UPMC | University of Pittsburgh Medical Center

Testimony

Submitted on behalf of the University of Pittsburgh Medical Center

Before the
Aging and Older Adult Services Committee
Pennsylvania House of Representatives

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House Aging and Older Adult Services Committee
Proposed Assisted Living Residence 2800 Regulations, IRRC No. 14-514

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Good afternoon Chairman Mundy and members of the committee. I would like to thank you for the opportunity to speak today about the proposed assisted living residence regulations. My name is Dan Grant, I am the Vice President of Operations for UPMC Senior Communities and I am here today to present our views on the proposed regulations. UPMC is the region's largest employer, with over 48,000 employees and more than $7 billion in revenue. UPMC comprises 20 hospitals, 400 outpatient sites and physician offices, and senior care services provided through UPMC Senior Communities and Community and Home Based Services.

UPMC Senior Communities is southwestern Pennsylvania's only provider of senior housing owned and operated by an academic medical center. We offer a continuum of care which includes not only four skilled nursing facilities, but also six independent living communities, and five personal care facilities. On an annual basis, UPMC's hospitals discharge 167,363 patients, and about 25% go directly into skilled nursing facilities. Our owned facilities accept a majority of these patients. Increasingly, our skilled nursing admissions are truly "post acute", short-stay patients, who require specific skilled services before their discharge to home. It is apparent to us that many of the traditional "long term residents", can be cared for elsewhere.

During my 30 year career in healthcare I have had the opportunity to function as a critical care nurse in the civilian sector and serve 21 years in the Pennsylvania Air National Guard Medical Squadron as a nurse caring for military members in both the states and overseas. My experience includes various management and administrative positions in acute care hospitals and the long term care industry. I believe my experience provides me a unique perspective with regard to the continuum of healthcare and most importantly the basic function of what the regulations address which is the provision of quality resident care.

Over the years, certain aspects of healthcare services have shifted from acute hospitals to lower levels of care, including Long Term Acute Care (LTAC), Transitional Care units (TCU's), Rehabilitation Hospitals, Skilled Nursing Facilities and Home Health. It is not unexpected either to the UPMC Health System that the long-term resident, traditionally

found in skilled nursing facilities, can be transitioned to a lower level of care. It is in this context that we acknowledge the need for regulatory oversight of Assisted Living. We applaud the Commonwealth for adopting the goals of providing choice to consumers, of protecting our senior citizens and their families, and of assuring consistency and integrity in the industry.

We have previously submitted detailed comments on the regulatory language. I will not review all of the specifics here but as an interested and active stakeholder in senior care services we request the members of the committee consider our concerns. Our comments focus on the concern that the regulations apply a mandated approach to residential services, significant administrative burdens, and substantial increase in operation costs while having minimal effect on improving the care delivery system. Further, these regulations, while demanding significant cost increases, provide no funding of the care which has previously been provided in skilled nursing. Assisted Living is today, a private pay product. Incremental costs that result from these requirements will be passed directly to the consumers – making this a less accessible product than it is today. Moreover, the regulations promulgate a medical model environment rather than the social model atmosphere desired by consumers. The nature of the regulations is much akin to those in place for skilled nursing facilities, and in some cases more prescriptive than skilled nursing. This, we suggest, will make Assisted Living less attractive, not only from a provider perspective, but from a consumer perspective as well. While we respect the goal of ensuring quality of care and resident safety, we have concerns that these regulations will "institutionalize" a flexible alternative to long-term skilled nursing care.

The purpose of the proposed regulations was to adopt minimum standards for issuance of licensure for assisted living residences operated in our Commonwealth. From a policy perspective, moving services to lower levels of care is typically pursued as a means of public cost reduction, in this case reduced Medicaid expense in skilled nursing. To achieve this policy goal however requires policy makers to allow providers to in fact maintain a lower cost setting. In these regulations the expectation for increased service levels is not accompanied by a corresponding increase in financial support. When we contrast the proposed regulations against those designed for skilled care, many of the assisted living regulations exceed that which is required in facilities that provide the highest level of long term care. To comply with the regulations, facilities must provide higher levels of care and services, increased operational costs, higher utilization of employee resources and costly physical plant upgrades.

We realize Skilled Nursing services will not go away. They will however, continue to become more focused on acutely ill individuals – those recovering from acute hospitalization for short term stays, those suffering from significant dementia or neurological conditions, and potentially those receiving hospice care. These are the residents who generally will not come into Assisted Living facilities. We suggest that the prescriptive nature of the current regulations is designed not for the majority of our residents – those who can and want to age in place, but potentially for the minority. The more complex residents, with higher patient care needs.

The regulations identify as ***exceptions*** residents requiring tracheotomy, intermittent intravenous therapy, skilled care, stage III and IV wounds and even mechanical ventilation. We would suggest to you that care for these conditions would be provided to Assisted Living residents, much as they are for home-bound patients – through certified home health agencies, infusion therapy providers, and the like. Their skilled care would be paid through their health insurance, as it would be for a home-based patient. These services are overseen by regulations of the Department of Health. That said, the services provided directly by the Assisted Living facility, are truly personal care services, and should be regulated at that level.

While we certainly recognize the need for oversight for the purposes of resident safety, our concern is with the level of the regulations. In many ways the requirements push assisted living from a "home like" environment to one of skilled care. To safely and competently care for certain residents in assistant living and meet regulatory compliance facilities must seek higher skilled staff, expensive equipment and supplies to assure quality care. All of this is being regulated without identified funding mechanisms, which make it difficult for providers to evaluate participation in this level of care.

We have concerns about the cost increases associated with regulatory compliance. These increases include physical plant requirements, such as room sizes, which we feel should be determined by the marketplace. Also, staffing requirements, such as registered nurses and dieticians, as well as staff to provide escorts service and administrative functions, contribute significantly to the cost of services.

These increased costs of development and operations will lead to higher resident fees, ultimately leading to less access for seniors. Until the Commonwealth is able to identify a source of payment for these higher services, we should be concerned about keeping regulatory costs in check with the private pay consumer's ability to absorb them.

Other areas of concern include maintaining flexibility and resident rights. An example of this is in the bundling of services which eliminates the ability of provider to offer choice in serving resident's individualized needs.

The informed consent process should be initiated long before the standard of "imminent risk of substantial harm." No resident should be permitted to be placed in any risk of harm, regardless of imminence or whether the harm is substantial. Additional language should be added in the waiver section to include the possibility of providing a waiver for an aspect of the regulations for which the provider and resident have signed an informed consent agreement.

UPMC Senior Communities values this opportunity to provide public testimony on these regulations and appreciates your consideration of our concerns and views with the proposed regulations. We have also submitted detailed written comments which we hope you will review. As we finalize this decision making process as advocates, regulators, lawmakers and providers I want to leave you with one last comment. **We must and cannot fail the elderly of the future for they are us.**