Healthcare

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A Risk Management Resource for Aging Services | 2023 Issue 2

New Models of Care: A Look at Five Aging Services Trends and Challenges

The COVID-19 pandemic exposed systemic problems within the healthcare system, including, but not limited to, chronic staffing shortages, widespread lack of access to necessary care, and outdated and cumbersome payment systems. In response to the public health crisis, new models of care are emerging across the healthcare continuum. This new paradigm reflects advances in technology, growing consumer demand for more flexible and convenient care options, as well as the financial constraints experienced by many organizations and providers.*

No healthcare sector is immune to these forces, including aging services, which is poised to undergo transformation in the years to come. Industry leaders are taking a critical look at the spectrum of late-life care, asking how organizations can best adapt to a radically changing environment, including the migration from facility-based care to community- and home-based solutions.

This edition of *CareFully Speaking*® focuses on five trends – from artificial intelligence (AI), to higher resident acuity levels, to shifting care and reimbursement models – that are shaping the aging services industry of the future. Each trend description is followed by a set of risk management takeaways, intended to help facility administrators better understand and address emerging liability exposures.

In this issue…

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* See *Vantage Point*® 2023-Issue 2 "Evolving Models of Care: New Delivery Methods Present New Risks," a CNA resource that highlights some of the large-scale changes that will alter healthcare delivery over the next decade.

Use of AI to improve staff efficiencies.

Many aging services facilities are seeking technological solutions, including AI, as a means of reducing burdensome administrative tasks and streamlining operational processes. However, despite the efficiencies of AI applications (hereafter "apps"), it is unlikely their use will supplant the role of caregivers. Rather, AI technology can empower overstretched staff by freeing up time for resident observation, problem solving and critical thinking, as demonstrated by the following examples:

Clinical support programs. AI-driven software can help streamline documentation and minimize errors by merging disparate findings from resident healthcare information records and other clinical databases into a unified and comprehensive resident profile. AI-based analytics also can identify at-risk residents, alert staff to imminent emergencies and assist providers with clinical decision-making.

Robotic assistants. AI makes possible such innovative technology as virtual living assistants and robotic pets. Virtual assistants can perform such functions as measuring vital signs, delivering medications, checking on residents between staff visits, delivering reminders and detecting changes in cognitive status. Robotic pets may simultaneously help to reduce depression and anxiety in residents with dementia or mental illness.

Sensor technology. AI-based sensing systems – incorporating motion sensors, surveillance cameras and infrared laser scanning – have proven useful in fall mitigation programs, supplementing caregiver observation with critical resident data for more timely and accurate clinical responses. These systems also can support the diagnostic process by noting behavioral changes with clinical implications – for example, an increase in the number of bathroom visits by a resident, possibly indicating urinary tract infection.

Mobile telepresence robot (MTR) systems. MTR systems – basically HIPAA-compliant videoconferencing tools on wheels – autonomously roam from room to room in aging services environments, permitting staff to remotely check on residents. Utilizing AI features, these systems also collect and report data to families regarding resident care and health status. (See "Quick Links" on page 8 for additional information on MTR systems.)

As with any transformational technology, an overreliance on tools designed to replicate human mental functions and decision-making processes presents ethical challenges, including data privacy, safety and transparency in use, and algorithmic fairness. Before adopting AI technology, organizations should develop a structured vetting process to fully evaluate tools in terms of their ethical limits, safety and effectiveness.

Risk Management Takeaways

Aging services providers and organizations need to think strategically about the risks and hazards associated with the use of AI tools, utilizing the following suggestions to guide the policy-making process:

Strategic Planning

- **Identify the function and/or process that AI technology will potentially enhance,** and undertake a prospective AI risk analysis, including the benefits, limitations and hazards of selected AI tools.
- **Institute a long-term plan for AI adoption,** clearly communicating benefits, risks, process changes, timelines, training opportunities and performance expectations to caregivers well in advance of implementation.
- **Test selected AI tools with caregivers** prior to full-scale implementation, in order to identify system performance strengths, as well as data gaps, biases and other potential problem areas.

Error Prevention and Reporting

- **Emphasize to staff that AI is not infallible,** and questionable outputs should be challenged.
- **Establish a mechanism for reporting real and potential errors** involving AI technology, and for documenting follow-up actions.

Privacy and Security

- **Incorporate effective security measures** into AI tools and associated databases, in order to prevent improper disclosure of protected health information.
- **Perform routine risk assessments of AI systems and databases** to detect potential cybersecurity vulnerabilities and devise preventive measures.
- **Revise informed consent forms** to ensure that they address the use of AI technology and indicate the risk of privacy breaches and invalid or biased conclusions.

Greater number of higher-acuity residents.

As low-acuity residents increasingly tend to select home-based care, more aging services facilities are confronting lagging census levels. In order to maintain bed occupancy, some organizations are redesigning spaces to accommodate in-house dialysis, infusion therapy and ventilator care.

Another factor resulting in the admission of sicker residents reflects the increasing pressure on hospitals to free up bed space. Often with little notice or preparation, skilled care settings are forced to admit individuals who no longer require inpatient care, but who lack the financial and family resources, or the mental or physical capacity, to attempt home care. In response to this challenge, a growing number of aging services organizations are partnering with local hospitals in bed-leasing or "bed reservation" programs, in which hospitals pay a negotiated daily rate to facilities to hold open a certain number of skilled care beds. These partnerships serve to smooth the transition of hard-to-place patients into post-acute care settings, and also help ensure that these residents receive needed care in a timely manner.

To protect residents and reduce liability exposures associated with high-acuity care, facilities must employ a greater range of in-house provider types, including clinical specialists, geriatric nurse practitioners, behavioral health providers, and pharmacy and transitional professionals. In addition, they must maintain safe staffing numbers and provide employees with adequate training and supervision. If hiring sufficient permanent staff is impossible or impractical, organizations should consider forming long-term partnerships with temporary staffing agencies.

Risk Management Takeaways

The escalating demand for higher-acuity care has produced numerous changes for aging services settings, including the introduction of new provider types, expansion of the roles of existing staff (within the limits of applicable laws and regulations), and closer partnerships with temporary staffing agencies and local hospitals. The following strategies can help ensure that residents with complex needs receive adequate care:

Staff Readiness

- **Formulate written policies and procedures** governing the assessment and management of high-acuity residents, focusing on observation protocols, safety precautions, and documentation and communication requirements.
- **Retain full-time clinical specialists** to facilitate diagnosis and management of complex and/or chronic disorders.
- **Include geriatric specialists in staff education and in-service training programs,** especially with respect to resident assessment, reporting procedures, emergency care and documentation requirements.
- **Draft supervisory guidelines for acute care personnel,** focusing on compliance with practice protocols, quick response to unexpected situations, accurate documentation, and timely communication with providers and family regarding resident health status.

Agency Staff Safeguards

- **Convey clinical and behavioral expectations to agency staff members before the first assignment,** and ensure they have been thoroughly oriented prior to commencing resident care duties.
- **Standardize acute care protocols** to reduce undue practice variation and the potential for error in such areas as standing orders, laboratory requisitions, resident handoff reports and telehealth practices.
- **Promote ongoing two-way communication** by instituting regular staff meetings, huddles and clinical rounds.

Transitional Care

- **Seek out partnerships with local hospitals to facilitate the transfer of hard-to-place patients,** and request that these hospitals assign appropriately credentialed nurse practitioners and case managers to the facility in order to ease transitions and minimize readmissions.
- **Designate transition coordinators** to review care records and consult with treatment teams regarding relevant health information, baseline needs, medication history, and pending laboratory and diagnostic tests.
- **Require active communication between caregivers at each location** commencing at least 24 hours prior to resident transfer, and prohibit off-hour transfers to the extent possible.
- **Establish a multidisciplinary intake procedure** that includes medical directors, unit nurses and clinical specialists, and that reflects evidenced-based transitional care models and guidelines.
- **Foster a collaborative approach to residents with complex care needs,** including frequently updated care plans, sustained attention to underlying chronic conditions, multidisciplinary input from specialty providers and ongoing pharmacological management.

Development of high-tech resident monitoring tools.

"Virtual care" technologies – including wearable and implantable devices, software apps and interconnected health platforms – are poised to revolutionize aging care. By connecting data-gathering technology with analytical AI programs, aging services providers now can remotely monitor a range of acute medical conditions across a variety of settings.

While digital technology is *not* designed to replace human observers, it can potentially enhance efficiency and improve workflow. More specifically, digital and wearable technologies may help …

- **Streamline caregiver work processes** by automatically capturing routine clinical information, such as vital signs and oxygen saturation levels.
- **Partially compensate for short-term staffing deficiencies** by improving the efficiency of hourly nursing rounds with video connections and movement-tracking technology. (Notably, however, an overreliance on technology may have serious liability and compliance consequences for aging services organizations.)
- **Provide supplemental monitoring of highly vulnerable residents,** including those with Alzheimer's disease, dementia or memory loss.
- **Foster collaboration among providers** by facilitating data sharing and access.
- **Improve compliance with care directives** by issuing electronic reminders to residents.
- **Reduce hospital readmission rates** by alerting providers to early signs of clinical changes.

Risk Management Takeaways

As settings and providers increasingly rely upon digital health tools, they must be aware of relevant standards of care. The following measures, incorporated into operational and clinical routines, can help reduce the risk associated with remote monitoring:

Policy and Operational Framework

- **Clearly define the clinical functions of wearables and apps,** as well as the problem behaviors or disease states for which they can be used.
- **Incorporate wearables and apps into the facility's digital infrastructure,** linking them to electronic health records, online educational programs, resident portals, automated medication dosing tools and other systems.
- **Appoint a "tech concierge"** to answer questions about digital tools, assist residents with device set up and use, and troubleshoot technical problems.

Regulatory Status

- **Be aware of the regulatory status of devices.** In general, implantable devices are FDA-regulated, thus requiring a higher level of compliance documentation, including reporting of therapeutic failures and errors. Conversely, devices designed to maximize health and wellness – e.g., watches, bracelets, vests, glasses – typically have a lower FDA classification, such as Class I or II, and may have less stringent documentation rules. (For relevant FDA guidance documents, see Quick Links on page 8.)
- **Distinguish between those apps that make specific care recommendations or render clinical diagnoses and those that do not.** The former are more strictly regulated, requiring documentation of the rationale for their use and formal designation of the individual responsible for collecting and interpreting data. The latter – including devices that help users self-manage conditions without offering specific treatment suggestions – are often unregulated and may lead to dissemination of false information with potentially adverse health consequences for users.

Consent and Disclosure

- **Obtain and document residents' informed consent,** including, but not limited to, the benefits, risks and alternatives of remote monitoring; contingency plans in the event of system failure; confirmation that the resident understands and accepts the risks of remote care; and an explanation of how care is to be documented and data accessed.
- **Inform residents of the data security and confidentiality measures to be employed,** and alert them to potential privacy breaches notwithstanding such safeguards.

"Big Data" Management

- **Be prepared for the volume of data associated with digital technology expansion,** and develop a strategic plan for storing and analyzing large quantities of data in clearly identified databases.
- **Explain to residents the role of data analysis** in the clinical decision-making process and document these discussions in the resident healthcare information record.

Proliferation of home care.

The development of remote care technology is providing the impetus for a rapid expansion in home-based care. One example is the hospital-at-home care delivery model, which enables physicians to treat home-based patients via a telehealth link, thus minimizing the need to discharge hospital patients to skilled care or rehabilitation settings. (See "Hospital-at-Home Programs: Implications for Aging Care" on page 7.) Another emerging option is on-site virtual "nursing home" units in hospitals, which are designed to care for post-surgical patients who cannot be transferred to conventional rehabilitation centers due to staff or bed shortages.

The shift toward home and virtual care has significant implications for the aging services industry. Experts warn that up to $265 billion in services now billed by post-acute care settings for Medicare beneficiaries – representing approximately one fourth of the total – could shift to home care providers by 2025.

Risk Management Takeaways

As consumer preferences evolve and reimbursement pressures intensify, many aging services organizations are reinforcing their own home healthcare programs and/or contracting with agency-based home healthcare providers. The following tips can help improve the consistency and outcomes of home-based care, while strengthening legal defensibility in the event of litigation:

Scope of Practice

- **Ensure that job descriptions of all licensed personnel – including nurse practitioners, RNs, LPNs, physical therapists and social workers – are aligned with state scope of practice laws** and associated regulations, and that job descriptions for unlicensed assistive personnel conform to national guidelines.
- **Conduct routine audits of tasks delegated to unlicensed assistive personnel** and, if any deficiencies are noted, implement corrective plans and document these plans in personnel records.

Communication

- **Document all home care-related communications with residents and family** in the resident healthcare information record, including discussions of care provided by agency home care providers.
- **Conduct weekly video conferences or other regular meetings** between home care agencies, facility staff and family members to discuss care issues and changes in resident condition or care plan.
- **Mandate prompt communication between home care providers and the facility regarding new or changed orders,** the occurrence of falls or other incidents, and noncompliant or disruptive resident behavior.

Documentation

- **Promote sound documentation practices** that support continuity of care and responsiveness with respect to resident assessments, observations, communications and actions taken.
- **Inform staff about common documentation deficiencies,** including failure to record reexaminations, resident education sessions, and instances of resident noncompliance with health and safety recommendations.

Environment

- **Regularly perform safety assessments of residential living spaces,** documenting inspections, associated findings and actions taken.
- **Conduct and document ongoing visual inspections of common areas,** including equipment safety checks.

Resident Safety

- **Draft a policy statement on sexual misconduct and elder abuse,** focusing on response and reporting protocols, post-incident investigation procedures and follow-up action plans.
- **Establish formats and timeframes for reporting incidents to law enforcement,** state protective agencies, licensing boards and insurers, conveying these protocols to staff during orientation and training sessions.

Changing payment models.

As previously noted, the federal Medicare and state-based Medicaid programs are expected to focus increasingly on home and community care options. In fact, many industry leaders advocate giving states more freedom to support home care, thereby helping seniors remain in the residential setting of their choice.

In general, payers are moving in the direction of austerity and value-based care principles. In view of this trend, aging services organizations should expect to encounter new risk exposures and greater stringency in existing payment programs, including the following:

- The Medicare Advantage payment system, which has long declined to cover assisted living costs, proposes to pay these facilities a per-resident capitated rate in order to incentivize facilities to keep residents in-house, rather than seeking urgent or skilled care for residents with decompensating conditions.
- The Program of All-Inclusive Care for the Elderly (PACE), the longstanding managed-care payment system for frail adults aged 55 and older who prefer to live at home, makes beneficiaries predominantly ineligible for aging services care placement, rendering transitions between service models a growing challenge.
- The Patient-Driven Payment Model, the Medicare Part A reimbursement system for skilled nursing facilities, potentially places residents' access to certain therapies and other essential services at risk.
- The Patient-Driven Groupings Model – the Medicare reimbursement system for home healthcare – could potentially diminish access to home care for many beneficiaries with chronic conditions. In addition, by removing prior utilization payment thresholds (which previously worked to increase reimbursement), the program ultimately may cause aging services facilities that provide home-based services to limit therapeutic options.

Risk Management Takeaways

Providers and facilities should consider embracing value-based care concepts, forming new partnerships and networks, and expanding in-house clinical capabilities, in order to adapt to new payment systems and other emerging challenges.

Operational

- **Select well-informed staff members to educate others about upcoming changes in payment methodologies,** their potential impact on day-to-day care and the role providers play in minimizing short-term financial losses.
- **Explore promising service expansion possibilities** – such as home health and hospice care, dialysis services, ventilator care and behavioral health – and invest in data-driven systems to guide clinical care decisions.
- **Create diversified referral networks** with hospitals, home health agencies and other healthcare partners, in order to respond to lagging census levels.

Clinical

- **Refine the care-planning and care delivery process,** focusing both care plans and integrated care teams on specific disease states or acute care episodes.
- **Monitor the legal status of pandemic-era waivers and flexibilities,** especially regarding telehealth rules and reimbursement policies. (See the Centers for Medicare & Medicaid Services (CMS) website.)

The aging services industry is on the cusp of major change, both in the way care is delivered and how it is reimbursed. The description of marketplace trends and challenges in this issue is intended to spark discussion among administrators, staff members and providers about changing regulatory and marketplace conditions, as well as the need to manage and mitigate related risks. Irrespective of how technology and payment systems evolve, long-term success in the aging services field requires an unwavering commitment to resident safety and quality of care.

Hospital-at-Home Programs: Implications for Aging Care

Hospital-at-home (HaH) programs assign a multidisciplinary team to manage acute conditions, such as pneumonia, congestive heart failure, COPD, cellulitis, dehydration and urinary tract infections. HaH programs differ from traditional home care in that they are designed for managing acutely ill patients outside of the customary hospital setting.

HaH program utilization surged during the COVID-19 outbreak, not only reducing exposure to the virus, but also cutting recovery time and total costs, while enhancing clinical outcomes and patient experiences. Their popularity continues post-pandemic, with the American Hospital Association voicing support for the Hospital Inpatient Services Modernization Act (S. 3792, H.R. 7053), which would extend the current HaH program waiver by CMS to December 2024. Time will tell if HaH programs become a permanent alternative for acute care, especially among seniors, where chronic conditions would otherwise often require post-hospital admission to a skilled care facility or rehabilitation center.

As HaH programs expand, aging services organizations may find themselves admitting seniors who have been treated at home for an acute care episode without noticeable improvement. The following measures are designed to smooth the transition process for these residents:

- **Create a referral network of HaH providers,** after carefully reviewing their rates of hospital admission and patient mortality.
- **Identify conditions in HaH patients that require hospitalization rather than skilled care admission.** These include (but are not limited to) unstable vital signs, pulmonary congestion associated with ischemic chest pain, the presence of an acute co-existing illness requiring hospitalization and significant pulmonary congestion after initial treatment.
- **Verify that HaH patients meet the qualifications for skilled nursing care or assisted living admission,** paying close attention to insurance requirements and Medicare/Medicaid benefits.
- **Identify the names and contact information of all in-home care providers** – including licensed personnel, therapists, home health aides and family members – in the event that aging services staff members need to confer with them during the transition process.
- **Secure a complete and up-to-date record of in-home care,** including a history and physical, medication list, recent laboratory and diagnostic testing results, therapy records, on-site visits by medical professionals and responses by emergency medical personnel.
- **Request a record of correspondence between in-home patients and emergency responders,** in order to assess their health status and potential need for urgent care.

Quick Links

- CNA *Vantage Point*® 2023-Issue 1, "Home Healthcare: Common Exposures and Effective Mitigations."
- Eaton, J. "Reimagining the Nursing Home Industry After the Coronavirus." Published on the AARP website, June 8, 2020.
- Hung, L. et al. "Facilitators and Barriers to Using Telepresence Robots in Aged Care Settings: A Scoping Review." *Journal of Rehabilitation and Assistive Technologies Engineering*, January 21, 2022.
- List of FDA Guidance Documents with Digital Health Content, compiled by the FDA Digital Health Center of Excellence, updated August 11, 2023.
- Smuck, M. et al. "The Emerging Clinical Role of Wearables: Factors for Successful Implementation in Healthcare." *Digital Medicine Journal*, March 10, 2021.

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