The Physician's Role in Assisted Living

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Where does medical care fit into the current structure of assisted living facilities? With the development of a "new model" for ALFs that focuses heavily on nursing care, many residents may hope or expect that this will enable them to delay or even prevent entry into a nursing facility. Some facilities are promoting this care model as having such benefits. This is a far cry from the days when ALFs distanced themselves from "medical models" of care.

In light of this new paradigm for ALFs, what is the role of medical care—and the physician—in this setting?

Primary Medical Care

Although hard data on how ALF residents receive medical care is difficult to come by, there do seem to be several of options. Although most residents of traditional model ALFs probably leave their facility for medical appointments, many new model residents get at least some care—including visits from physicians—right where they live. As most facilities are not licensed to provide medical care, primary care providers usually have the same status as any outside vendors and abide by whatever state and local regulations exist. For example, in a highly regulated state such as New York, the facility is required to verify professional licenses and preferred provider (PPD) status, but not much more.

In some cases, visits are made on an individual basis—with the providers coming to the resident's apartment. If the provider is coming to see a group of patients, either scheduled or sick visits, there often will be an arrangement to rent space or staff time onsite at the ALF. This is usually required by billing or other regulations so that the facility is not seen as supporting or actually owning the practice, although the facility staff usually helps organize the sessions.

One or more providers may have several sessions a week, with a variable number of patients in each session. This arrangement is similar to what is done at many skilled nursing facilities, although the exact level of medical illness and needs may vary significantly between the two settings.

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In the future, there is no reason why this type of arrangement can't expand to many more facilities or why clinician visits can't be more frequent or prolonged. My own situation, serving as a full-time onsite clinician, exists because my employer (a hospital) desires to use my practice to increase hospital admissions.

The ALF Medical Director

When I was hired to provide medical care at my ALF, my title became medical director. Since the appointment did not include a description of a medical director's duties, I have been developing my own job description. Most states do not require a medical director at an ALF, with only Alabama requiring one for "specialty care" ALFs. To some degree, I am setting the example for others to follow as regulations evolve and ALF medical directors become more common.

It became clear to me early on what an ALF medical director was not, which is not the same as a nursing home (NH) medical director. In most cases, NH physician leaders must comply with state and federal regulations, see that their staffs and the nursing home comply, monitor physician credentials and performance, and oversee general medical quality care issues.

I have not found any regulations specifically related to medical care, as opposed to nursing care, that pertain to my facility. Neither the state of New York nor any other body has required my involvement in any regulatory decisions. All such issues are addressed by the administrative and nursing staff of the facility, at least for now.

As for medical decisions and quality of care issues, they vary with the status of the patient. For those patients who use me as their primary care doctor, I oversee the care I provide as well as the care provided by other primary care physicians and specialists. I have a role in decision making about care for my residents when this is appropriate. However, I try not to interfere when residents have their own private physicians. No legal statute or facility policy gives me the right to intercede in these medical decisions.

My facility requires that outside physicians send something in writing explaining changes in plans, medications, treatments, tests, follow-up appointments, and so on. The facility keeps these on record for documentation purposes, and the nurses carry out these orders when necessary. I don't interfere in this process. However, when outside orders are ambiguous or the nurses have questions, they can seek my guidance or interpretations as needed.

I also usually review notes so that I can be familiar with all residents' conditions. Although I do not interfere with the patient-doctor relationships, I often am called in emergency situations and when there is an acute change of condition. And I need to have at least a rudimentary knowledge of each resident's health and history to respond effectively in these situations. This provides an additional level of care and usually reassures residents.

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In addition to these major medical duties, I also attend team meetings, review admission applications and miscellaneous medical documents from outside physicians, hospitals, and emergency rooms, and interpret illegible physician handwriting, including my own. All of these duties are being refined and slowly expanded daily.

The Future Holds...

I like to think my role as a medical director is a model that other facilities will emulate in the coming years. I believe that my presence at the facility has enabled the highest possible level of care for residents. As the new care-based model becomes more prevalent in ALFs, it will become increasingly clear where opportunities and needs for physician leaders exist in this setting.

If regulations evolve, as I believe they will, the physician medical director's clinical experience and knowledge of geriatric care and research will be important to ensuring quality care for residents. As for the formal role of a medical director in ALFs, we have to be careful.

Both facility policies and state regulations must make the duties and authority of this position clear. Otherwise, if medical directors are placed in facilities without clear guidelines, we can end up with physicians who have lots of responsibilities without the authority to carry them out. This would serve only to significantly increase the legal liability of the medical director, as exists in the nursing home industry; and this possibly could kill the ALF medical care movement before it can grow to fruition.

The presence of a medical director can enable provision of a new level of clinical care in ALFs and help the residents who need it most. We just need to move forward with caution and purpose to maximize the value of the physician's presence in this setting. ALC

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Legal Corner

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unavoidable weight loss—with starvation or neglect. It is important to make sure that family members understand what is causing the weight loss, what (if anything) can be done about it, the advantages and disadvantages of any interventions, etc. Facility staff must be encouraged to find out about resident preferences and attend to these as much as possible.

Communication Strategies to Reduce Risk

There are many strategies that ALFs can implement to reduce risk and improve communication. These include:

- Communication with families via phone calls, e-mails, family night presentations
- Addressing expressed or potential conflict promptly
- Resident education via luncheon programs and other activities
- Team communication via meetings, quality initiatives, and other activities
- Documentation of any refusal of recommended treatment by residents
- Protocol for when it is appropriate to contact the resident's physician
- Documentation of residents' advance directives and other preferences

These activities can help make working at the facility less stressful and more enjoyable for staff. They also can maximize quality of life for residents and satisfaction on the part of family members. ALC

This column is adapted from the module on Clinical Risk Management in the Nursing Facility from the American Medical Directors Association's Curriculum on Geriatric Clinical Practice in Long Term Care Teaching Kit. To order this kit or for more information, go to www.amda.com.

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