Experts' Roundtable

What is the single most significant change or focus you are implementing for 2007 to be successful in enhancing care for residents of assisted living? What do you consider the greatest barrier?

Robert Fusco, RPh, CCP, FASCP
Director, Government Affairs NJ
Omnicare, Inc.

My focus for 2007 for enhancing care for the assisted living (AL) community will be one of preventing medication problems. I will be presenting to our NJ Department of Health and Senior Services' Office of Boards and Council evidence that promotes regulations mandating medication management by consultant pharmacists. The Centers for Medicare and Medicaid Services (CMS) has promulgated several new F-tags* for the nursing home industry that consultant pharmacists and other healthcare providers must adhere to. These new guidelines are meant to justify the need for all medications, require goals for therapy, and eliminate the prescribing of inappropriate medications.

I believe that as healthcare providers, we need to protect AL residents by using the new nursing home guidelines as a starting point to justify why regulations need to be implemented for AL. Since most states do not mandate consultant pharmacist services in AL settings on a routine basis, I feel that we must try to make the people who promulgate AL regulations aware that something *can* be done. Routine medication monitoring, if mandated, could help keep these residents free of inappropriate therapy and provide guidance for achieving therapy goals that heretofore have been nonexistent.

Why is CMS treating the AL resident like a second-class citizen by not setting national guidelines to protect residents living in AL? The AL community should advocate for medication monitoring since it will protect the resident from deteriorating physically, which then leads to more costly care, especially if the AL resident must be moved to a skilled-care facility. Regulatory boards and the AL industry must both strive to promote medication management for economic reasons and the well-being of the residents they serve.

AL staff may be burdened with the need to follow up with physicians regarding recommendations made by consultant pharmacists. Unfortunately, there is no mandate for a physician to act either negatively or positively on the recommendations of the consultant pharmacist. In many cases, there are no laboratory test results or sufficient information in a resident's chart to allow a consultant pharmacist to perform a thorough medication management review.

With the implementation of the new State Operations Manual on December 18, 2006, in our nursing homes, we should all try to make our state regulatory boards aware of the two differing sets of standards for nursing homes and AL facilities.

Scott Bolhack, MD, MBA, CMD, FACP, FAAP
Chief Executive Officer
TLC HealthCare Quality Improvement Organization

The greatest barrier in the AL arena continues to be the challenge of creating a continuum of care; this same issue exists across the entire geriatric healthcare market. Even if primary care can be delivered by clinicians in this setting, the connectedness with the rest of the healthcare continuum will continue to be challenging.

The external barriers to the continuum of care include coordination of all ancillary services (eg, laboratory, radiology, specialty care, diagnostic testing, home health, hospice, and transportation), all of which take considerable time and are minimally, if at all, reimbursed. The internal barriers to the continuum result from individual facilities that "promise" a medical model to residents (or their families), but provide no system in which to deliver this model of care effectively.

Over the next year, we will continue to work with our external partners, exchanging ideas about how to be more effective and efficient. We applaud our current home health partners who meet with us weekly to review patient care issues for the patients whom our practice follows. We will attempt to develop the same system for our hospice patients. It is one thing to receive a standardized form reviewing your patients' care; it is a completely different experience to meet face-to-face with the providers to whom you have entrusted the care of your mutual patients. For the future, we have begun to develop videoconferencing to enhance communication with our partners.

The internal barriers to the care continuum will be overcome eventually, although not completely, in the next year. The continued desire among the senior population to age in nonnursing home settings will drive the need for greater regulation of AL arenas. No longer will a hotel management–style of providing services be acceptable; these models merely promote the ambiance of medical care without guaranteeing the substance.

We continue our efforts to bring nursing home concepts of medical care into these settings; the lessons learned from nursing home experiences are quite transferable. The current industry reluctance about creating

*"F" tags are Centers for Medicare and Medicaid Services (CMS) data tags assigned to each of the requirements in 42 CFR 483. Part 483 of Title 42 of the code of Federal Regulations (CFR) are the requirements for long-term care facilities.

another nursing home setting in AL needs to be defeated so that future patients are as safe as possible.

The results of overcoming these barriers to the continuum of care will be financial: with increased coordination in the external environment, reimbursements will need to increase; with greater regulation in the internal systems, costs will be higher. Both increases in costs will be passed onto the residents of AL facilities.

Daniel Haimowitz, MD, FACP, CMD
Medical Director, Geriatric Assessment Program
St. Mary Medical Center

As Medical Director at the Brunswick at Attleboro Assisted Living, I plan to become more involved with the staff and administrator this year to enhance resident care. Because of time constraints and lack of a formalized meeting structure, I did not meet regularly last year with the administrator and staff of this free-standing AL facility. A good medical director can do much to improve care, including reviewing policies, educating staff (especially about medications), improving lines of communication, and proactively identifying potential problems. These are my goals for 2007 and beyond. Taking practices that work in the nursing home next door, where I am also Medical Director, and adjusting them for our AL setting is an equally important objective aimed at improving resident care.

As a neutral third party, I hope to defuse tensions among staff members, which have contributed to staff turnover. Development of a system to help new staff adjust to our environment is planned to reduce the turnover rate. As Medical Director, I envision my efforts having many positive results—helping the facility pass its state survey, empowering staff (as a physician participating in "culture change"), reducing errors, being a positive marketing tool for the facility, and increasing staff, family, and resident satisfaction. The goal of increasing satisfaction will include efforts to create a more seamless transition from independent living to the AL facility to the nursing home. I feel fortunate to work in this particular facility, where my input is valued and respected, so that everyone benefits.

Nancy E. Moore
Partner, Atlantic Retirement Group
Topsfield, MA

As times change within the AL community, are we prepared to attract the next generation of seniors and meet their needs? Through resident focus groups, we have concluded that our goal for 2007 will be to enhance and in some cases reinvent resident services. Most communities offer the same amenities, but we believe it's the quality and breadth of services that distinguishes a community. So what will those include for our communities?

- Creating a more active lifestyle both inside and outside of the community. It's important that residents have the opportunity to be active and to contribute to the external community. These opportunities may include volunteerism and development of alliances with colleges and universities with lifelong learning programs to keep the learning experience an integral part of resident life.
- Enhancing food and the dining experience. By investing in experienced, creative chefs, we can improve the dining experience for our residents.
- Banning the word *activities* and focusing on social, health, spiritual, educational, and cultural programs.
- Looking for ways to enhance concierge services. We are in the business of helping people. What services will make their lives easier?

These changes will take an enormous team effort and a reframing of the "this is the way we've always done it" mindset. The key is to promote staff and resident participation. Communities may need to spend a little more on chefs' salaries to get the desired dining services program, but with careful planning and the right staff, an increase in food costs is not necessary. In fact, communities may find that they can save money.

Linda Hollinger-Smith, RN, PhD, FAAN
Senior Vice President for Research
Life Services Network

As Senior Vice President for Research for Life Services Network (www.lsni.org), the Illinois affiliate of the Assisted Living Federation of America (ALFA) and the American Association of Home and Services for the Aging (AAHSA), I work with our AL members to evaluate key trends that will guide future aging services by these providers. In 2007, Life Services Network's annual conference will showcase innovative and cutting-edge technologies to enhance resident care in AL as well as across the continuum of aging services. Several of these technologies have direct implications for enhancing care for AL residents, particularly in the areas of Web-based adaptive computer technology and "smart" behavioral-monitoring safety systems (see *Intuitive System Monitors Resident Behavior Patterns*, p 21). Adaptive computer technology enhances the quality of life for residents by enabling "connecting" with long-distance loved ones, developing

a legacy through autobiographies, and enhancing intellectual experiences (see *Technology to Enhance the Resident Experience*, p 26). "Smart home" technologies are being used by care providers in AL communities to detect potential problems with activities of daily living (ADLs) earlier to reduce falls and medication errors and to identify behavioral changes. Particularly for AL residents, "smart home" technologies are promoting quality of life and independence through a proactive approach to managing risks.

The greatest barrier to implementing these technologies in AL communities is funding. With our aging population, a growing proportion of older adults are at risk for having inadequate financial resources to meet AL needs. Several states have established affordable AL programs for low-income older adults, but current funding may not be adequate to bring such technologies to these growing programs (see *Affordability in Assisted Living*, p. 17). Some organizations have looked towards foundations, private donations, or matching grants to support technologies that have demonstrated a positive impact on care of AL residents.

Nancy L. Losben, RPh, CCP, FASCP, CG
Chief Quality Officer
Omnicare

One of the most important tenets of modern AL services is to allow the customer (ie, resident or guest) to age in place. However, as our residents live longer and their expected clinical needs progress dynamically, the ability to continue spending their years in their selected AL home becomes more difficult without the provision of higher levels of service. One of the most critical issues we face is the ability to provide a continuity of care over time.

Hospitality models are faced with the need to increase nursing hours for coordination of care and services, and the associated increased costs. Facilities with a clinical focus now look like the skilled nursing homes of yesterday. Additionally, keeping lifelong couples, each with individual healthcare needs, living together in the same facility is a struggle.

In the future we will need to adjust our models to meet the clinical needs of a new generation of seniors. It is wise to realize that longevity has caused two different generations to become Medicare beneficiaries—the healthy, thriving 65-year-old senior, and his or her aging parent. AL facilities must be able to provide wellness programs for the healthy and modified programs for guests with chronic diseases who do not yet require skilled nursing care. That will take strategic change, tiered services, higher cost, and innovation.

Anne Ellett, NP-C, MSN
Health Services Vice President
Silverado Senior Living

Silverado Senior Living is a company that specializes in dementia care. We have 14 AL communities, as well as hospice and home care companies. Our focus is on maintaining our "culture" as we grow. While we expand into new markets and spread out geographically, how can we continue to inspire our leadership and our associates to provide the quality of care that we want to offer?

Our philosophy is to make decisions from the position of "love not fear." We have initiated discussion sessions throughout our company to talk about care that starts with love. We want our nurses, caregivers, activity staff, housekeeping, and leadership to understand that concept and relate to our residents and families from that perspective. Our company is in a growth stage, opening new communities. Keeping the dialogue going with our new associates to understand Silverado's standards of care and the underlying philosophy of delivering care from "love not fear" is our continuing goal.

Marty Smith Clark, RN
Community Resource Team
Kisco Senior Living

Key changes taking place in the industry are: (1) residents staying in their homes longer before moving to a senior living community; (2) increased frailty among residents seeking senior living options; (3) greater involvement from family members in the decision-making process; and (4) greater awareness and appreciation of health-related issues (exercise and wellness programs, healthy diets, etc.).

We view these industry changes as opportunities for us to enhance the services for and care of our residents in AL in 2007 and beyond. One of the most exciting strategic areas we will continue to expand is "The Art of Living Well," which involves all areas of operations within our communities and is keenly focused on increasing the depth of our programs for residents and associates to surround them with a culture of wellness. The great thing about this approach is that it is not just a program, but a change in how our communities operate. Our goal is for our communities to promote and provide a great place to live for our residents and a great place to work for our associates.

Our offerings to residents on the wellness programming side will include enhanced and expanded fitness activities using senior-specific equipment and a broader

experience in other physical options. These programs will be geared toward increasing balance and mobility to meet the goals of reducing the number of resident falls, decreasing the potential for injuries due to falls, and decreasing depression through a better sense of well-being. We also have a commitment to brain fitness programs for our residents that allow them to become active participants in the maintenance of their cognitive capabilities.

Since nutrition and dining experience are key areas in "The Art of Living Well," we are including new menu options, resident choice in what they eat and where they choose to have their meals, and an improved dining experience through excellent service.

The challenges that we anticipate are related to change and the length of time many of our AL residents have spent with us. We expect that some will be slow to see the benefits that this culture change to wellness can provide. We plan to actively involve families in the communication of our commitment to this program and the benefits that their parent or loved one may experience. We also know that the associates are key to the implementation of this change and how successfully it is embraced! They are the "essential pieces" in this process and in increasing overall resident satisfaction.

Paul Willging, PhD
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Former President, ALFA and AHCA

A major concern facing those who would understand long-term care (LTC) in America is the problem of fragmentation. As customers move through the LTC continuum, they experience a disjointed system, which fails to promote communication, cooperation, or seamless delivery among providers. In its acclaimed report, *Crossing the Quality Chasm*, the Institute of Medicine underscored the healthcare system's poor organization. "Care delivery processes are often overly complex, requiring steps and handoffs that slow down the care process and decrease rather than improve safety," the report stated. "These processes waste resources; leave unaccountable gaps in coverage; result in loss of information; and fail to build on the strengths of all health professionals involved to ensure that care is timely, safe, and appropriate."[1]

Similarly, the fragmented LTC system in place today fails to effectively integrate or target services to vulnerable senior and disabled populations. This failed integration, in turn, results in the absence of meaningful and coordinated data. Data collection is limited and data sharing virtually nonexistent among LTC delivery systems. The lack of shared data impedes a provider's ability to leverage resources for the purpose of clinical, disease, and quality management. Databases vary in adequacy from one LTC setting to another, and they seldom interact or intersect. The minimum data set (MDS) used by nursing homes is, for example, wholly separate from the outcome and assessment information set (OASIS) database used by home health agencies. And each state has its own approach to collecting data regarding AL. These separate databases perpetuate the silos that fragment LTC. As a result, when patients move from one part of the continuum to another, data collection continually begins frustratingly anew.

The entire senior care system should be linked by a common assessment tool to facilitate care and data coordination. As part of its "senior strategy," the Center on Aging and Health at Johns Hopkins University has undertaken to pursue that goal. In LTC, everything is determined by and follows the assessment, including the plan of care, data collection, and quality management. Currently, the assessment tools used by home health agencies, nursing homes, AL programs, and adult day care programs are each very different, one from the other. As a result, the same customer evaluated in different settings ends up with an assessment that is limited in scope and oriented primarily to the setting in which he or she is currently receiving care. Moreover, the customer has to be reassessed at each level of the continuum.

A standardized assessment form would produce a *holistic* view of an individual's needs, *regardless* of where he or she receives services. This assessment would maintain the same format as it follows the customer throughout the system and would be updated as the customer moves across provider types and experiences significant changes in status. By ensuring uniformity across the continuum, the assessment process would become truly customer centered, producing a care plan unrelated to a particular setting and driven uniquely by individual needs.

A common assessment tool would also facilitate data-driven management. In today's healthcare system, robust data collection and analysis can maximize care planning, oversight, and quality management. Just as a standardized assessment form that follows an individual across the continuum would enhance care coordination, a common database housing clinical, social, and demographic information from various settings would bolster that same objective.

A common database, drawing together information from home health agencies, nursing homes, AL communities, and adult day care programs, would facilitate data sharing and promote seamless care. Ultimately, this comprehensive overview of each customer would optimize quality and outcomes management, strengthen

care planning, and support individual choice. And that is the ultimate goal of Johns Hopkins University's "senior strategy" for 2007.

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Increasingly, AL facilities provide care to a vulnerable and medically, functionally, and cognitively impaired population.[2-5] The majority of these individuals require some assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs),[3,4,6] and they demonstrate functional declines over time that are similar to what is found in nursing home residents.[7,8] Unfortunately, nursing care is too often focused on providing care *for* (bathing or dressing an individual) as opposed to *with* (helping the individual to complete as much of his or her own care as possible) older adults in AL facilities. This may be particularly problematic in AL settings in which care is paid for on a fee-for-service basis (eg, pay is given specifically for help with bathing or dressing). Unnecessary care performed for residents can result in functional decline, deconditioning, and disability.[9-15] To alter this declining trajectory, restorative care is a philosophy of care that focuses on the restoration and/or maintenance of physical function so that residents achieve their highest level of function and increase time spent in physical activity. While many believe the greatest barrier to implementing a restorative care philosophy is related to staffing, I believe the greatest barrier is related to the residents' lack of motivation to engage in functional activities and exercise. We need to establish techniques to optimally motivate these individuals. While I never said it would be easy. there are some effective motivational interventions to help AL residents optimize their function and their quality of life. Helping residents to believe in the benefits of physical activity and performing functional tasks, giving them verbal encouragement in performing these activities and setting realistic goals, eliminating the unpleasant sensations (eg, pain or fear of falling) associated with doing an activity, and providing lots of love and caring are all effective motivational strategies. ALC

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