and Potential Solutions

3. Financing

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Investors and operators have focused on wealthier consumers ▪ Median monthly cost is $4300 (range $3000 - $6690) ▪ Growth has outpaced other long-term care options and inflation	

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Almost half of communities are Medicaid certified but a minority of residents use Medicaid ▪ Access is limited due to waiting lists ▪ Payments vary widely (per beneficiary spending $1,680 - $108,400)	

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Various business models exist; most communities are for-profit ▪ Single owner and operator ▪ Provide services and lease real estate	Promote new models that link housing, primary care, care coordination, and financing ▪ PACE ▪ Medicare Advantage

Tensions and Potential Solutions

4. Residents

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Tension	Potential Solution
The vast majority of residents are White and non-Hispanic ▪ Diversity in race, ethnicity, and sexual orientation will increase	

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Resident acuity has increased
▪ Chronic illnesses are common
  ▪ 25%-50% those of nursing home residents
  ▪ One-quarter are hospitalized each year
  ▪ Medical care is typically provided off-site
▪ Cognitive and mental health needs are notable
  ▪ 42% dementia, 31% depression, 11% serious mental illness
  ▪ Psychosocial care is insufficient
  ▪ Segregated memory care is often ineffective	

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	Allow residents with nursing home level of care needs (regulations and Medicaid)
	Provide, coordinate, or integrate health services
	▪ Provide care on-site
	▪ Develop infrastructure
	▪ Modify payment models
	▪ Change the mindset about medicalization
	Reconsider integration

Medical and Mental Health Care in Assisted Living

- The medical complexity of residents living in assisted living has increased over the past several years, blurring the distinction between NH and AL residents
- Lack of a structured and accountable medical staff (health care team) impacts overall care
  - Quality
  - Intensity
  - Frequency

Medical and Mental Health Care in Assisted Living

AL Memory Care: Specialized unit versus integration

Medical and Mental Health Care in Assisted Living

CONCERNS

Regarding care

- Infection prevention, medication use, poor communication with staff when change in condition occurs

Regarding outcomes

- Acute and chronic conditions, falls, depression, emergency department visits, hospitalization

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Increase in nursing presence

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CHALLENGES

No guidance regarding optimal structures and processes of care

- Recognizing variability in staffing, medical records, training, regulation, services

Concern that AL not become too medicalized

- Erosion of original intent, call for federal oversight, increased cost, reduced accessibility

Developing Expert Panel Recommendations

Methods

Compiled items of potential importance to medical and mental health care

- 200 items based on literature review, advisory panel, input of panelists
- Items related to community demographics/administration, staff/staff training, nursing/related services, resident assessment/care planning, policies/practices, medical/mental health providers/care

Nineteen experts (medicine, nursing, mental health, dementia, assisted living organization, regulation), rated items in terms of importance and feasibility

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10350914/

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Resident assessment/care planning (sample items)

	Importance to Quality of Care	Feasibility (None/Some/All Communities)		
	Rate 1 - 9	None	Some	All
Conducts a formal cognitive assessment as part of resident assessment	☐	○	○	○
Conducts a standardized assessment to determine cause when a resident is agitated	☐	○	○	○

Policies/practices (sample items)

	Importance to Quality of Care	Feasibility (None/Some/All Communities)		
	Rate 1 - 9	None	Some	All
Requires all residents to have advance directives	☐	○	○	○
Has a policy/procedure requiring a visit to an emergency department after a fall	☐	○	○	○

Results: 43 Consensus Recommendations (Examples)

	Importance Mean (SD)	Percent Agree Importance ≥ 7.0	Feasibility Mean (SD)
Staff and Staff Training			
Training for any staff on person-centered care	8.89 (0.32)	100.0	2.89 (0.32)
Nursing and Related Services			
Provision of routine toenail care on-site	8.16 (1.17)	89.5	2.58 (0.51)
Resident Assessment and Care Planning			
Resident present during assessment/care planning	8.32 (1.16)	94.7	2.74 (0.45)
Conducts formal cognitive assessment	8.32 (1.11)	84.2	2.74 (0.45)
Policies and Practices			
Has a policy/procedure regarding aggressive or other behaviors	8.68 (0.58)	100.0	2.79 (0.42)
Informs responsible party if emergency department visit occurs	8.67 (0.59)	100.0	2.88 (0.33)
Discussions about advance directives occur and are documented	8.65 (0.70)	100.0	2.94 (0.24)
Medical/Mental Health Care Providers and Care			
All off-site medical/mental health visits include post-visit notes	8.59 (0.62)	100.0	2.82 (0.39)

Note: Importance scored 1 (least) through 9 (most); feasibility scored 1 (none), 2 (some), and 3 (all) communities.

A Model to Optimize Medical Care in Assisted Living Communities

- Establish a Medical Director position
  - Develop policies and procedures re: medical practice
  - Set credentialing standards
  - Attend regular meetings with Executive Director and Nursing Director
  - Paid position with clear expectations/accountability
  - Role involves staff education; infection control
  - Establish a QAPI program with PDSA template

A Model to Optimize Medical Care in Assisted Living Communities

- Medical Staff - Ideal
  - Closed (limited numbers caring for all residents)
  - Committed to PALTC
  - Regular medical staff meetings
  - On site, scheduled visitation and rounds with nursing staff
    - Frequency every 60-90 days?
    - Medicare Annual Wellness Visit
    - Collaborative practice model with physician and APP
  - 24/7 call coverage with consideration for televideo visits
  - Clearly delineated Practice Standards in policies and procedures
    - Infection control, psychotropic medication use, advance care planning
    - Clear accountability

Controversies

- Does an onsite medical staff result in over-medicalization?
- Who determines medical standards? (professional organizations? State? Federal?)
- Are existing QMs (CEAL;NCAL;Argentum) relevant to provision of medical care?
- What is the role of families and residents in determining medical services? Do they fully understand the potential differences related to accessibility and competence of the medical provider? Are they willing to pay extra for such?

What about coding in Assisted Living?

Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services

New Patient

►(99324, 99325, 99326, 99327, 99328 have been deleted. For domiciliary, rest home [eg, boarding home], or custodial care services, new patient, see home or residence services codes 99341, 99342, 99344, 99345)◄

Established Patient

►(99334, 99335, 99336, 99337 have been deleted. For domiciliary, rest home [eg, boarding home], or custodial care services, established patient, see home or residence services codes 99347, 99348, 99349, 99350)◄

Home and Assisted Living Care 2023

(Place of service codes have not changed)

"The following codes are used to report evaluation and management services provided in a home or residence. Home may be defined as a private residence, temporary lodging, or short-term accommodation (eg, hotel, campground, hostel, or cruise ship).

"**These codes are also used when the residence is an assisted living facility**, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility."

Home or Residence Services

Patient: New				
Code	**99341**	**99342**	**99344**	**99345**
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
OR				
Total Time (On Date of the Encounter)				
Minutes	15	30	60	75

Home or Residence Services

Patient: Established				
Code	**99347**	**99348**	**99349**	**99350**
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
OR				
Total Time (On Date of the Encounter)				
Minutes	20	30	40	60

Tensions and Potential Solutions

5. Nurse and Direct Care Workforce

Nurse/Direct Care Workforce

Tension	Potential Solution
More than 8 in 10 communities have staffing shortages ▪ Low wages, insufficient benefits, poor supervision, strenuous workloads, poorly designed job roles, limited career advancement, stigma ▪ Few evidence-based practices to recruit and retain staff	

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Staff training is variable, often nonspecific, and insufficient ▪ Only 40 states require training; required hours range from 1-80 ▪ Only some states specify training topics	Make training more rigorous Promote competency-based training

Summary: Tensions and Potential Solutions

Five Tensions and Twenty Potential Solutions

Tension in Assisted Living	Potential Solution to Reimagine Assisted Living
Models	• Promote consumer education using common definitions and including important details • Endorse standardized reporting • Decouple services from housing • Evaluate models in reference to person-centeredness • Consider quality measures that address social and health components
Regulation	• Create regulations in partnership with stakeholders and review them regularly • Encourage and evaluate quality improvement initiatives • Examine outcomes related to regulations
Financing	• Limit unnecessary new construction • Diversify housing options and modify services to lower costs • Provide tax incentives and public subsidies • Develop partnerships • Expand Medicaid coverage
Residents	• Coordinate health care consistent with resident acuity • Train all staff on dementia care practices • Reconsider segregated dementia care • Prepare for increased resident diversity
Nurse and direct care workforce	• Embrace strategies being recommended in nursing homes • Address training needs specific to assisted living • Establish acuity-based staffing recommendations

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