

Assisted Living: State Strategies for Meeting Residents' Health Care Needs

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- The Assisted Living Consumer Alliance (ALCA) is a national collaboration of groups and individuals working together to promote consumer safety, choice, and rights in assisted living.

Thanks to the California HealthCare Foundation

- This webinar is supported by the California HealthCare Foundation, based in Oakland, California.

Housekeeping

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Today

Provide an overview of how state assisted living systems meet residents' health care needs

- Brief background on residents' health care needs, and how those needs have changed over time.
- Different state strategies for meeting residents' needs.
- Information on Medicaid retroactive eligibility.

Background on Assisted Living Residents' Health Care Needs

Resident Needs Changed in the Last 10-15 Years

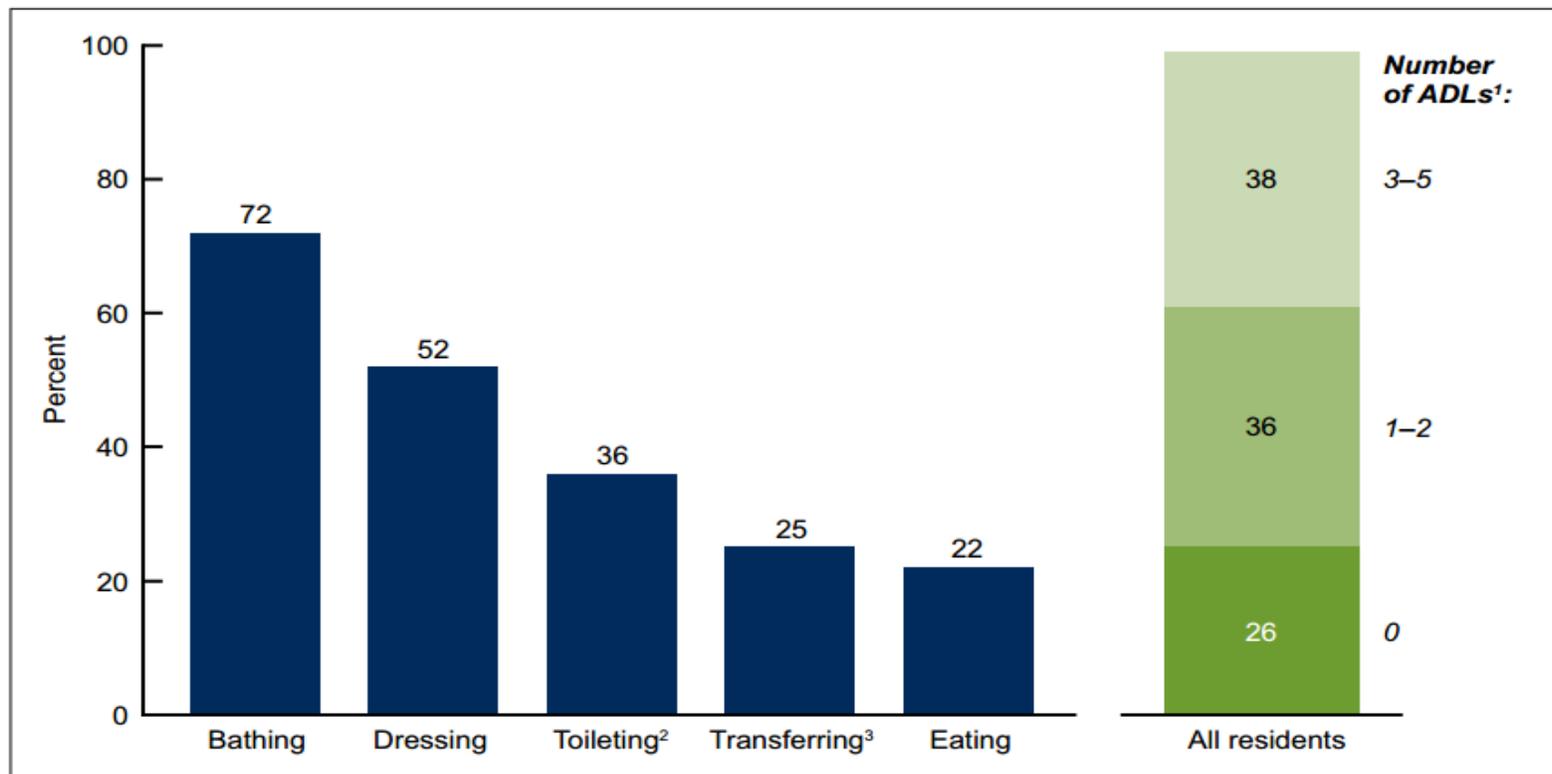
- In past, a relatively bright line between a “typical” nursing facility resident and a “typical” assisted living resident.
- Now, many persons who formerly would have required nursing facility care, instead are residing in assisted living facilities.
- More and more, assisted living facilities are caring for residents with significant care needs.

The 2015 assisted living resident has significant care needs.

- “A vulnerable population with a high burden of functional and cognitive impairment”:
 - Female, non-Hispanic white and aged 85 and over.
 - Median length of stay of 22 months.
 - 40% have Alzheimer’s disease or other dementia.

SOURCE: National Center on Health Statistics Data Brief, No. 91 (2012): <http://www.cdc.gov/nchs/data/databriefs/db91.pdf>.

Almost 4 in 10 residents receive assistance with three or more activities of daily living.



¹Activities of daily living.

²Includes 2% who receive assistance with a toileting device, such as ostomy, indwelling catheter, chairfast, or similar devices.

³Comprises 12% confined to a bed or chair and 13% receiving assistance with transferring.

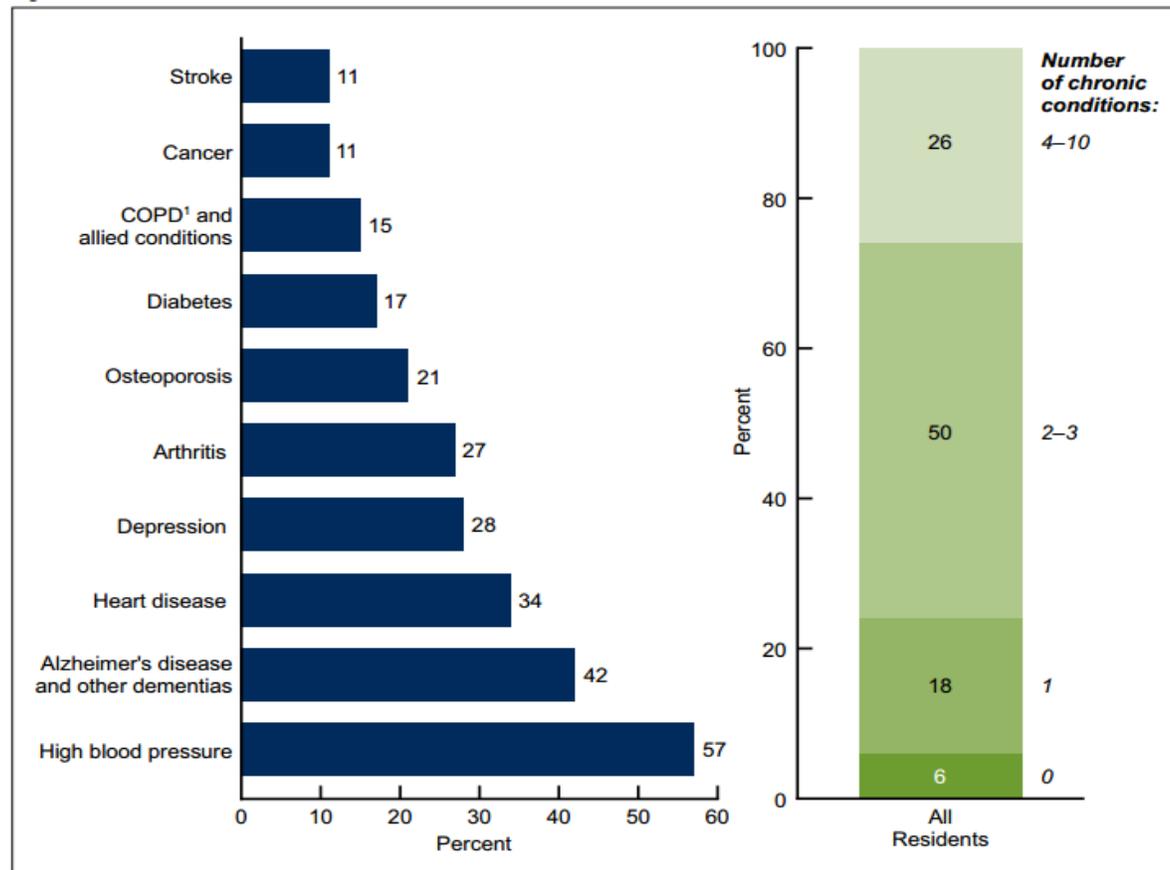
NOTE: Cases with missing data are excluded; see "Data sources and methods" section for detail.

SOURCE: CDC/NCHS, National Survey of Residential Care Facilities, 2010.

SOURCE: National Center on Health Statistics: <http://www.cdc.gov/nchs/data/databriefs/db91.pdf>.

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75% of residents have been diagnosed with at least 2-3 chronic conditions.



SOURCE: National Center on Health Statistics: <http://www.cdc.gov/nchs/data/databriefs/db91.pdf>.

State Strategies to Meet Growing Resident Health Care Needs

Important: Assisted Living laws vary from state to state

- Resources:
 - U.S. HHS, Assistant Sec’y for Planning and Evaluation (ASPE), Compendium of Residential Care and Assisted Living Regulations and Policy (2015): <http://1.usa.gov/1TDvAgU>.
 - Justice in Aging (formerly NSCLC), Best Practices in Assisted Living: Considering Potential Reforms for California (Feb. 2014): <http://bit.ly/1U8VDNQ>.

Is there a bright line between resident acuity in nursing facilities vs. assisted living?

- In the past: State assisted living regulations formerly prohibited admitting or retaining a resident who needed nursing facility care.
 - This is a less meaningful standard now.
 - Note acuity overlap between NFs and ALFs.

Overview of Sample State Strategies

- Resident admission and retention based on mobility
- Levels of care for different health care needs
- Bringing in care from a third party agency
- Expanding the role of nurses in assisted living
- Establishing specific roles for medication administration
- Introducing pharmacy review

Do states place assisted living admission limits based on resident mobility?

- In the past, mobility limitations often were a disqualifying factor for assisted living admission.
- Now, limitations often are accommodated:
 - ALFs want to expand their market, &
 - Americans with Disabilities Act (ADA) requires accommodation.

What limits do states place on admission and retention in assisted living?

- Some states prohibit admission and retention based on specific conditions:
 - Communicable disease (e.g., tuberculosis).
 - Gastric feedings.
 - Suctioning.
 - Intravenous care.
 - Stage 3 or 4 pressure sores.

What **CAN** be provided vs. What **MUST** be provided:

- Level of care ceilings generally have been raised.
- But regulations generally do not require facilities to provide services up to the regulatory ceiling.

Assisted Living facilities may offer multiple *levels of care* depending on resident need

- One-third of states recognize more than one level of care.
 - Generally two or three levels.
 - Higher levels reflect greater health care capabilities.
 - E.g., Ark. Code of Rules and Regulations, sections 016 06 001 and 016 06 002.

The case in *favor* of multiple levels of care in assisted living facilities:

- Different types of facilities require different types of standards.
- When licensing standards are drawn in a one-size-fits-all model, standards tend to drop to the lower common denominator.
- A facility maximizes its ability to retain residents by licensing at the highest level, *e.g.*, Level 3 in 3-tier system.

The case *against* multiple levels of care in assisted living facilities:

- By pigeonholing residents into specific regulatory boxes, multi-level systems force residents to move multiple times.
- Flexible licensing standards allow assisted living facilities to adjust services as necessary.

In reality, all systems are multi-level.

The real question is whether the levels are being set by the state, or by individual facilities.

Third-Party providers are commonly used to help meet residents' care needs.

- **24** states use home health agencies.
- **32** states allow hospice agencies in assisted living facilities.
 - In **19** of these 32 states, hospice care is an exception to the transfer and discharge requirements.

There is a limited provision of mental health services in assisted living facilities.

- Only **four** states require assisted living facilities to make arrangement with mental health providers:
 - AZ, NY, VA & WV.

Implementing hospice in assisted living facilities has included challenges:

- From 2007 to 2012, Medicare payment to hospice doubled.
- Compared to providing hospice in other settings, hospice in assisted living facilities provided care for longer periods of time.

See HHS OIG, Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities, OEI-02-14-00070 (Jan. 2015).

Additional challenges with relying on hospice for health care in assisted living:

- Hospice patients in assisted living facilities generally required less complex care from the hospice agencies.
- Typically < 5 hrs./week, for an average of \$1,100/week.
- OIG has identified incentive for hospices to target assisted living facility residents.

The role of nurses in assisted living facilities:

- Assessment.
- Participation in care planning.
- Coordination of care.
- Medication administration.

Some states have expanded the role of nurses in assisted living.

- In Oregon:
 - Nurses regularly scheduled for on-site duties.
 - Always available for phone consultation.
 - Nursing services required as necessary to meet resident needs.
 - **RN** performs assessments; **licensed nurse** participates in service planning and provides education.

Effectively administering medication is a component of meeting health care needs.

- Medication administration generally a task for nurses under state Nurse Practice Acts.
 - 3 primary options for medication administration:
 - **Self-administration** (often with **assistance** by staff or families).
 - Administration of medication by **nurses**.
 - Administration by **medication assistants**.

Some states limit help to “assistance with self-administration”

- Scope of assistance varies. Can be extensive, and include:
 - Reminding resident to take medication.
 - Removing medication from container.
 - Assisting the resident with taking the medication.
 - Documenting that medication has been taken.

In other states, families can offer “assistance with self-administration”

Example:

- Montana permits families to set up medications, including insulin injections.
- Louisiana permits families to transfer medications from original container to pill organizer box.
- In Utah, family signs waiver accepting responsibility for medication administration and documentation.

States have created roles for medication assistants

- **36** states permit unlicensed staff to administer medications.
- Two models:
 - Individual delegation by nurses.
 - Certification of aides.

Nurse delegation of medication administration to a med aide:

- Regulations guiding nurse delegation vary among the different states.
- Generally, the medication aide must receive some required education under the discretion of the nurse.
- Nurse also required for supervision, although the extent of this supervision will vary.

States determine the level of training certified medication aides receive

- Kansas: 75 hours, state outline of content, written exam.
- Oregon: 84 hours, state-approved curriculum, written exam.
- Texas: 140 hours, state curriculum, written exam.

State-to-state variation regarding who trains the medication aide

- Generally an RN.
- But not necessarily:
 - ME and PA, for example, each rely on a train-the-trainer model.

Use of injectable medications highlights the need for medication assistance

- **Unlicensed** staff
 - Can administer injections in **eight** states.
 - Can “assist” with injections in **two** states.
- Compare
 - Georgia: Medication aides can administer insulin and Vitamin B-12 by injection.
 - Massachusetts: Not even nurses can administer meds by injection.

More on diabetes and medication assistance:

- Important issue considering prevalence of diabetes in the assisted living population:
 - 17% of residents have diabetes.
 - The need for blood sugar monitoring and insulin injections should not necessitate a move to a nursing facility.
 - But state laws are split on whether to allow assisted living facilities to monitor blood sugar and administer injections.
 - Monitoring of blood sugar is more widely allowed than the administration of injections.

Administering PRN or “as needed” medications:

- This is questionable for a medication aide because PRN administration requires assessment, and RNs are most qualified to assess.

Pharmacist Review of Medications:

- **14** states require pharmacist review of medication records.
- High standards in Arkansas Level II facilities.
 - Quarterly reviews including:
 - Areas in which facility appears to be deficient.
 - Instances in which medication was improperly prescribed or administered.
 - Medication regimens that should be reviewed by MDs.

Pharmacist Review of Medications in Kansas:

- Quarterly review to include:
 - Lack of a clinical indication for use of medication.
 - Failure to receive prescribed medication.
 - Medications with excessive dosage or duration.
 - Adverse reactions.
 - Lack of adequate monitoring.
- Q: How meaningful are these reviews in real life?

Retroactive Coverage for Home and Community-Based Services

Retroactive HCBS Eligibility

- Federal law provides for retroactive eligibility.
 - *See* 42 U.S.C. § 1396a(a)(34)
- No exception for HCBS.
 - But federal guidance provides for coverage only after approval of a service plan.
 - *See* Olmstead Letter No. 3 (July 25,2000); CMS, Instructions, Technical Guide and Review Criteria for Home and Community-Based Waivers.

Federal Guidance on First Date of Coverage for HCBS

- All of the following must be met:
 - Medicaid-eligible.
 - Determined to need specified level of care.
 - Determined to meet waiver-specific eligibility requirements.
 - Written plan of care established.
 - Plan of care must include at least one waiver service.
 - Olmstead Letter No. #3 (July 25, 2000).

Price v. Ohio Medicaid (S.D. Ohio Sept. 1, 2015)

- Court rules that Ohio must offer retroactive coverage for assisted living services.
 - Federal guidance cannot alter the federal statutory requirement that retroactive coverage be offered.
 - Services can be provided “pursuant to” a written plan of care even if the plan of care is developed after services are provided.
 - No reason that retroactivity should be available in nursing facilities but not in assisted living facilities.

Further Advocacy is Needed on the Retroactivity Issue

- Advocacy with CMS.
- Advocacy with state Medicaid programs, including possible litigation.
 - For information, contact Justice in Aging's Eric Carlson at:
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 - ecarlson@justiceinaging.org

Questions?

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