Networking the Assisted Living Facility with the Community

Richard G. Stefanacci, DO, MGH, MBA, AGF, CMD, and Scott Bolhack, MD, CMD

Today's assisted living facility (ALF) is isolated from other facilities and programs within its community. Medical directors, largely absent from ALFs, are typically confined physically and mentally within the walls of their nursing homes. However, the needs of their community's seniors exist well beyond these confines.

Currently, senior health care is delivered through an inefficient, confusing process that does not provide much guidance or coordination to elders and their caregivers. As a result, they often wind up in an isolated "silo of care" rather than within a medical system. In addition, this process supports acute care while neglecting preventive or palliative initiatives. It supports diagnosis, treatment, and cure models at one end of the care continuum (the usual Medicare benefit) and end-of-life care at the other end of the continuum (the Medicare hospice benefit). There is no financial support for any medical or social models that maintain individuals in their community-based residences. How do we move towards a system that supports our seniors throughout the continuum of medical care, whether they live in assisted living facilities or in their own homes?

Our journey begins with the medical director leaving the confines of the nursing facility, but one easily could substitute "administrator" for "medical director" and "assisted living facility" for "nursing facility." While the starting point may be different, both paths traverse the same community network. Many of these networks will include nursing facilities, adult day care centers, and assisted living facilities.

The model for this discussion involves a medical director and a four-year-old nursing facility built in Newark, New Jersey. Government-financed housing complexes, aging city houses, assisted living facilities, and group homes house poor, frail seniors who populate the surrounding neighborhoods. The vision we have undertaken is to develop this facility from an isolated "silo of care" to a "community care continuum (CCC)." If a continuing care retirement community (CCRC) is a system of care (medical and social) that provides services through a continuum of housing alternatives on the same campus, then a CCC can be thought of providing similar medical and social services via a system of interconnected programs, entities, systems, and services.

Let's start by looking specifically at three area seniors to demonstrate the effects of a CCC on their lives. Rose Liso, a frail senior, chooses to live in her own home, despite being

eligible for nursing home placement as a result of her end-stage congestive heart failure. Under the current Medicare system, she is left to care for herself unless she chooses to accept placement in a nursing home. Non-acute community services are not an option for her. Mary Ortiz is another frail senior who recently suffered a fracture and will move from the acute care hospital to a skilled nursing unit because community options are not available. Lastly, Ron Fairsmith suffers from Alzheimer's dementia. He is able to perform most of his activities of daily living, but he is deteriorating because of a lack of in-home or community services. All three of these seniors qualify for and can be treated in a skilled nursing facility (SNF) at great financial cost, but they could be treated more effectively in other types of community housing—including their own homes—with supportive services.

The benefits for seniors living outside of the nursing home have been demonstrated in several studies. For instance, a 1996 study of Washington, Oregon, and Colorado seniors eligible for nursing home placement concluded that the expansion of home and community-based services was a cost-effective alternative to institutional care in these states.[1] A 1994 study drew similar conclusions about the expansion of home and community-based services in Washington, Oregon, and Wisconsin.[2] In addition to the cost-effectiveness of home-based services being offered in the community, medical directors should realize the advantage of developing a referral source to the nursing home for those who truly require that level of care. Further, by expanding the reach of the clinical team, other disciplines can be recruited because of the larger base population served by the CCC.

To establish a continuum of care community, two critical first steps are required: 1) the medical director must move from a traditional role to that of the CCC leader, and 2) a non-profit care team organization must be developed. The remaining elements that are essential for success can easiest be demonstrated through a review of five Ps: Philosophy, Payments, Place, People, and Process.

Operational Plan for a Continuum of Care Community

1. Move beyond the traditional Medical Director, administrator, social worker, or lead nurse's role to that of the CCC leader.
2. Form a non-profit care team: an interdisciplinary team to provide services across the CCC.
3. Build the five *P*s:

   Philosophy: Involve a Medical Director 24/7 in all aspects of the operation to instill a common culture of proactive caring.

   Payments: Pull together all available funding sources (such as Medicare and Medicaid) and other outside funding (such as donations and grants) to provide the needed resources to support the CCC mission rather than fee-for-service acute care only.

   Places: Align the area senior housing units and assisted living facilities with a nursing facility and build a community health suite and an intergenerational day care center as the core of the CCC.

   People: Build an interdisciplinary team led by a geriatrician that includes nurses, social workers, therapists, pharmacy consultants, dietitians, and nurse practitioners.

   Process: Develop systems and communication links for smooth information transmission throughout the CCC.

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Philosophy

As highlighted by William Thomas, MD, with his Eden Alternative Program and—more recently—his Green Houses, the CCC philosophy targets three of the serious problems plaguing the elderly: loneliness, helplessness, and boredom.[3] To eliminate these problems effectively, one needs to start as early as possible in the community. For those who truly require 24-hour nursing supervision, a link back to the community is needed.

Examples of programs that can tie assisted living facility residents back to the community include Internet computer lab access, intergenerational day care programs, pet therapy, and the Green House project.[4,5] These programs should be designed to include the frailest and poorest in the community. High-end assisted living facilities, private pay social workers, and concierge medical practices support for the wealthy elderly, while still leaving the poorest seniors without care. This is especially true for those seniors who live in poverty—but just above the Medicaid level—and so are not eligible for many additional services. The CCC can provide a range of services that can accommodate the basic needs for all seniors while offering a menu of options from which they may choose to purchase. We need to move away from the all-or-none concept of benefits that presently defines our current system of health care benefits.

An example of the philosophy that is required to develop a CCC is illustrated in Malcolm Gladwell's

book, *The Tipping Point*. In it, Gladwell explains that the reason for improvement in the New York City crime rates was that there was a focus on the "little things."[6] By focusing on cleaning the streets and repairing buildings, for example, a sense of law and order was restored; and crime fell. So, too, in building a CCC the little things can not be underestimated in their importance—such things as a common stationery, frequent staff gatherings, and even similar uniforms can provide a sense of common purpose to the organization. Finally, all successful care systems cannot be developed and function as an "I" organization. Rather, they must be developed and function as a "we" organization to succeed.

Payments

All available resources should focus on providing care to this special population through such payment sources as Medicare, Medicaid, and other outside funding—including donations and grants. This gives providers the freedom to develop programs that are not covered under traditional fee-for-service (FFS) Medicare. This was made a little easier recently with the Medicare Modernization Act, Section 241, which provides for "Specialized Medicare Advantage Plans." These are managed care plans that provide care to "special" groups: seniors that are institutionalized, dually-eligible, or suffering from chronic illnesses.

By moving from an FFS format to an all-inclusive program, the CCC is free to provide not only preventive care but also services not currently provided under traditional funding sources. By creating a non-profit care team organization, the CCC is positioned to attract many available resources such as grants and donations that are not available to for-profit providers.

An example of a currently-existing program that is able to operate as a somewhat restricted CCC is the Program for All-inclusive Care for the Elderly (PACE). PACE is centered on the belief that it is better for the well-being of seniors with chronic care needs, their families, and payors to be served in the community whenever possible. The PACE model is limited in that it only serves nursing home and dually-eligible seniors who are insured by both Medicare and Medicaid.

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The five core elements of PACE that make up the basic principles are:

- serving the frail elderly
- providing a comprehensive set of services
- using an interdisciplinary team of service providers
- accepting capitated payment
- assuming full financial risk.[7]

By delivering all needed medical and supportive services, PACE is able to provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as possible.

By partnering with an area hospital, additional funding options—as well as a way to pull a health system into the CCC—are possible. In Philadelphia, for example, the Jefferson Health System has established a program that awards grants to local non-profit organizations to employ full-time nurses who provide services to the elderly. The nurses' responsibilities include providing education and intervention to those in the community to promote appropriate use of the health system.[8] Other similar grants and programs are available to non-profit care team organizations to provide care to community seniors that would not be offered to a for-profit organization.

Another funding source comes from community-based service waivers. Like most states, New Jersey has obtained Medicaid home and community-based service waivers in an attempt to expand non-institutional services. Regulatory changes implemented by the Clinton administration have made obtaining waivers fairly routine in recent years.

Using these waivers, a state can cover a wide range of non-medical long-term care services, including personal care services, adult day care, rehabilitation, and respite care. States must target people at high risk of institutionalization and assure the Centers for Medicare and Medicaid Services (CMS) that the average cost of providing services with the waiver will not exceed the cost without the waiver. States may provide these services only to a pre-approved number of people, limiting the potential financial liability that would accompany an entitlement benefit.[9] As a result of state waivers and other funding opportunities, the CCC can have the revenue bases necessary to provide the full continuum of care services throughout its community.

Place

The CCC needs to go beyond the four walls of the nursing home; it must extend into the community. To do this it must include independent living units, assisted living

facilities, skilled nursing units, acute care hospitals, intergenerational day care, a community health suite, and nursing home beds. In developing this CCC, not only does the health of the seniors in its community benefit but the parent nursing home enjoys an increase in the number of referral sources.[10,11]

These components are brought together by the medical director and care team organization and rely heavily on regular and complete communication. The process should start by first identifying the key players in the community, then agreeing to operate under one common CCC philosophy. While it is not necessary for all these "places" of care to come under one ownership structure like a CCRC, it is vital that all the components operate with a common vision. Specifically, efficient and effective operation of the different places in the CCC relies heavily on detailed transfer agreements, communication, and processing.

Besides the non-profit care team organization bringing the CCC components together, seniors can be gathered through a community health suite or intergenerational day care center built within the nursing facility. These units can reach out to community seniors by providing 24/7 clinical care and providing an increased level of service to nursing home residents.

It is important to have seniors utilize the services of the non-profit CCC care team rather than outside nonaffiliated providers. Studies have shown that access to care is the number one determining factor for seniors in choosing a provider.[12] The main reason that seniors choose a provider (especially an on-site provider) is convenience. When most residents move into a community that has a highly accessible provider, the first visits are for urgent care services. Chronic care management still is rendered by the nonaffiliated provider, but this quickly moves to include even the chronic care management after a comfort level has developed. In fact, preference for access appears to be more important to residents than qualifications, often making highly accessible nurse practitioners the preference over more highly trained yet less accessible physicians. By having a care team highly accessible either at the bedside or the community health clinic, seniors can obtain the care that meets their needs within the CCC.

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People

The people in the care team are critical to the success of the CCC. In particular, the availability of the entire interdisciplinary team is vital. This includes a geriatrician team leader and nurses, social workers, therapists, pharmacy consultants, dietitians, and nurse practitioners. The role of the nurse practitioner is particularly important. The expanding level of responsibilities has made nurse practitioners excellent providers of care for senior health systems. Their skill sets, training, and background in nursing make them well equipped to handle many elder care issues. In addition, expanded legislation has made it possible for nurse practitioners to evaluate and treat patients more independently and also bill Medicare for these services.[13] The value of nurse practitioners has been demonstrated in several studies[14,15] that have shown improved medical outcomes resulting from these practitioners' involvement as the cornerstone of the care team.

Process

The processes of care throughout the CCC should be consistent across all settings. A geriatric team that can assess a patient in any of several settings within the CCC will by nature begin to solidify medical processes of primary care. The entire group then will begin to learn how to best utilize their resources, both internally among the group of professionals and externally with partners in the community. These partners will include home health agencies, hospices, mobile radiology units, phlebotomists, counselors, and social workers, among others. The methods by which resources are utilized will need to be continually developed and refined.

Physician leadership is one key component to the CCC's success. Modifying practices learned from American Medical Directors Association (AMDA) resources can provide the initial starting point for many processes of care in the CCC. For example, analysis of falls within the SNF is well-established with clinical practice guidelines published by AMDA (see page 26 of this issue of *ALC*). Utilizing these resources in the assisted living facility or an adult day care center is an easy step for the involved medical director and will provide staff with an advanced starting point at which to begin their quality assurance programs.

The CCC Organization

At the end of this process, we have a medical director who—working with a non-profit care team organization—is able to pull together the five Ps needed to create a continuum of care community. Under the auspices of this organization, someone like Rose Liso, who just celebrated her 92nd birthday, can live

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