Evolution of Assisted Living in an HCBS Framework

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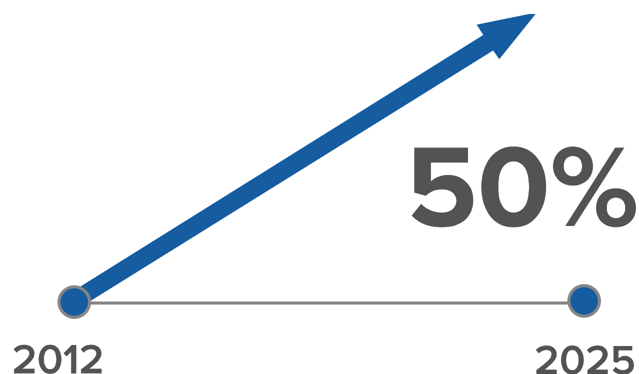
Introduction to Assisted Living

Assisted Living: Mission and Philosophy

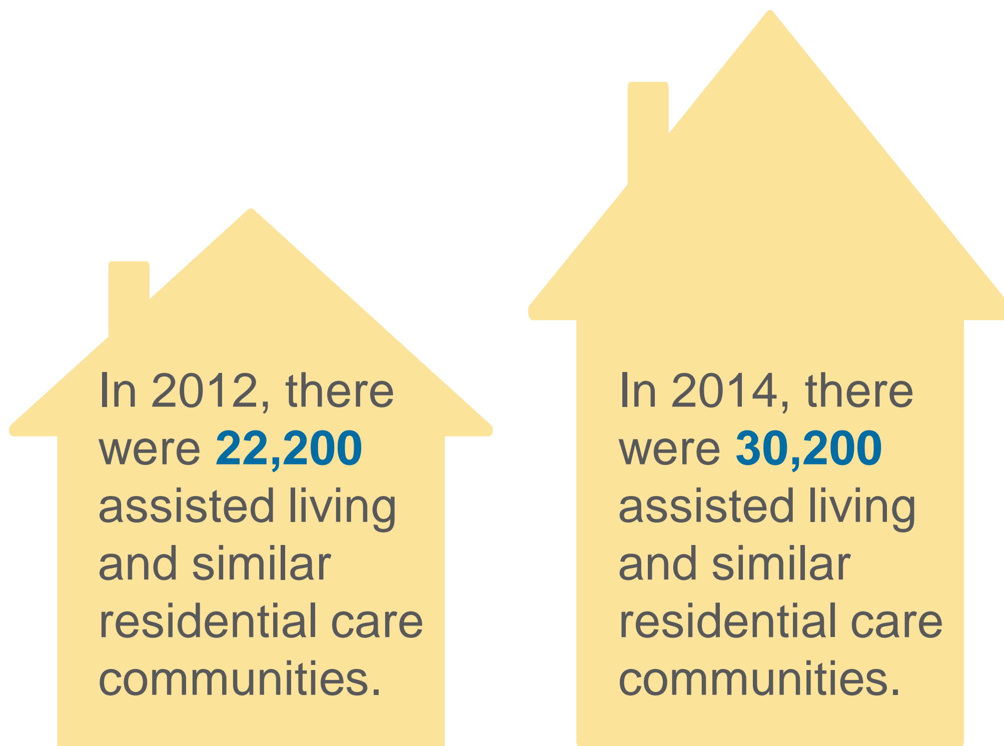
- Home and community based Alternative to Nursing homes
- Residents age with freedom of choice, independence, dignity, respect, privacy
- Quality of Life as important as Quality of Care
- Embrace Person Centered Care
- Right to make own decisions even if “ bad decisions”
- Balance safety and risk

Growth of Assisted Living Industry



There will be approximately **1.1 million daily residents at residential care communities in 2025,** an increase of 50 percent from 2012.

Argentum projections based on data from the National Study of Long-Term Care Providers (NSLTCP)

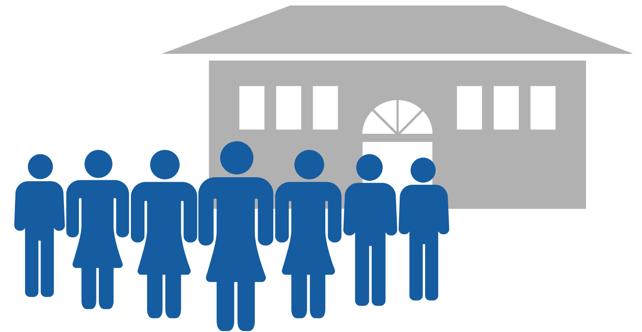


Centers for Disease Control, National Center for Health Statistics

Until the 1980s, seniors who could not live safely in their own home or with family had few alternatives to institutional care.

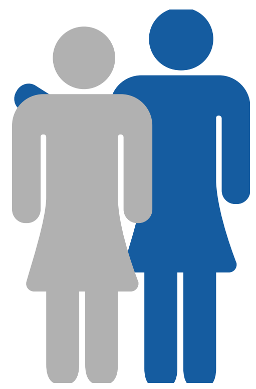
835,200 seniors

live in senior living communities.



They get assistance they need while maintaining privacy, dignity, and respect.

National Study of Long Term Care Providers, 2013 Overview



Average Assisted Living Resident Profile

- 87 year old white female
- Needs assistance with 3 ADLs
- Has 2 chronic conditions
- Needs assistance taking 9 meds daily
- Private pays for care
- Will live in AL community for 22 months

QUALITY IMPROVEMENT
AN INDUSTRY OF SERVICE

Nurturing environments that enhance the quality of life for senior living residents

10 YEARS
OF RISING ACUITY IN ASSISTED LIVING

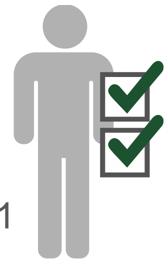
Average Age in 2001	80
Average Age in 2010	87
Average Length of Stay 2001	36 Months
Average Length of Stay 2010	22 Months

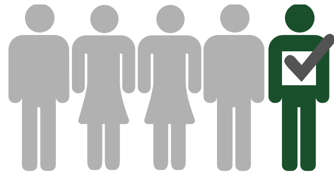
	Using a Walker	With Heart Disease	With Diabetes	Using a Wheelchair
2001	30%	28%	13%	15%
2010	45%	34%	17%	23%

NCAL, National Survey of Residential Care Facilities

QUALITY IMPROVEMENT

75% of senior living residents currently are diagnosed with at least two **chronic conditions**.[1]





High Blood pressure – 57%
Alzheimer's/ related – 42%
Heart Disease – 34%
Arthritis – 27%
Diabetes – 17%

1. Centers for Disease Control

Private Pay/ Medicaid Residents

- 81% - private pay, family supports, LTC insurance, VA benefit
- 19% Medicaid
  - 56% under age 65
  - 19% age 65-74
  - 16% age 75-84
  - 10% age 85+

Assisted Living Provider Profile

- Assisted Living is the person’s HOME
- Provide Person Centered Care: Living with Purpose
- Resident’s rights include right to be “non- compliant”
- Integration within AI community and community at large

provide physical, occupational or speech therapy

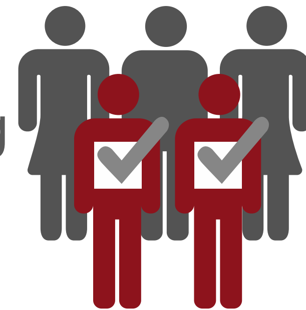
89% provide hospice care

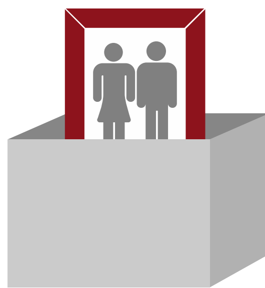
76% provide skilled nursing sevices

68% provide disease-specific programs for residents with dementia

MEMORY CARE

More than **40%** of assisted living residents have Alzheimer's disease or other dementias.





Senior living industry best practices for dementia care include building design, memory boxes, Snoezelen rooms, enhanced dining experience and custom activities.

Centers for Disease Control

CONCLUSION

- Senior Living industry will continue to grow over next 20 years as baby boomers age.
- State laws and regulations need to allow providers to meet higher acuity needs of residents in the setting of their choice.
- Provision of more care does not necessarily translate to a “medical model”.
- State laws and regulations need to be flexible enough to allow the next version of assisted living to thrive.

Health Care in Assisted Living

Medical v. Social Model

- These distinctions often are a barrier to developing an adequate system.
  - Do health requirements turn an assisted living facility into a nursing facility?
  - Or are health requirements useful in developing a model that combines a residential setting and adequate services?

Who's In?

- Originally, a bright line between nursing facilities and assisted living facilities.

- Now, admission prohibition is generally phrased in terms of around-the-clock nursing care.

Expanded Ability to Admit and Retain Residents

- Why?
  - Consumer demand.
  - Provider desire to expand potential market.
  - Lower cost of assisted living, compared to nursing facility services.
  - Legal requirements, i.e., the Americans with Disabilities Act.

“Limits” Often Malleable

- E.g., nursing care, NG or gastrostomy feeding, IV therapy, etc.
- Exceptions if, e.g.,
  - Care provided by appropriately skilled professional,
  - MD approves care provided in facility,
  - State agency issues exception, or
  - Care provided by hospice agency.

Services Often Provided by Third-Party Providers

- Home health agencies.

- Hospice agencies.

Nursing Services

- Generally not required.
  - But may be provided at facility's option.

- Some states require some level of nursing services, especially those states with multi-level systems.

Some Models Require Some Level of Nursing Services

- Oregon requires “nursing services,” which include:
  - Assessments.
  - Delegating tasks, and training staff.
  - Participating on service-planning team.
  - Teaching and counseling.
  - Intermittent direct nursing services.

Medication Administration

- The Dilemma:
  - Most residents need medication administration, but
    - State law generally requires that administration be done by a nurse or other health care professional.
    - Most facilities do not have nurses on staff.

Strategies for Facilitating Medication Administration

- Rely on staff assisting residents with self-administration.
- Have nurses delegate authority to staff members.
- Use “medication aides” who have completed training and competency testing required by state law.

Trend to Allow Non-Nurses to Administer Medication

- 36 states permit unlicensed staff to administer medications in assisted living.
  - Mostly through authority granted by state certification, although some states operate through individual nurse delegation.

Catch-Up in California

- Currently, a bright line between "social model" and so-called "medical model."
- Working with stakeholders to develop proposal.

Why Nurses Should Support Proposal

- Medication administration should be open, and should not hide under the pretense of being only assistance with self-administration.
- Since few nurses are currently administering medication in AL, change will not reduce nurse employment.
- On the contrary, the proposal will increase nurse involvement with the system.

HCBS Settings Rules for Assisted Living

Basic Standards

- Integration with Community
- Choice
  - Services and supports, and who provides them
  - Optimizes individual initiative and autonomy, without regimentation
- Rights – privacy, dignity, and respect

“Provider-Controlled Settings”

- Protection from eviction
  - Dwelling is specific physical space

- At least the protection provided by state landlord-tenant law

Privacy Rights

- Lockable entrance doors
- Choice of roommates in shared units
- Furnishing and decorating living unit

More Facility Standards

- Control of schedule and activities
  - Including access to food at any time
- Right to receive visitors
- Physical accessibility

Some Facility Protections Subject to Modification

- Modification under service plan possible for
  - Privacy (e.g., lockable doors, choice of roommate, right to decorate)
  - Control of schedule & activities
  - Access to food at any time
  - Visitors at any time

Process for Modifications

- Modification process must include
  - Consideration of alternatives
  - Periodic review
  - Participant’s informed consent

Discussion

Thinking Through the HCBS Requirements

- Integration with community – MB
- Dementia care – RG
- Locked/secured units; delayed egress – EC
- Heightened scrutiny due to co-location with nursing facility, and/or likelihood of isolation – MB

Thinking Through the Requirements (cont.)

- Locked doors – RG
- Choice of private occupancy (subject to ability to pay) – EC
- Choice of roommate – MB
- Access to food – RG
- Eviction Process - EC

Let Us Know If We Can Help

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