Experts' Roundtable

There is increasing pressure to regulate assisted living (AL) facilities in a manner similar to the way that skilled nursing facilities (SNFs) are currently regulated. What impact do you think this would have on quality in AL?

Linda Hollinger-Smith, RN, PhD, FAAN
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The growth in the AL industry has significantly expanded options for older adults needing care and services, making it possible for them to remain independent and active in a residential setting. Most families of older adults living in AL settings are pleased with the many benefits for their loved ones, including the "social" model of care, choice in services and amenities, privacy and dignity, and safety and security.

Recent national media attention on AL has not been positive with such headlines as *USA Today*'s "Havens for Elderly May Expose Them to Deadly Risks" and a CBS News investigation, "Assisted Living, Erratic Regulation." Such public notice has brought attention to quality issues in AL stemming from inadequate numbers and training of staff, medication errors, and admission or retention of residents requiring more care or supervision than communities may be able to provide.

The question of how regulation would impact quality in AL begs the additional question—what or whose regulations are we talking about? Although both nursing homes and AL facilities are inspected by department of health staff in each state, most AL providers would not view the oversight and regulations imposed on nursing homes as beneficial to their settings. Nursing home regulation and inspections are imposed by federal regulations that take a punitive approach to quality, targeting deficiencies and applying penalties or sanctions. Without federal oversight of AL, states are placed in the situation of developing licensing requirements, quality standards, and implementation procedures.

According to Michael Venzon, General Manager of Victorian Village, a senior living community in Chicago's south suburb of Homer Glen, Illinois, AL communities should strive towards building bridges of credibility and integrity with state regulators based on performance, while enhancing the "consultative" role of reviewers in AL. Working in collaboration with Life Services Network (LSN), Illinois' state affiliate of the American Association of Homes and Services for the Aging (AAHSA) and the Assisted Living Federation of America (ALFA), a number of member AL communities utilize an annual resident and family satisfaction survey program, called *Confidence*, that was developed by LSN and its members as a core component of their quality improvement initiatives. *Confidence* satisfaction survey results give voice to AL residents and families and demonstrate to state regulators the organization's commitment to quality. Additionally, customer satisfaction results have provided substantial information to offset the very limited number of AL complaints received by the state health department. Working as partners, LSN members and the state are striving to lengthen the 2-year review cycle for AL facilities. This would have not occurred without AL providers taking a proactive, collaborative view of AL regulation to ensure resident protection and quality while continuing to respond to individual preferences, choice, and independence—the basic tenets of AL.

Stephen L. Axelrod, MD
President and Chief Executive Officer
SeniorMed

I have never been a proponent of regulation and feel that if the proposed regulation mirrors that of SNFs, the AL industry will have missed the opportunity to self-regulate in a more proactive way. We have had the chance to work on risk assessment and to tailor programming to the special needs of a community or an individual resident. Regulations usually require applying standards in a homogenous manner.

However, I do believe that the quality of care in AL is inconsistent and needs guidance. Because of the regulatory burdens of multiple states and multiple state agencies—ie, AL, nursing, and pharmacy—it has become virtually impossible to apply any standards even within individual companies that span more than one state. Only a small percentage of AL providers have instituted quality monitoring measures, and few understand the value of consulting pharmacists or the medical safety nets provided by more formal programming. Therefore, I believe that the overall impact of regulation would be to enhance the quality of care. The risk is that such standards would too closely mirror the SNF industry. If that were the case, some of the most elegant benefits of AL would be lost, and the cost of providing care would begin to approximate the costs of SNFs.

The devil is in the details. Thoughtful, outcomes-driven regulation could have a positive impact on quality, whereas archaic regimentation would place the emphasis on meeting the regulations, not providing a higher level of quality care.

Scott Bolhack, MD, MBA, CMD, FACP, FAAP
Chief Executive Officer
TLC HealthCare™ Quality Improvement Organization

TLC currently performs data analysis for several AL facilities using the same techniques and analysis that we perform for SNFs. In AL facilities that do not have medical services, aging senior patients have increasing dysfunction that in turn, increases the risk of injury from falls and of infection due to the close living situations. When senior clients live in close quarters in an AL facility in which certain "medical" services (like medication administration) are *promised* (to increase census), the services must be delivered appropriately.

Although many owners of the AL facilities will resist regulation, standards (regulations) will be *necessary* to ensure that resident safety and care meet certain standards. From an ownership perspective, these properties no longer will just be part of real estate portfolios, but will begin to look and feel like another level of healthcare facilities for our senior population (*Hey, wait a minute, aren't we there yet?*) with their own set of regulations. The real change for most of the larger chains will be moving from risk management, in which the focus is on decreasing litigation, to quality improvement, in which the focus will be on improving the delivery of healthcare.

Linda C. Drummond, NHA, MSM
President
Drummond & Associates

Federal regulation of AL is a highly charged, emotional issue. Whether one is pro or con depends greatly on one's vantage point—that is, being internal or external to the industry. Regulations of any kind are only one factor in the quest for quality in any setting. The more prescriptive, restricted, and compliance oriented regulations are, the less they have to do with quality.

If we are committed to the core values of AL—what differentiates AL from skilled nursing care—then we must embed those values in a regulatory framework that is centered on the resident or person. Granted, this approach is difficult to achieve on a state-to-state basis; however, many professional and trade associations have provided model language and guidelines to assist states in developing regulations that are achievable and resident centered.

The AL industry as a whole must also commit to "hard wire" quality measurement systems into the way facilities conduct business. Many resources and models that can support facilities in the quest for quality are available, including the National Center for Assisted Living's Quality First, the Eden Alternative, and the Pioneer Network. Plus we've learned from the culture change movement in nursing homes. These models share basic principles and values that begin and end with the resident (customer) in mind. That is both the challenge and opportunity for the AL industry—to create and enhance a regulatory framework that first meets customer needs and experiences.

Robert Fusco, RPh, CCP, FASCP
Director, Government Affairs, NJ
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From a medication management standpoint, guidelines should be implemented on a national level to regulate this aspect of care in the AL setting similarly to how medication management is mandated in SNFs. In AL, most care that a resident receives involves their medications. How can we take the best care of our residents when we are not monitoring their medications? Data from AL facilities that we and other consultant pharmacists service show that AL residents take more medications than do residents in SNFs. Why? Because their medications are not being correctly monitored. Nationally, millions more dollars are spent every year to treat adverse effects of medications (inappropriate drug therapy or polypharmacy) than to purchase the medications themselves.

In SNFs, federal guidelines require a consultant pharmacist to review patient medication regimens monthly. I would like to see a federally mandated standard in the AL setting requiring a consultant pharmacist to perform a medication management review (MMR) on each resident at least quarterly. Physicians in AL facilities (like those in SNFs) should be required to consider the consultants' recommendations and respond affirmatively or negatively. Data show that when pharmacists intervene, mortality, adverse effects, and medication errors are reduced, resulting in better care of the resident, increased quality of life, and, ultimately, savings in healthcare costs.

Daniel Haimowitz, MD, FACP, CMD
Medical Director, Geriatric Assessment Program
St. Mary Medical Center

Regulating AL is extremely difficult because of the great variability in AL facilities and opposition to regulation from providers. The greater overall

question is: how do we define quality and from whose perspective? The answers would likely be different depending on whether the respondents were residents, families, facilities, owners, physicians, or surveyors.

I believe everyone agrees that we don't want to turn AL facilities into overregulated nursing homes, where all staff does is worry about doing paperwork. On the other hand, federal regulation *may* help prevent some of the abuses that are too frequently documented in local and national press. Personally, I favor development of very basic regulations based on the recommendations put forward in the report of the Assisted Living Workgroup. One important concept that would immediately improve care is a mandatory qualified pharmacist review of medications. Another is encouragement of trials to taper antipsychotic medications.

Proposed federal regulations would need to apply different standards to smaller versus larger facilities to accommodate their differences. I would also like to see a government "agency" (such as the Center for Excellence in Assisted Living) serve as a clearinghouse for novel ideas and research center to demonstrate what really works, with formalized processes to act, along with funding and authority to mandate change. "Unfunded mandates" don't work as well as official federal policy that applies to all states.

Nancy L. Losben, RPh, CCP, FASCP, CG
Chief Quality Officer
Omnicare

Healthcare regulations from federal or state governments are seldom accompanied with the funds to implement them. This is a true concern for the AL industry. Already financially stretched by the increase in minimum wage passed by the new Congress, AL facilities, faced with more regulations, may be unable to affordably provide services without passing along the cost to residents and guests.

Although Democrats are more likely to positively support reimbursement, they are also more likely to address quality of care issues through regulations. We will have to keep a watchful eye on the new Congress to determine if their oversight committees, such as Aging or Ways and Means, will support regulation of the industry.

While we all embrace the highest standards of practice to promote wellness and hospitality models in AL, regulations may be inevitable as the population grows in number and their level of needed care increases.

Barbara Resnick, CRNP, PhD
Professor of Nursing
University of Maryland School of Nursing

Regulation and policies that support regulations have been shown to be effective in changing health behaviors in areas such as wearing seat belts. I believe, therefore, that regulations are potentially a useful way to ensure quality in AL facilities *if* the regulation is one that is relevant or related to high-quality care. What we need before we establish regulations, however, is evidence of what best practice is in these sites. At the current time we do not know, for example, whether nighttime awake staff is critical in all facilities, whether mandating a consultant pharmacist or medical director in AL impacts quality of care, or what tool to use to establish safety in independent medication management. Moreover, everyone's definition of "quality care" may vary given the many stakeholders involved.

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A resident's perspective on quality may differ from a family's perspective, which may differ yet from that of healthcare providers. I would vote to use what we have learned from policy impact in nursing homes and think this through a bit, answer some critical questions through combined qualitative and quantitative research, and then introduce policies that would truly optimize quality of care in AL facilities. Once regulations are implemented, it will be just as important to monitor the utility of those policies and be open and willing to change those that provide no benefit but serve only as a burden to caregivers and residents.

Paul Willging, PhD
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Former President, ALFA and AHCA

Avedis Donabedian, in his seminal work on quality assessment,[1] posited 3 measures of quality: structure (the resources available to provide care), process (adherence to procedures), and outcomes (the results actually achieved). Our system of measuring quality in nursing homes is, unfortunately, still oriented primarily toward structure and process and less toward outcomes.

That approach has two major disadvantages, as has been pointed out eloquently by Rosalie and Bob Kane in a publication coauthored with Dick Ladd, *The Heart of Long Term Care*—to wit: "(1) The majority of the regulations are based not on empirical evidence of what activities are associated with better outcomes but on professional judgments, which quickly approach dogma. (2) Strict statements about what should be done for whom become rapidly restrictive at a time when long term care dearly needs innovation and creativity. Especially because so little has been proven about how to deliver the best care (and there is every likelihood that more than one way is available to achieve this end), it is premature to ossify the process."[2]

Yet ossify the process we have, thanks to an enforcement system that—like measurement itself—has worked counter to the very goals it was designed to foster. Just as measurement is focused on structure and process (not outcomes), enforcement is focused on punishment (rather than remediation). Punishment is a most appropriate reaction to those who have consciously abused and neglected the customer. However, for those who have *inadvertently* acted contrary to "professional judgment," punishment (certainly punishment absent any evidence of adverse outcomes) is totally inappropriate. This enforcement system has created an atmosphere in our nursing facilities, as it most assuredly will in assisted living, attractive only to those whose interests are not in professional fulfillment, but in finding a "job."

A study published by the Institute of Medicine in 2000 attributed 98,000 deaths annually in the nation's hospitals to medical mistakes. The title of that study was *To Err Is Human*.[3] That title did not minimize the seriousness of the issue, nor did the audience to which it was directed take the problem any less lightly because of it. It *did*, however, recognize the distinction between a callous disregard for customer well-being on one hand and provider recognition of the compelling need for enhanced skills and improved procedures on the other.

Let's hope we can learn from the nursing home experience and avoid the mistakes we've made there. Otherwise AL will prove little more than a nursing home under a different name. ALC

References

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