Negotiating the Complexities of the Long-Term Care Continuum

Paula M. Podrazik, MD, and Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD

Assisted living facilities (ALFs) are being built and filled at an accelerated rate in the United States. But the increasing need for such alternatives in affordable housing and care for aging adults is accompanied by a stream of questions about the real purpose of these settings and the targeted population and services that can be supported in ALFs. These considerations raise tough questions, including how to balance individual choice and cost with safety for an aging population that is economically diverse and medically disparate. Consequently, any ALF must be prepared to recognize when the medical, functional, and safety needs of an aging applicant or resident outweigh its capacity to provide safe, quality care.

In an environment where many have perpetuated the AL mantra of "aging in place," ALFs sometimes may feel pressured to take and retain residents whose care needs push the limit of the facility's capabilities. However, there are steps ALFs can take to maintain their place in the continuum and ensure adequate care for residents with varying needs and expectations.

ALFs—Start with a Definition

Understanding how ALFs can secure their place in the long-term care continuum and effectively serve residents, it is important to look at how the industry is viewed and defined by government officials, consumers, and other sources. Originally, ALFs began as a response to a need for alternative forms of housing for older adults who were searching for a more supported lifestyle but were not ready for a nursing facility. Today, there are different shapes, sizes, and compositions of ALFs; and there are many

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definitions of this care setting. Even government and industry leaders can't agree on a precise definition.

The Centers for Medicare and Medicaid Services (CMS) define AL as "a type of living arrangement in which personal care services, such as meals, housekeeping, transportation, and assistance with activities of daily living (ADLs), are available as needed to people who still live on their own in a residential facility." In most cases, the agency suggests, the residents of these facilities pay regular monthly rent, with additional fees for other supportive services.

Elsewhere, the Assisted Living Federation of America (ALFA) defines assisted living as a special combination of housing, supportive services, personalized assistance, and health care designed to respond to the individual needs of those who require help with the ADLs and the instrumental activities of daily living (IADLs). ADLs are the everyday activities involved in personal care—such as feeding, dressing, bathing, moving from a bed to a chair (also called transferring), toileting, and walking. IADLs include using the telephone, getting to locations that are beyond walking distance, grocery shopping, preparing meals, handling housework or other chores around the house or yard, doing laundry, taking medications, and managing money.

Finally, the Assisted Living Workgroup Report to the U.S. Senate Special Committee on Aging defines assisted living as a state regulated and monitored residential long-term care option. This definition states that assisted living provides or coordinates oversight and services based on assessment of the resident and a care plan to meet, as they arise, the resident's individualized needs and unscheduled problems.[1] As required by state law and regulation, services to be provided or coordinated must include but are not limited to:

- 24-hour "awake" on-duty staff for oversight and to meet scheduled and unscheduled needs
- Provision and oversight of personal and supportive services (assistance with activities of daily living and instrumental activities of daily living)
- Health related services
- Social services
- Recreational activities
- Meals
- Housekeeping and laundry
- Transportation

ALFs—Troubleshooting Potential Problems

While the definitions of assisted living vary, implicit in all is a supported lifestyle that involves consumer choice and minimal regulations to ensure preference and affordability. Yet, the aging population that uses these ALFs is complex and often medically, cognitively, and functionally impaired.

Any ALF must be prepared to recognize when the medical, functional, and safety needs of an aging resident outweigh its capacity to provide safe, quality care.

A snapshot profile of this complexity from one national study shows:

- more than half of ALF residents are 85 years old or older
- 25% have moderate or severe cognitive impairment
- 33% experience urinary incontinence
- 51% receive assistance with bathing
- 77% receive assistance with medications[2]

Of the residents who currently live in assisted living facilities, 81% need help with one or more ADLs and 93% need help with IADLs.[3] Further, as older adults age in ALFs, an accumulation of disease, as well as cognitive and functional impairments, are predictable. So residents' needs only will increase as they age in place. This is where many facilities face their greatest challenge in terms of determining when it is appropriate to retain or accept a resident and when an individual would be better served in another, more rigorous care setting.

Given that most residents either enter ALFs with some level of frailty or impairment and/or become increasingly frail or impaired over time, it is imperative that each ALF have a:

- Mission statement with detailed information about service offerings and limitations
- Screening process that examines the medical, cognitive, and functional disabilities of the potential resident to determine the facility's match for care needs
- Monitoring process for the health and functional needs of each resident in the ALF to ensure that the individual is receiving the appropriate level of care, as well as a continued care-needs match for that particular facility[4]

Having these processes in place helps ensures that residents and family members know what they can expect in terms of care and services. As unreasonable expectations are a common source of conflict in long-term care settings, ensuring that everyone is on the same page at the start can prevent problems down the road.

At the same time, clear systems and processes give staff a strong sense of their roles and responsibilities and what goals and objectives

are realistic for residents. The key is to not just have processes but to make sure that these are communicated to and understood by all stakeholders.

ALFs and the Shared Objectives of Long-Term Care

A "seamless continuum" generally is considered to be an ultimate goal for individuals moving between care settings. A basic set of overarching care objectives shared with other long-term facilities helps perpetuate such a smooth transition of aging individuals and helps ensure that the ALF is an effective link in this chain. These objectives must shape the ALF mission statement and provide the basis for the philosophy of care and services offered at a given facility. They include:

Resident Assessments. A resident's move to assisted living represents a critical life change. This transition provides a special opportunity for a comprehensive review of the individual's health and social needs. For the aging adult, a move to an ALF often signals some medical, cognitive, or functional need which makes a comprehensive assessment all the more crucial. It also offers the opportunity to provide optimum interventions designed to maintain independence and prevent existing conditions from deteriorating.

All residents entering an ALF should have a baseline evaluation of their physical, medical, and psychosocial needs completed by a qualified, licensed independent practitioner. Residents also should receive periodic reassessment to determine if care needs have changed.

Plan of Care. A written, comprehensive care plan provides the support staff with a specific process for interventions and encourages thoughtful assistance to residents. Such a care plan should focus on treatment of the resident's chronic medical and mental health conditions—while providing functional and social interventions and spiritual supports—to enhance quality of life and maintain independence. Finally, end-of-life care planning also should be discussed.

A care plan should be available to all staff. And this plan should focus on the resident's physical and psychosocial needs, along with resident preferences for treatment, medical necessities, and services required to accommodate those needs.

Nutrition Needs. Nutrition affects multiple outcomes in the older adult. Continuing attention to nutrition communicates a dedicated concern for residents—not only a concern for their health care-related nutritional needs but also a desire to cater to their tastes and preferences. The facility should attempt to meet cultural and dietary desires that promote choice and respect for individual wishes.

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The resident's nutritional needs—including proper caloric and fluid intake—must be assessed initially. Ongoing assessment is necessary to prevent weight loss, malnutrition, and dehydration. Unexpected weight loss should trigger a medical evaluation of the ALF resident.

Medication Administration. These policies and procedures are important to ensure safety and consistency in medication administration. Effective and accurate medication administration not only ensures that residents receive full benefit of the drugs but also prevents medication-related problems that can result in hospitalizations or even death. Adverse drug reactions are most strongly tied to the number of medications, the number of comorbid conditions, and certain higher-risk/low-benefit drugs or classes of such drugs. On average, the assisted living resident takes six medications per day. Based on this statistic alone, it is clear that these individuals are at higher risk for adverse drug reactions.

Assisted living offers the opportunity to decrease adverse medication outcomes through implementation of additional support in the administration and monitoring of drugs for those requiring assistance. At the same time, ALF residence alone should not imply automatically that all residents need such assistance. These decisions should be individualized and based on professional assessments.

Residents should have the opportunity to self-medicate and keep their medications (prescription and non-prescription) in their rooms, provided the products are placed in a safe, secure place. An initial assessment by a qualified professional can help determine whether the resident has the necessary cognitive skills to self-medicate. Review of proper medication administration by residents should be monitored regularly through periodic medication use review.

Medications for all other residents—ie, those not able to self-medicate safely—must be administered by qualified, trained medication assistants or licensed staff. Continuous training of medication assistants should be provided on a regular basis to ensure competence. Medication administration policies and

procedures are vital to medication administration safety and consistency.

Physicians and consultant pharmacists can provide invaluable review and oversight of medication choices. This oversight can be part of a formal review policy for all residents in a given ALF or individualized for particularly frail and failing residents.

Maintenance of Functional Ability. There is increasing evidence that physical activity is important for preventing functional decline and maximizing independence. ALFs offer special opportunities to develop programs to support physical activity and make adherence to such programs more likely.

All ALF residents should have opportunities to exercise and enjoy physical activities of their choosing. Individuals for whom physical activity is risky or who are observed to have problems with activity should be encouraged to seek physician evaluation.

Focus on Prevention. In the higher-risk aging population, congregate living presents increased hazards from some conditions such as influenza or other infections. However, the very nature of community living also may facilitate successful preventive programs through peer support, ease of administration, and group educational interventions. Preventive interventions can have the greatest impact when applied to such high-risk populations.

Preventive health care policies should be in place at ALFs; and they should include a schedule for immunizations, falls prevention programs, and other continuing educational plans for residents and staff alike.

Promoting Independence. Recognizing an ALF resident's autonomy remains a key component in the ALF care philosophy and promotes respect for the individual's right to make decisions regarding lifestyle and plans of care.

In some instances, the resident's decision or actions may involve increased risk of personal harm. The most appropriate balance between risk of liability and independence can be reached through agreement between the provider and the resident concerning independent decisions or actions. This is possible provided the resident does not have impaired judgment stemming from significant cognitive impairment or psychiatric conditions. If any concern exists with regard to the resident's decision-making capacity, medical, cognitive, and psychiatric evaluations are essential.

Preventive health care policies should be in place at ALFs and should include a schedule for immunizations, falls prevention programs, and other continuing education plans.

Ensuring a Safe Environment. For those residents requiring assistance, control over one's environment is an important quality of life measure. The ALF environment should be comfortable, accessible, and provide a residential atmosphere. It should provide freedom of movement for residents between common areas and their personal space. Residents should receive any necessary assistance decorating and/or furnishing their rooms with personal items. Of course, all of these activities should be consistent with local fire and safety regulations.

Ensuring Access to Available Health Care Services. Clearly, health care services are highly valued by assisted living residents—as well as their family members (who often are footing all or part of the resident's ALF bill). Staff should ensure that health services (ie, medical, mental health, dental, and emergency services) are readily available and obtained when required. At the same time, residents must have access to transportation as needed for physician appointments and other health care services.[5]

Structuring Oversight. Screening a prospective ALF resident and continued monitoring of that individual requires oversight and accountability. These begin with the administrative imperatives of the ALF and flow down to the staff. Development of screening systems, oversight activities, and other checks and balances can be facilitated best through consultation with or under direction of a physician and staff trained in the care of the aging adult.[6]

Establishing a Medical Role in the ALF. Care of the chronically ill or frail elderly necessitates regular and timely physician assessment; and the complexity and severity of medical problems in long-term care makes increased medical oversight necessary. Toward this end, physicians and nurse practitioners can contribute significantly to direct medical care, the coordination of care, and the development of policies and procedures within a variety of areas. These documents should address:

- Screening residents for admission
- Continued monitoring of at-risk residents
- Ensuring a safe, comfortable physical environment
- Infection control programs and activities

- Employee health
- Ethical decision-making

Physicians trained in geriatric care particularly can be helpful in the evaluation and coordination of care of the vulnerable and failing elder resident. They also can provide medical quality review and continuing education for the staff and other practitioners at the facility; and they can oversee facility-wide systems of care.

Addressing ALF Staffing Issues. Staff working onsite providing 24-hour coverage should be sufficient in numbers and experienced enough to meet the continuous needs of residents. In addition, staffing levels and expertise should be discussed with all potential ALF residents to assist them in choosing the best facility for them.

Comparing facilities can be challenging. As there are differences in level of medical care expertise at ALFs, it can be like comparing apples to oranges. Generally, according to at least one national study, 40% of ALFs reported having full-time registered nurse staff, 55% had either a registered nurse on staff full- or part-time, and 71% had a registered nurse or licensed practical nurse on staff full- or part-time. About half used outside agencies to supply registered nurses or licensed practical nurses. Most states do not require ALFs to employ licensed nurses.[7]

In general, staff should be knowledgeable regarding basic changes in aging, geriatric drug pharmacology, falls prevention, incontinence care, ADL skills, communication techniques, dementia care, and recognition of acute illness/delirium. Staff must be able to assist residents in a way that preserves residents' cognitive and functional independence to the greatest possible degree. Additionally, staff must be able to discern when significant medical, cognitive, and functional changes have occurred and evaluation by qualified medical professionals is necessary.

A licensed staff person should initiate initial assessment of health status changes, supervise care provided onsite, coordinate further care if needed, and ensure appropriate follow-up. A competent staff person trained in the principles of geriatric care can facilitate continuity of care, collaboration by different care providers, and coordination of complex care plans. A physician trained in the care of the aging can aid staff in coordination of care, educational endeavors, and system changes to better serve both residents and staff at a given ALF.

Assistance for low-income seniors or those living in rural areas often is frustrated by lack of affordable ALF options.

Integrating with Other Long-Term Care Components. ALFs are part of a comprehensive system of care that accommodates the varied needs of older adults as they traverse different levels of health and function in the aging lifetime. ALFs—by the very nature of the medically, cognitively, and functionally vulnerable aging population that they service—need to be tied to other facilities, providers, and systems of care to produce optimum outcomes for seniors.

This larger community of care includes family, physicians, visiting nurses, social workers, pharmacists, acute inpatient care, skilled nursing, and rehabilitation facilities. Other issues that affect care include medical insurance and drug prescription plan choices. Understanding the responsibilities and capabilities of each component of the complicated health care continuum of the aging adult is key to coordinating care for ALF residents. Systems of improved communication, particularly at each transition in the resident's care, must be further developed.

ALFs and the Underserved

Assistance for low-income seniors or those living in rural areas often is frustrated by lack of affordable ALF options. This lack of non-institutional, long-term care services in many rural areas may explain why residents of nursing homes in these communities tend to be younger and less disabled than their urban counterparts.

Few ALFs that integrate health, personal care, and social services have been developed in smaller communities or in rural America; and fewer still focus on low-income seniors. To date, the major barrier has been a lack of technical assistance and pre-development capital to help states plan, design, and develop such long-term care resources.

Increasingly, resources need to be available in ALFs that are within the reach of those living in rural and low-income communities. To some degree, this has been accomplished through funding of the 1915[c] Home and Community Based Services waiver program to provide these needed services. This waiver is the primary Medicaid funding vehicle for low-income persons requiring assisted living. However, in most states the waiver funding is quite limited and over-subscribed. Unmet and increasing need for such funding support must be explored to close this gap in assisted living for the low-income senior populations living in rural communities.

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In either case, residents and staff will need education about what options are available, what use of the PDPs will mean, and how these plans will work.

Ultimately, this storm preparation really comes down to three elements: education, planning, and collaboration. You already are working on the education piece by reading articles in *ALC* on MMA. Planning begins with providing resources to your staff and residents so that they can operate in an efficient and effective manner. Lastly, collaboration—including communication and cooperation between the full care team—will enable everyone to work together to ensure that residents have access to the medications they need.

Strategies for weathering this storm are becoming clearer as we learn more about the final plans for the MMA and the prescription drug benefit. Facilities that begin preparing now are more likely to come through the turmoil safely; they then will be able to focus on what they do best—providing a safe, healthy, and happy home for millions of our nation's seniors. ALC

Special Treatment for LTC

Residents	Special Enrollment Period Copayments Waived for dually eligibles
Pharmacy Providers	Unique Any Willing Provider Standards PDPs required to include LTC pharmacies in their network
Plans	Special risk adjuster for institutionalized enrollees

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Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD, is editor-in-chief of *Assisted Living Consult.*

For a listing of special MMA-related Web sites, please see Suggested Resources on page 34.

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The Future of ALFs in the LTC Continuum

For ALFs, advancing better understanding of quality and affordability requires study to develop and test systems of care designed to optimize outcomes. Such research includes exploring innovative team and financial models to address the housing and care needs of all seniors.

ALFs face a particularly difficult task of juggling the need for consumer choice and autonomy while keeping costs in check. At the same time, they need to provide these services to a medically disparate and often frail or failing aging population that will continue to accumulate disabilities with advancing age.

A variety of allied health care professionals, most prominently physicians trained and skilled in the care of aging patients, can provide consultation and direction to aid ALFs in developing appropriate and effective systems of screening, evaluation, and ongoing care.

Overcoming the challenges, establishing effective systems and processes, ensuring that residents are safety and comfortable, and providing effective staff education will go a long way toward making ALFs a powerful and enduring part of the long-term care continuum. And effective and innovative facilities, staff, and practitioners can see to it that the continuum is smooth and seamless. ALC

Paula M. Podrazik, MD, is the medical director at the University of Chicago outpatient senior health center at South Shore. Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD, is editor-in-chief of *Assisted Living Consult.*

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