LONG-TERM CARE SUPPORTS FOR ALZHEIMER'S AND DEMENTIA FROM THE REGULATOR'S POINT OF VIEW

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Cabinet for Health and Family Services
August 1, 2019

FOOD FOR THOUGHT

The goal of this presentation is to inform the task force of issues we have observed in residential care below the level of nursing facility care. This is a creative exercise and should be viewed as "food for thought" that may generate ideas for transitioning the care continuum.

OIG would, of course, involve all stakeholders and industry representatives before moving forward with any significant change to the care continuum.

HOW LONG-TERM CARE IS PROVIDED TO INDIVIDUALS WITH ALZHEIMER'S & DEMENTIA

--Home with assistance of family or informal caregiver

--Home health agency and private nursing services can assist individuals in their homes or other residential settings, including provider types that do not provide skilled nursing (assisted living, personal care, independent living)

--Residential care community (differences in nomenclature, but in Kentucky this is assisted living, personal care, independent living)

--Nursing facility care SNF/NF (reimbursement distinction), "nursing home", intermediate care facility, Alzheimer's nursing home

--Hospice provider or hospice in the home

National Center for Health Statistics: percentage of individuals with Alzheimer's or Dementia receiving care from the listed provider type

Percent of nursing facility residents: 47.8% (2016)

Percent of hospice patients: 44.5% (2015)

Percent of residential care community residents: 41.9% (2016)

Percent of home health agency patients: 32.3% (2015)

Percent of adult day service center participants: 30.9% (2016)

WHAT WE SEE

DRAMATIC INCREASE (10-15 YEARS) IN ALTERNATIVES TO NURSING FACILITY CARE IN THE "RESIDENTIAL CARE COMMUNITY" SETTING. REASONS INCLUDE:

--Increasing cost of nursing facility care. Avoidance of spend down for Medicaid NF eligibility;

--Differing reimbursement structures depending on level of care (100 day SNF, Medicaid spend down NF, LTC insurance);

--Avoidance of "nursing facility" label;

--Effective marketing with a controlled message by residential care providers;

--Flexible market with no certificate of need and significantly reduced regulatory burdens;

--Ability to cater to a niche population ("senior living", "dementia care", "supportive services");

--Perception of greater resident independence;

--Change in assisted living statutory definition and scope in 2000.

WHAT WE SEE (cont.)

CHANGE IN KENTUCKY'S USE OF ASSISTED LIVING AND PERSONAL CARE FACILITIES

--Individuals with Alzheimer's and other dementia are living longer in residential care settings.

--Providers are finding creative options for care.

--Significant differences in approach nationwide for assisted living and other residential care settings. Most states define assisted living as a health care model, rather than a "social" model.

A SEA CHANGE

The Legislature amended the assisted living law effective July 14, 2000 by:

--Replacing voluntary certification with mandatory certification;
--Developing additional standards; and
--Moving away from a purely social model to a quasi-medical model.

New requirements added in 2000:

--3 meals;
--Assistance with ADLS and IADLS;
--Assistance with self-administration of medications;
--Requirement of scheduled activities; and
--Authorization of “special programming” (not defined).

OTHER FACTS

--The course of illness is such that we know with certainty Alzheimer's and dementia clients will eventually need supervision, ADL assistance, and other supports due to decline in cognition.

--Kentucky law does not fully embrace the provision of healthcare in an assisted living facility, although many states do and some have moved past purely private pay model to include covered services (but not room and board):

- --39 states have HCBS waivers
- --12 states have 1115 demonstration waivers
- --3 states have state plan home and community-based services
- --9 states have general fund plans
- --8 states have other plans

--Kentucky is one of three states that do not provide any Medicaid funding for residential care (Kentucky, Louisiana, West Virginia).

WHAT IS THE DIFFERENCE?

Kentucky's personal care standards are dated and inadequate. Likewise, Kentucky's assisted living standards are insufficient to adequately address the need for residential care for individuals who require limited health care supports, but who do not need high intensity nursing care, have an unstable medical condition, or require skilled care.

--Kentucky should modernize its residential community standards to enable individuals who enter care with nearly full cognition to age in place in a setting that meets their non-skilled needs.

--Personal care and assisted living currently focus on the provision of supervision, personal care, and basic health services.

Ironically, current regulation and statute for the social and health models are similar

ONE OPTION

--Recognize that Kentucky's "social model" for assisted living is too restrictive and differs from other states' models.

--The focus should be on the continuum of care and should enable a resident to age in place as long as possible and avoid discharge until clinically unstable or in need of high intensity nursing services.

--Combine current concepts in PCH and AL and create a single congregate care model that is tiered and focused on the provider's ability to provide care as the client ages in place.

--Carve out the existing PCH regulations and amend for free-standing facilities that provide services primarily to individuals with serious mental illness.

--The "assisted living" model that most resembles this structure has been adopted in Florida. Possible tiers under one licensure umbrella include the following:

1. Standard Assisted Living
2. Limited Nursing Services
3. Extended Congregate Care
4. Limited Mental Health

ONE OPTION (cont.)

The Extended Congregate Care model may include continued stay with exceptions to admissions criteria, for example:

1. A resident may be bedridden for up to 14 consecutive days.

2. A terminally ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:
   a. The resident qualifies for, is admitted to, and consents to the services of a licensed hospice that coordinates and ensures the provision of any additional care and services that may be needed;
   b. Continued residency is agreeable to the resident and the facility;
   c. An interdisciplinary care plan, which specifies the services being provided by hospice and those being provided by the facility, is developed and implemented by a licensed hospice in consultation with the facility;
   d. The provider has the ability to meet the resident's needs; and
   e. Documentation is maintained in the resident's file.

PLAN DETAILS

--The newly-designed "assisted living" provider type would share similarities with our existing AL and PCH models and include the provision of housing, meals, and one or more personal care services (e.g., assistance with ADLS and self administration of medication).

--From there, the AL will be tiered from standard AL and specialty AL.

--Admission criteria would still require the resident to perform activities of daily living with supervision if needed, be able to transfer with assistance if needed, be capable of taking medication unless the facility employs a trained nurse, not be bedridden, not be a danger, and not have any special needs that cannot be met by the facility.

--Would not permit admission or stay when complex medical needs are present (suctioning, tube feeding, monitoring of blood gases, treatment of surgical incisions, 24 hour supervision, etc.)

Questions or comments?