WAHSA's Assisted Living Document: A Discussion on the Differences Between Assisted Living and Nursing Homes

Members of the Wisconsin Association of Homes and Services for the Aging (WAHSA) worked tirelessly a decade ago to keep the "community" emphasis in the rewrite of the community-based residential facility (CBRF) rule, HFS 83. At the same time, we were presenting our concept of what is now the residential care apartment complex (RCAC) to representatives of the Department of Health and Family Services (DHFS) and to interested legislators.

Our members have been leaders in the provision of congregate care for the elderly and disabled and have been instrumental in the development of the programs that fall under the umbrella of assisted living (AL). Much of what they brought to assisted living care came from years of experience in providing nursing home care, both the good and the bad. They vowed to fight a regulatory environment which would attempt to mirror what they believe to be the seriously flawed nursing home survey and enforcement system.

With the creation earlier this year of a new section in the Bureau of Quality Assurance (BQA) dedicated solely to assisted living came hope and a fair amount of skepticism. While consistently stating its intent was a regulatory system in assisted living that would incorporate collaboration and best practices, one of the first acts of this new section was to hire eight nurse surveyors from the BQA Resident Care Review (nursing home) Section. Thus, both hope and skepticism: the hope that a new assisted living regulatory system will be better and improved from the system regulating nursing homes and the skepticism it will not.

In the context of discussions on the new Assisted Living Section and what it might mean, several members of the WAHSA Housing Committee noted that we speak about the differences between the philosophy of assisted living and how it should be regulated and that of nursing homes, but nowhere are those differences clearly delineated. The document you have before you is an attempt by a number of WAHSA Housing Committee members to delineate those distinctions.

This document provides the provider's perspective on the distinguishing characteristics of nursing homes, CBRFs and RCACs. It has not been endorsed by the BQA nor has such an endorsement been sought. Indeed, there may be differences in interpretation and beliefs between the state survey agency and those it surveys. But the document's authors believe this is an objective analysis, from the provider's point of view, of how the

regulations and regulatory environment which govern nursing homes, CBRFs and RCACs differ from one another. The document is intended to highlight the distinctions between these three care-settings, not the similarities, so references to the similarities generally are absent. Code citations, for instance, are referenced solely to emphasize these distinctions and therefore are not usually addressed in their entirety. Finally, this document in no way questions the statutory and regulatory responsibility of the BQA to promote and protect the health and safety of the resident/tenant through the enforcement of Chapter 50, Wis. Stats., and the enforcement of HFS 83, 89 and 132, Wis. Adm. Code, for CBRF residents, RCAC tenants and nursing home residents respectively. What the document does note, however, are areas where the BQA has greater flexibility in how they may enforce those statutes and codes.

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WAHSA Housing Committee
Assisted Living Task Force

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Purpose of the Assisted Living Task Force of the WAHSA Housing Committee

The State of Wisconsin has shifted resources into the monitoring and oversight of assisted living facilities by creating a separate section in the BQA. Early in 2003, the Bureau moved eight nurses from the Resident Care Review Section, which is responsible for nursing home oversight, into the Assisted Living Section to support the existing licensing specialists and provide closer supervision over the growing number of assisted living providers.

While the WAHSA Housing Committee doesn't necessarily disagree with these moves, there is concern that this may result in a regulatory environment similar to the nursing home survey process that we believe to be seriously flawed. Further, the Housing Committee feels there is an urgent need to clearly articulate the practical and philosophical differences between nursing homes and assisted living facilities so that BQA staff members who have transferred into the Assisted Living Section and others do not carry a nursing home bias into this environment. It was for these reasons that an Assisted Living Task Force of the Housing Committee was formed to create a document that would describe these differences.

Task Force Process

The Task Force agreed that the primary audience for the results of this process would be the BQA leadership and Assisted Living Section staff, ombudsmen, assisted living/nursing home providers, residents, families, and staff and the general public. Members of the Task Force agreed that their goal was to create a document highlighting the practical and philosophical differences between nursing homes and assisted living facilities.

The Task Force identified 10 broad categories where it was felt that it was possible to identify differences. These categories included:

-Who We Serve
-Program Philosophy
-Activities
-Meals/Nutrition/Diets
-Documentation
-Resident Competency
-Negotiated Risk
-Minimum Required and Defined Services
-Staff Requirements
-Staff Training

The Assisted Living Task Force has attempted to explain the differences between nursing homes and assisted living facilities in these 10 areas by citing actual sections of the appropriate administrative rules (HFS 132, HFS 83, and HFS 89) and, whenever possible, providing actual examples.

Resident Choice/Control in Nursing Homes versus Assisted Living Facilities

If the degree of resident choice/control is thought of as a continuum, it could be argued that RCACs provide the greatest amount of resident/tenant choice/control, nursing homes the least and, depending on the persons they are serving, CBRFs are somewhere in between. While it is difficult to find statutory or regulatory language which supports this contention, perhaps the first line of defense might be in the Authority and Purpose provisions of the codes governing nursing facilities (NF), CBRFs and RCACs.

(For purposes of clarification, it should be noted that CBRFs serve thirteen different client groups: advanced aged, alcohol/drug dependent, correctional clients, developmentally disabled, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, MA waiver contract, persons with AIDS, physically disabled, pregnant women/counseling, terminally ill, traumatic brain injury and Veterans Administration. Because of the make-up of our membership, our discussions of CBRFs refer primarily to those serving the advanced aged and persons with irreversible dementia/Alzheimer's.)

The Authority and Purpose section of the codes governing these three entities is the logical place to begin an examination of the degree of resident choice/control either allowed or encouraged. In HFS 89.11 of the RCAC code, it states that these facilities are to *"operate in a manner that protects tenants' rights, respects tenant privacy, enhances tenant self-reliance and supports tenant autonomy in decision-making including the right to accept risk"* (emphasis added). In HFS 83.01(2) of the CBRF code, it states that facilities are obligated to provide a living environment that is as homelike as possible and *"is the least restrictive of each resident's freedom as is compatible with the resident's need for care and services…and that care and services are provided in such a manner that the resident is encouraged to move toward functional independence in daily living or to continue functioning independently to the extent possible"* (emphasis added). Similar language does not exist in the statutory authority section of HFS 132, the nursing home code.

How then are the differences defined in the degree of resident choice/control in assisted living facilities (ALFs) versus NFs? Or, stated another way, what factors seem to influence the extent to which residents have control over day-to-day activities in ALFs versus NFs? (ALFs are defined to include both CBRFs and RCACs).

Before addressing those questions, there is a simple philosophy which we believe neatly conveys a key difference between the role of a nursing home and an assisted living facility. In a nursing home, "we will take care of you;" in an assisted living facility, "we will help you take care of yourself." Another distinction is in terminology: While it might appear that the terminology distinguishing a nursing home resident from a RCAC tenant is a mere case of innocuous semantics, it wasn't intended to be. The Legislature specifically referred to the occupant of a RCAC as a "tenant" to highlight the distinction between an individual who lives in his/her own apartment and has their needed health care and supportive services brought to that apartment and an individual residing in a regulated health care setting. The distinction may be slight and subtle but it was intended.

The regulatory environment and the threat of sanctions by the BQA certainly influence the extent to which providers feel comfortable allowing residents to exercise choice/control. Indeed, nursing home providers really are in no position to either allow or disallow residents from exercising choice; they don't have the authority. Resident autonomy and control are limited in nursing facilities not because that's the way nursing facilities want it or prefer it but because federal and state statutes and codes

require it, because the law demands it. All a nursing home provider has to do is permit a resident to choose a standard of care outside the scope of a "community standard of care;" the facility, by law, will be held accountable for any poor outcome regardless of the resident's choice.

In the RCAC environment, however, the tenant is able to exercise independent control and decision-making in nearly all aspects of his or her life, including medical care, largely without the need for approval from the RCAC provider. In those situations where the tenant is acting in a manner that goes against the recommendations of the facility, the RCAC code permits the parties to negotiate a risk agreement that incorporates the tenant's wishes while recognizing the provider's concerns. CBRFs stand somewhere in the middle. CBRF providers who serve residents with dementia are probably more likely to attempt to influence the decisions of residents while facilities that serve a geriatric population might be more willing to allow the resident to make decisions independently. CBRF and RCAC operators are willing, able and, in some instances, required to permit residents to exercise greater control of their lives because, unlike nursing homes, they are not hamstrung by federal oversight or limiting rules and regulations.

Families of residents in NFs tend to exert greater control over resident decision-making than they do in RCACs and CBRFs. By and large, residents who live in NFs are more physically and cognitively impaired than those living in RCACs and CBRFs and the physical losses that lead to nursing home placement often have affected the resident's ability to make independent choices as well. The RCAC code, on the other hand, assumes that the individual tenant is capable of independent decision-making since the code prohibits a RCAC from admitting anyone who has an activated power of attorney for health care or has been declared incompetent. By definition, the RCAC is intended for an individual who is capable of entering into a contract and making his/her own choices. The role of the family is primarily one of support rather than decision-making. The families of residents living in dementia-specific CBRFs are likely more actively engaged in the decision-making process than are the families of residents in non-dementia-specific CBRFs and are more closely aligned with families of NF residents. Families of residents of non-dementia-specific CBRFs are more closely aligned with families of RCAC tenants.

Resident choice/control and privacy also can be either enhanced or limited by facility design and corresponding regulations. In RCACs, apartments are required, which usually will provide their tenants with more space, functional variation of space, and privacy (e.g., choice of roommate, private bathroom, and locked door). Common space expands options for personal decision-making. CBRFs can offer increased privacy, but many don't because, unlike the RCAC statute/code, apartments are not mandated. Nursing home residents, due to federal and state statutes and regulations, frequently have little or no choice/control over space use, and options are limited.

Resident control also is dictated by the policies and procedures of the facility. By their very nature (and licensure), NFs are much more policy-and procedure-driven than ALFs. This is due partially to regulatory requirements but in large measure to the environment of NFs, which is often described as a "medical" model. Under that model, the policies which dictate how care is delivered tend to reduce the amount of choice/control residents are able to exercise in their day-to-day lives. ALFs are typically considered to be a "social" model, and provide supportive services based on resident/tenant preferences rather than facility policy considerations or requirements. Indeed, in the Authority and Purpose sections of the RCAC and CBRF codes, it is clear that both types of facilities are intended to provide living accommodations that are home-like and residential in nature rather than institutional. **Homes don't require policies and procedures; institutions do.**

A final and unique aspect of RCACs is the concept of tenant autonomy in decision-making, including the right to accept risk. Negotiated risk agreements give the tenant significant opportunity to exert

control over the most fundamental aspects of their lives. Tenants are free to make decisions, even in cases where the decision might be against the advice of family, the facility or their physician. For the most part, these choices relate to relatively simple issues – conforming to a prescribed diabetic diet, using a cane instead of a walker, self-administering medications. And yet, research clearly shows that greater personal control significantly increases the individual's perceived quality of life and well-being.

The ability and right of a resident/tenant (where appropriate) to exercise control over decisions that affect his or her everyday life is a fundamental difference between ALFs and NFs. Many ALF staff who previously worked in NFs find themselves stepping back and rethinking their approach to various resident situations. Procedures and approaches that were clearly defined in the NFs become less so in the ALF when the resident expresses his or her opinion about (or at times, objection to) an issue. That is the beauty of assisted living and the key to its operating philosophy.

Recommendations on the Assisted Living Survey Process

Members of the WAHSA Housing Committee Assisted Living Task Force fully accept the State's legal authority to provide assisted living oversight. Because State resources are limited, however, the Task Force recommends that the focus of the assisted living survey process should be on poor providers and not a broad brush or one-size-fits-all approach to facility oversight. The Task Force recommends the following process of review:

1. **Visit and tour the building.** Look at the condition of the residents. Look at the condition of the building. Smell for odors (urine, feces, etc.). Look into a couple of resident apartments or rooms. Look for an activity calendar. Page through a couple of charts to see if there is reasonable documentation (assessments, care or service plans, progress notes, etc.) – but this is only at the 35,000 foot level – not a detailed review. Look at the staff schedules. Walk through the kitchen. Walk through the dining room. Review how medications are administered.

2. **Interview several residents** and ask about their satisfaction with the facility. Are they satisfied with the way they are treated by the staff of the facility? How is the food? How are the activities? Is the building comfortable in winter and summer? Is the manager approachable? Do their concerns get addressed? Do they feel safe? Does the facility seem to operate well?

3. **Meet with several family members**, particularly in those situations where the facility primarily serves residents with dementia. Discuss their satisfaction with the facility. Are their concerns addressed? Do their loved ones seem well cared for? Are the manager and staff approachable?

4. **Ask about the availability of the services of a registered nurse**. Even though the code may not require it, is a RN available on a regular basis and is the RN a permanent staff member or under contract from an outside entity? What happens if a resident's need for nursing care increases? Who makes those determinations?

5. If concerns arise from steps 1-4, **conduct a more thorough evaluation.**

Task Force members understand that this approach is rather subjective but they believe that if it were followed, an experienced surveyor would quickly separate the facilities that need closer inspection from those that do not.

WAHSA members also promote the use of the assisted living checklists and compliance statements available online from the Department of Health and Family Services (CBRF Checklist: http://www.dhfs.state.wi.us/bqaconsumer/AssistedLiving/CBRFchoose.htm; RCAC Compliance Statement: http://www.dhfs.state.wi.us/forms/DSL/dsl2381.pdf) as helpful tools in reviewing the quality of assisted living facilities.

Finally, WAHSA members are committed to pursuing a peer assistance program under which assisted living providers offer technical assistance and quality improvement services to facilities in need. Although this concept has not yet been fully developed, the WAHSA Housing Committee Assisted Living Task Force is interested in working with BQA staff to determine if these peer-directed services can be utilized within the State's quality assurance and oversight system.

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