National Assisted Living Update
Kansas Center for Assisted Living
October 23, 2014

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National Study of Long-Term Care Providers

✓ Conducted by the National Center for Health Statistics (CDC)
✓ Includes: Adult Day Centers, Nursing Homes, Residential Care Communities, Hospice, & Home Health Agencies
✓ Report available at: cdc.gov/nchs/nsltcp.htm

Geographic Distribution of Providers

Percent Distribution of Providers by Provider Type and Number of People

Nursing FTEs by Provider Type and Position

Average Hours Per Resident by Provider Type and Staff Type
Hospice Services

LTC Users: Daily Use of Residential Care

Age of Long-Term Care Users

How much does LTSS Cost in Kansas?

<table>
<thead>
<tr>
<th>Service</th>
<th>Kansas Median</th>
<th>National Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lic. Home Care</td>
<td>$43,358</td>
<td>$45,188</td>
</tr>
<tr>
<td>Adult Day</td>
<td>$18,200</td>
<td>$16,900</td>
</tr>
<tr>
<td>ALF Single</td>
<td>$44,760</td>
<td>$42,000</td>
</tr>
<tr>
<td>NF Semi-Pvt.</td>
<td>$58,400</td>
<td>$77,380</td>
</tr>
<tr>
<td>NF Private</td>
<td>$63,875</td>
<td>$87,600</td>
</tr>
</tbody>
</table>

Source: Genworth 2014 Cost of Care Survey

Major Challenges include:
- Rates often inadequate.
- Payment for AL incomplete (housing, food, utilities not covered; SSI check insufficient to fill gap).
- States rapidly shifting to managed care.
- Assisted living will need to adapt to CMS’ new rules pertaining to Medicaid waiver programs

Medicaid & Assisted Living
CMS Final Rule (1915 c, k, & i)
Executive Summary

- Flexibility to combine populations and align waiver authorization periods likely will:
  - Further foster development of managed care arrangements
  - Eliminate administrative barriers to further HCBS expansion
- Availability of a final Section 1915(i) rule with budgetary control clarifications may increase state interest
- For Assisted Living delivered under 1915(c), (i), or (k), the HCBS setting definition is improved notably over proposed rules
- New public notice and input requirements will provide new opportunities to provide input and require state responses to such input including on changes considered “Substantive”

Under the Final CMS Rule, HCBS Settings Must:

- Be integrated in and support full access to the greater community
- Be selected by individual from among setting options
- Ensure right to privacy, dignity, and respect and freedom from coercion and restraint
- Optimize autonomy and independence in making life choices
- Facilitate choice regarding services and who provides them

Additional Requirements for Provider Owned & Controlled Settings

- Individual has a lease or other legally enforceable agreement providing similar protections
- Right to privacy in the sleeping or living unit
- Lockable entrance doors with individual and appropriate staff having keys
- Freedom to furnish and decorate unit
- Control over his/her own schedule including access to food 24/7
- Individual may have visitors at any time
- Setting is physically accessible
Modifications to Additional Requirements for Provider Owned & Controlled Settings

- Must be supported by specific assessed need
- Justified in the person-centered service plan
- Documented in the person-centered service plan

Documentation of Modifications Must be Included in the Service Plan

- Specific individualized assessed need
- Prior interventions and supports including less intrusive methods
- Description of condition proportionate to assessed need
- Ongoing data measuring effectiveness of modification
- Established time limits for periodic review of modifications
- Individual’s informed consent
- Assurance that interventions and supports will not cause harm

Settings That are not HCBS

- A nursing facility
- An institution for mental diseases
- An intermediate care facility for individuals with intellectual disabilities
- A hospital
- Any other locations that have qualities of an institution
Settings Presumed NOT to be HCBS

- Settings in a publicly or privately-owned facility providing inpatient treatment
- Settings on the grounds of, or adjacent to, a public institution
- Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS

Key Dates

- Published in the Federal Register on January 16, 2014
- Effective March 17, 2014
- States will have one year to submit written plans for bringing existing HCBS programs into compliance
- CMS may approve transition plans for a period of up to five years as supported by individual state circumstances
- New plans must meet the new requirements

HCBS Final Rule Implementation

- State affiliate reports are concerning:
  - Bias against rural communities
  - Bias against seniors living in ALFs/RCFs
  - Bias against those with Alzheimer’s
  - Lack of consistency/oversight of MCOs in making HCBS setting determinations
  - Net Effect: Medicaid beneficiaries will have to move to higher cost settings.
CMS Guidance on HCBS Final Rule Implementation

- Who can evaluate providers for HCBS determination:
  - Managed care organizations (MCOs)
  - Individuals receiving HCBS
  - Consumer advocacy group representatives
  - The state itself

CMS Final Rule Implementation

State Remedies - Provider Compliance

- Revised training requirements or programs
- New rules, laws, provider qualifications or licensing standards
- Changes to the facility or program operations to ensure Medicaid beneficiaries have options that are considered person-centered
- Plans to relocate individuals into approved HCBS settings

CMS Final Rule Implementation

Provider Level Remedies

Program changes to assure greater resident control over critical activities such as:
- Access to meals
- Roommate choice
- Activities in the larger community
- Engagement of family and friends
- Resident employment opportunities
CMS Guidance on Heightened Scrutiny

If using heightened scrutiny, states must have in their plans:

- Evidence sufficient to demonstrate settings do not have institutional characteristics
- Evidence that the setting meets the HCBS requirements
- Evidence of a site visit
- State input
- Information collected in the public input process
- Information provided by other stakeholders
- CMS site visits also possible

CMS HCBS Final Rule Implementation

How states will ensure provider compliance with HCBS final rule:

- Self assessments
- Provide information to state
- State assessments of individual settings

CMS Resources

- Website: www.medicaid.gov/HCBS
- Four Fact Sheets & the Rule are located on the Web site
- Mailbox for Questions: HCBS@cms.hhs.gov
NCAL's Policy Priorities

- Keep Regulation at the state level
- Implementation of the new CMS’ definition of Medicaid HCB settings
- Protect, Improve Medicaid Coverage
- Ensure that AL thrives in an episodic payment/ACO Environment
- Help Members navigate health care reform
- Make the move to EHRs
- Demonstrate that we can manage quality
- Diabetic testing supply issues

Innovative Survey Models

- Colorado: On Jan. 1, 2013, the Assisted Living Residence (ALR) program began conducting risk-based re-licensure inspections, initially on a pilot basis.
  - Under the new system, ALRs meeting the following criteria will be eligible for an extended survey cycle: licensed for at least three years, and, within that prior three years, having had no enforcement activity, no pattern of deficient practice, and no significant deficiency cited in response to a complaint that negatively affected the life, health, or safety of residents.

Innovative Survey Models (2)

- New Jersey: In 2012, the state Department of Health (DOH) collaborated with The Health Care Association of New Jersey Foundation to create a voluntary program titled Advanced Standing. To receive the department’s distinction of Advanced Standing, a facility must comply with all applicable local, state, and federal regulations as well as submit quality data that reaches benchmarks established by a peer review panel.
  - A facility participating in the program does not receive a routine survey by DOH. However, any time a facility falls below DOH standards, such as poor performance on a complaint investigation, that facility can be removed for cause from the program by DOH. In addition, DOH provides follow-up surveys based on a random sample of facilities that participate in the program. The program is open to all licensed assisted living residences and comprehensive personal care homes.
Innovative Survey Models (3)

Other Innovative Assisted Living State Oversight Models:

- **North Carolina** recently extended survey cycle to two years for “Four-Star” assisted living facilities. Those with highest rating can be inspected every two years instead of annually.
- **Wisconsin** has abbreviated survey for consistently good performers (based on outcomes reported to the state).
- Many state agencies continue dealing with limited resources, personnel changes.

Federal Regulation of AL

- Over the past years, the U.S. Senate Aging Committee has focused several hearings on AL quality of oversight.
- In 2012, Sen. Bill Nelson (D-FL) considered introducing disclosure legislation after Florida legislature failed to act following a breakdown in the state’s AL regulatory system detailed by Miami Herald series.
- Sen. Nelson now chair of Aging Committee and AL likely to be a focal point of committee attention.
- “Frontline” investigative report on AL aired July 2013 and may increase scrutiny by the media. California is a focus.

Navigating the New Alphabet Soup

- ACO
- MCO
- OIG
- ACA
- HIT
- EHR
- EMR
- HIE
- HIE (but now you call me “HIX” if you mean insurance)
- LTSS
- Response: (LOL, OMG,)
Accountable Care Organizations

Advice from Hospital Sector Analysts...

• Engage Early
• Bring Data
  • Hospital Discharges
  • Discharges to their Hospital
  • DRGs (Resident conditions)
• Make an Investment (time & money)

ACOs will narrow who they work with and increase volume with their partners

Quality has Become and Will Continue to be a Reimbursement Issue

✓ Reimbursement tied to outcomes
✓ Examples:
  ▪ ACO’s
  ▪ Medicaid P4P
  ▪ Changing consumer expectations
✓ The key is the ability to adjust to metrics payers care about
✓ This will vary by market

Federal Agencies with Initiatives Impacting Assisted Living

• OIG looking at Hospice Care in Assisted Living
• CDC-- Infection Control + Hepatitis B Outbreaks
• AHRQ—LTSS Public Reporting
• DOL Wage and Hour Enforcement
• NLRB — Changes to Unionization Rules
• OSHA – Increased Tracking of Workplace Injuries
Federal Agencies with Initiatives Impacting Assisted Living

- DEA – Disposal of Controlled Substances
- EPA Disposal of Medications
- FDA Disposal of Narcotics and Fentanyl patches
- CPSC Ban on Portable Bedrails in Assisted Living
- CMS Implementation of the Final Definition of HCB Setting
- EPA Energy Star Program
- CFPB Efforts on Senior Fraud and Scams

Fair Labor Standards Act Enforcement Continues in LTC Settings including AL

- Working before and after shifts
- Working during an employee’s scheduled meal break including interruptions of short duration
- Employees not being paid for staff meetings and compensable training session

Why the violations?
- Lack of understanding of the FLSA
- “We did it that way the last place I worked”
- Caring employees
- LTC culture and environment

LTC Specific Fact Sheets are Available at: www.dol.gov/whd

- #31 Nursing Care Under the FLSA (Guidance applicable to all provider types)
- #52 Youth Employment
- #53 Hours Worked
- #54 Calculating Overtime
Health Information Technology will Transform Assisted Living and All Health Care

- EHR: electronic health record – across health care organizations
- EMR: electronic medical record – within a health organization
- eMAR: technology that automatically documents the administration of medication into certified EHR technology using radio frequency ID or bar coding
- HIE: health information exchange across providers, purchasers, regulators
- HIE→HIX: health insurance exchange
- m-Health: health care through mobile devices

What Does Interoperability Mean?

✓ Basic interoperability: ability to electronically communicate health data
✓ Semantic interoperability: enable the receiving computer to display the text or data received AND accurately interpret the meaning of the data
✓ Levels of Interoperability:
  - Non-electronic data (paper)
  - Machine transportable data (fax/e-mail)
  - Machine-organizable data (structured messages, unstructured content – documents and images)
  - Machine-interpretable data (structured messages, and standardized content) – Ultimate Goal!

New Architectural Guidelines Published in June 2014

✓ Published by the Facilities Guideline Institute
✓ Titled: Guidelines for Design and Construction of Residential Health, Care and Support Facilities
✓ Developed through consensus and NCAL was the only organization with provider members who served as advisers
✓ Emphasize person centered care & homelike environment
✓ Order at www.fgiguidelines.org/fpstore. Cost is $200 per copy.
Do you agree or disagree with the following statement: “Patients and residents receive high quality care in today’s assisted living communities.”

<table>
<thead>
<tr>
<th>Year</th>
<th>Strongly Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Strongly Disagree</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>55%</td>
<td>20%</td>
<td>11%</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>2013</td>
<td>47%</td>
<td>23%</td>
<td>13%</td>
<td>5%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Where would you want your 30 days of therapy to take place?

<table>
<thead>
<tr>
<th>Location</th>
<th>2012 Percentage</th>
<th>2013 Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>15%</td>
<td>16%</td>
</tr>
<tr>
<td>Nursing home</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Skilled nursing &amp; rehab center</td>
<td>68%</td>
<td>63%</td>
</tr>
<tr>
<td>Assisted Living</td>
<td>16%</td>
<td>18%</td>
</tr>
</tbody>
</table>

Liability: CNA Analysis of Allegations at Assisted Living Facilities

Highest Frequency Closed Claims:
- Resident fall 46.2%
- Abuse 9.5%
- Pressure ulcer 7.7%
- Elopement 7.1%
- Improper care 7.1%

Death occurred in 37.3% of the closed claims associated with falls.

*Aging Services 2013 Data Analysis Supporting the Need for Industry Changes.*
Liability: CNA Analysis of Allegations at Assisted Living Facilities (2)

Allegations at AL Facilities

Highest Average Total Paid for Closed Claims:

- Gross improper care $541,908
- Elopement $378,312
- Failure to follow physician’s order $360,939
- Delay in seeking medical treatment $256,309
- Pressure ulcer $251,370

“Aging Services 2012: Data Analysis Supporting the Need for Industry Change,” CNA.

Liability: CNA Analysis of Injuries at Assisted Living Facilities

Injuries at AL Facilities

Highest Frequency Closed Claims:

- Death 37.3%
- Fracture(s) 32.5%
- Pain and suffering 6.5%
- Emotional distress 4.1%
- Contusion/bruise 4.1%

“Aging Services 2012: Data Analysis Supporting the Need for Industry Change,” CNA.

Liability: CNA Analysis of Injuries at Assisted Living Facilities (2)

Injuries at AL Facilities

Highest Average Total Paid for Closed Claims:

- Death $291,060
- Emotional distress $230,926
- Contusion/bruise $215,590
- Loss of limb/amputation $188,080
- Fracture(s) $174,469

“Aging Services 2012: Data Analysis Supporting the Need for Industry Change,” CNA.
**HealthCap Resolved Claims**

2001 – 2011

<table>
<thead>
<tr>
<th>Common Causes</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fractures/Head Injuries</td>
<td>47%</td>
</tr>
<tr>
<td>Minor/No Injury</td>
<td>31%</td>
</tr>
<tr>
<td>Sudden/Unexpected Death</td>
<td>6%</td>
</tr>
<tr>
<td>Pain/Suffering</td>
<td>3%</td>
</tr>
<tr>
<td>Burns</td>
<td>2%</td>
</tr>
<tr>
<td>Sexual Assault</td>
<td>2%</td>
</tr>
<tr>
<td>Pressure Ulcer</td>
<td>1%</td>
</tr>
</tbody>
</table>

**Average Paid for Closed Claims**

- Choking: $214,168
- Burns: $203,580
- Unexpected Death: $145,470
- Pressure Ulcer: $133,503
- Pain & Suffering: $92,050
- Sexual Assault: $63,769
- Fractures/Head Inj.: $49,416

*HealthCap (2001 to 2011 Data)*

**What Led to the Litigation?**

Source: “HealthCap Data based on resolved claims from 2001-2011 for residential care/assisted living/independent living

**Common causes:**

- Fractures and head injuries primarily due to falls
- Sudden/unexpected deaths due to unnoticed change of conditions, elopements, bedrails and medication errors.
- Burns due to cigarette smoking and inappropriate use of hot packs
What are the common juror attitudes?

NCAL Risk Management Resources

ncal.org …community operations…risk management

Tools:

- Litigation Risk Management
- Motorized Mobility Aides
- CPR Policy
- Active Shooter

New Federal Resources About Senior Fraud and Scams

New Resource Center on NCAL’s Consumer Page

- Senate Special Committee on Aging’s Anti-Fraud Hotline and Website
- Consumer Financial Protection Bureau’s “Protecting Residents from Financial Exploitation” manual for NF and AL residents
- Federal Trade Commission’s “Pass It On” campaign
  - Identity theft
  - Imposter scams
  - Charity Fraud
  - Health care scams
  - Paying too much
  - You’ve won” scams
- NCAL continues working with these agencies
Consumer Financial Protection Bureau’s Four Pillars of Successful Intervention

- Prevent – through awareness and training
- Recognize – spot the warning signs and take action
- Record – document your findings
- Report – tell the appropriate authorities and trigger responses

Senate Aging Committee’s Top Reported Senior Phone Scams

- Jamaican Lottery Scams
- Tech Support Scams
- Grandparent Scams
- Tell your residents and families –
  - Most scammers are calling from overseas
  - They use spoofing technology to look legitimate & local

Other Senior Scams

- Precious metals scam
- Law enforcement scam
- Government grant scam
- Medical alert scam
- Debt collector scam
- Charity scam
- Publisher’s Clearing House (buying more magazines does not increase your chances of winning)
Senate Aging Committee on Identity Theft

☑ Tell residents that they are targets (families too)
☑ Teach residents to shred
☑ Tell residents to never give out personal information to anyone who initiates contact with them
☑ Limit which employees have access to what information
☑ Minimize how much information is kept at your community & eliminate unnecessary retention of personal information

Rising Acuity: Meeting the Challenges

☑ With increasing acuity of AL residents it is important to be able to provide quality care
☑ Data collection will be key in identifying areas your community is excelling in and areas that need improvement
☑ Health care is rapidly changing to integrated health care models such as ACOs
☑ Hospitals are concerned with readmission penalties and looking to partner with providers with low readmission rates

The Quality Initiative for Assisted Living
NCAL Quality Initiative Goals

- Safely reduce 30-day hospital readmissions by 15% by 2015
- Maintain nursing staff turnover below 30% until 2015
- Maintain customer satisfaction above 90% by 2015
- Safely reduce the off-label use of antipsychotics by 15% by 2015

INTERACT for Assisted Living

- Overview
- Quality Improvement Tools
- Communication tools including Stop & Watch, SBARs and tools for communication between the AL and hospital
- Decision Support Tools including Change in Condition Cards and Care Paths

Interact.fau.edu

Tips on implementing Stop & Watch

- Stop & Watch
  - Send staff to learn from another facility using tool
  - Pilot test 1 team on 1 unit
  - Let team decide how to use stop & watch
  - Meet with pilot team daily for feedback
  - Make changes based on feedback
- Start with CNA – Nurse using
  - Gradually expand to other staff, then to families
  - 6 months to successfully roll out Stop & Watch

Interact.fau.edu
**Tips on Implementing Stop & Watch**

- Need to work with staff to remind them to complete stop & watch
- Need to work with RN's to follow-up on submitted stop & watch
- Look at stop & watch forms (or lack thereof)
- Engage Physicians
  - Support notification of MDs/NPs on early signs

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**SBAR for Antipsychotics**

**SBAR for Assisted Living**

<table>
<thead>
<tr>
<th>Physician/NPI</th>
<th>Communication and Progress Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>To Discuss Possible Drug Reduction for an Individual</td>
<td></td>
</tr>
<tr>
<td>Antipsychotic Drug for SSRI Label Use</td>
<td></td>
</tr>
<tr>
<td>Before Filling the MSE/NPIA</td>
<td></td>
</tr>
<tr>
<td>✗ Review the resident and complete the SBAR form</td>
<td></td>
</tr>
<tr>
<td>✗ Check VS, BP, pulse, respiration, neurological check, lung sound, temperature, and pain</td>
<td></td>
</tr>
<tr>
<td>✗ Review Chart for</td>
<td></td>
</tr>
<tr>
<td>High risk conditions and to be hospitalized</td>
<td></td>
</tr>
<tr>
<td>✗ Antidepressant or psychiatric progress notes</td>
<td></td>
</tr>
<tr>
<td>✗ Notes on possible drug side effects</td>
<td></td>
</tr>
<tr>
<td>✗ Financial medication reaction issues</td>
<td></td>
</tr>
<tr>
<td>✗ Be prepared to stall on drug changes, changes in tapering/tope and potential side effects</td>
<td></td>
</tr>
<tr>
<td>✗ Have relevant information available when reporting medication for including doses, methods, and (if necessary)</td>
<td></td>
</tr>
<tr>
<td>✗ Be prepared to have a list of all medications, including PINS, and the individual's medical record</td>
<td></td>
</tr>
</tbody>
</table>

S

**Situation**

The drug and behavior (if problematic) I am calling about is:

- Drug name:
- Date of the last antipsychotic and dosage change

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**“In God we trust, all others bring data” — Elements of Statistical Learning**
What is a PSO?

- PSOs serve as a group of independent, external experts who can collect, analyze, and aggregate Patient Safety Work Products locally, regionally, and nationally to develop insights into the underlying causes of patient safety events.
- Communications with PSOs are protected from disclosure to allay fears of increased risk of liability because of collection and analysis of patient safety events.
- PSOs are certified by the Agency for Healthcare Research & Quality (AHRQ)

Benefits of Partnering with a PSO

- Improve safety and quality leading to better resident outcomes
- Participate in a non-punitive reporting system that is designed to reduce or minimize harm to residents
- Contribute to national safety initiatives
- Reduce liability costs and exposures
- Detect and address emerging quality issues as they arise
- Data for the AHCA/NCAL Quality Award Program

What Data will the PSO Collect?

- Demographics
  - Number of residents with dementia at the end of the target month
  - Number of residents with mental health diagnosis other than dementia or depression
  - Average age of current residents at the end of the month
What Data will the PSO Collect?

- Falls
  - Process measure: Initial assessment for fall risk
  - Outcome measure: falls with harm resulting in hospitalization
- Pain Management
  - Outcome: Pain unrelieved by medication
- Pressure Ulcers
  - Process: Pressure ulcer risk & skin assessment
  - Outcome: in-house acquire pressure ulcers

What Data will the PSO Collect?

- Infection Control
  - Process measure: Number of residents receiving influenza vaccine
  - Outcome measure: Reported urinary tract infection
- Medication Management
  - Process: Incidence of off-label use of antipsychotics
  - Process: Prevalence of off-label use of antipsychotics
  - Outcome: Medication errors

What Data will the PSO Collect?

- Unplanned Hospitalizations
  - Process: residents screened for risk of hospital admission
  - Outcome: number of all-cause, unplanned hospitalizations
- Hospice:
  - Process: number of residents with advanced directives
  - Outcome: number of residents enrolled in hospice
What Data will the PSO Collect?

- Elopements
  - Outcome: cases of elopement
- Depression
  - Process: number of residents screened for depression within 14 days
  - Outcome measure: number of residents who were referred for f/u

PSO Data Collection
PSO: The Cost

<table>
<thead>
<tr>
<th>Units</th>
<th>Cost Per Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 or less units</td>
<td>$35 per unit with a $250 minimum</td>
</tr>
<tr>
<td>26 or more units</td>
<td>$35 per unit with a maximum annual compensation of $3,500</td>
</tr>
<tr>
<td>Multi-community Entities (+100+ units)</td>
<td>$3,500 for the first 2 communities plus $800 for each additional community</td>
</tr>
</tbody>
</table>

*Note that multi-community entities with less than 100 units will pay $35 per unit with a maximum annual compensation of $3,500.

Units: A residential unit is defined as a separate apartment or unit for one or more persons. Such unit may include its own kitchen, bathroom, and sleeping area or bedroom.

Learn More & Sign Up

Want to learn more or sign up for the PSO? Visit ncalpsa.org
Questions about the PSO?

Lindsay B. Schwartz, Ph.D.
Director, Workforce and Quality Improvement
1201 L Street N.W. Washington, DC 20005
202-898-2848
lschwartz@ncal.org

• We are embarking on era of tremendous change that will transform traditional assisted living operations
  • Increased focus on health care
  • More physician involvement
  • Hospitals, MCOs and ACOs will steer
  • Staffing (quality and quantity)
  • Quality performers will win…But only if they prove their success with data
  • Diversification and specialization
  • New affiliations and partners

Final Thoughts on the Future…

Questions?

www.ncal.org

Dave Kyllo – dkyll@ncal.org