AMERICAN MEDICAL DIRECTORS ASSOCIATION
WHITE PAPER
RESOLUTION B09

SUBJECT: PHYSICIAN'S ROLE IN ASSISTED LIVING

INTRODUCED BY: ASSISTED LIVING AD HOC COMMITTEE

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Introduction

The opinions expressed in the position paper of the American Medical Directors Association[1] state that assisted living facilities (ALF) are expanding rapidly and face many of the same challenges that confronted the skilled nursing facility (SNF) industry in the 1970s and 1980s. The American Geriatrics Society (AGS) position paper[2] and other writings concur with the opinions expressed in the American Medical Directors Association position paper. As was the case in nursing facilities, there is great variation in assisted living operations across the U.S. with respect to staffing, size, options for care, and clinical support.[3]

As the AL industry has grown, the nursing facility population has changed, with an increasing percentage of individuals receiving nursing-intensive short-stay post-acute medical care in traditional skilled nursing facilities. Moreover, when we consider the demographics along the continuum of care for the elderly, there is an increasing utilization of formal supportive care at home. These shifts of care sites have enabled ALFs to fill a need previously met by skilled nursing facilities. Other reasons for the rise in ALFs include: geographic separation for potential caregivers, elders' wishes to remain independent and not burden their children, social reasons that combat isolation, and the promise of support that will accommodate their increasing needs at the same site.

The growing population of dependent elderly needs primary care physicians (PCP) because of multiple comorbid conditions and complex medical treatment regimens.[4] As residents in ALFs age, they may become ill and need hospitalization. As a result, the AL population may experience complications, functional decline, and avoidable unfavorable outcomes.

This evolution in AL resident characteristics and needs would seem to warrant oversight, regulation, and evidence-based care standards comparable to that governing nursing facilities. However, the AL industry as a whole continues to assert that ALFs are predominantly social models and should not be characterized as centers of medical care.

The Care Challenge

Many AL residents are elderly, have significant functional and cognitive impairments, have many medical and psychiatric comorbidities, and are at risk for developing geriatric syndromes such as falling and increasing confusion. So, despite the laudable goals of an environment that addresses social issues such as isolation, need for prepared food, and manageable living space, there is often an equally important need to address complications of aging and medical syndromes and illnesses that affect the frail elderly and other chronically ill individuals. As identified in nursing facilities, appropriate management of medical issues may significantly affect quality of life and personal and social function. The challenge is how to address these key medical issues in the context of a primarily social and residential setting.

Wide variation among ALFs makes it difficult to establish universal standards. Such standards would cover, for example, the extent of documentation; supervision of medications; and observations of clinical change. These standards would also address the expectations for handling common geriatric syndromes in this population. On-site visits and care planning tools to identify patient-specific risks, care objectives, and outcomes are recommended, to encourage PCP involvement in their patients' care and to assure appropriate care for AL residents

The Physician Connection

The PCP is a key clinical resource for AL residents. The American Geriatrics Society and American Medical Directors Association position papers acknowledge the importance of this patient-physician relationship. They also note the relevance to the AL setting of systematic approaches to identifying and addressing risk factors. Each individual entering an ALF should receive an initial assessment and should have a PCP approved care plan to address their clinical issues. Just as the Minimum Data Set came to be widely applied in nursing facilities and the OASIS in home care, there should be a similar tool to guide the care required by the typical AL resident. It would be imprudent to ignore the many lessons that we have learned over the past 40 years in nursing facilities.[5]

There is not much literature that addresses the relationship between PCPs and ALFs, staff, or residents. An article by John Schumacher[6] defines these relationships and other issues such as the gap that exists between the facility and physician responsibilities. The author notes that the PCP has valuable information about the patient in advance of the initial move into an ALF. However, the PCP faces a challenge in knowing what support the resident will have in the ALF. Without adequate information, the PCP may misunderstand the level of care and services that an ALF can provide, particularly related to issues of dementia and safety, observation of clinical changes, and medications. .

A series of interviews of residents, families, staff, and administration of various smaller ALFs revealed some interesting concepts regarding the PCP's role.[7] The four major physician-AL themes that were identified from the transcripts were: (1) magnification of physician authority; (2) disagreements with physician care; (3) physician communication; and (4) continuity/discontinuity of physician care.

The first theme found that the PCP may write an order that is misinterpreted (magnified) by the staff. For example, the order may say decrease the amount of sodium in the diet. The staff may interpret that order as no salt in the patient's diet thereby making it unpalatable. The second theme, disagreements by the residents, families, or staff with the

physician's care, is common and may reflect the limited information that the PCP had from the ALF or family on which he based his decision regarding the treatment plan. This issue pointed to the need for AL-PCP collaboration in determining and implementing the patient's plan of care. The third theme, physician communication, focuses on the need for the staff, family, and others to communicate with the PCP, which is time consuming for a physician. This warrants the development of convenient and efficient communication channels, which may require the PCP's on site appearance. The fourth theme, continuity/discontinuity of physician care, is prevalent in most ALFs because of geographic separation and the involvement of hospital physicians during hospital admissions and of specialists to manage specific diagnoses. This could result in contradictory orders, prognostication, and general clinical recommendations.

Many of these concepts also were covered in the discussion at the AMDA Consensus Conference to Develop Clinical Guidance for Assisted Living, convened in Washington, D.C. in October of 2006[8]. One workgroup was specifically charged with addressing communication issues between PCP/AL staff and applying AMDA's Physician Notification Protocol Manual in the AL setting. Much of the discussion revolved around practitioner complaints and not being notified about a resident's change of condition such as weight, appetite, and continence. Some of the agreed upon problems identified in this setting were:

a) AL staff is not skilled in recognizing when a problem exists and when to call the practitioner.
b) AL staff often does not know how to monitor a treatment/management plan and does not know how and when to notify a practitioner when it is not successful.

Examples of such problems may include:

1) Not being able to locate someone to communicate with staff at night (11PM-7AM).
2) The lack of responsiveness from providers and the inability to reach the PCP.
3) Inconsistent shift-to-shift communication.

Recommendations-

For the Facility

1. In keeping with legal obligations of disclosure, all ALFs, regardless of size or level of clinical services, should clearly identify their medication policies, clinical capabilities, and service and care limitations to potential residents and their families before admission. After admission, the facility should also provide this information about their clinical capabilities and limitations clearly to off-site pharmacies used by their residents and to each resident's PCP if not done previously.

2. For all medication issues, there should be clearly defined lines of communication. For example, when there are medication issues such as continuing indications for treatment or suspected adverse consequences, the facility staff should clearly know who to contact, such as the patient, the family, and/or PCP.

3. These plans should be patient-centered, and should accommodate patient preferences whenever possible. For example, a facility that requires residents to eat all three meals in the dining room may need to make an exception for someone who sleeps late and doesn't want to eat breakfast. There are other viable alternatives for trying to maintain stable weight. Another example would be in those ALFs that use an off-site pharmacy. The ALF may allow a patient to use his/her own private pharmacy or mail-order source while requiring the resident to inform the staff about all medications to permit adequate monitoring of effectiveness and adverse consequences.

4. Staff at an ALF should inform a PCP when they admit one of his/her patients and should give the PCP at least the following information: phone number to the appropriate clinical office, nursing supervisor, or administrator and explain the procedure regarding who to contact to communicate new/changed orders or status of resident.

5. Staff at an ALF need to develop policies that include notification of the PCP regarding hospital transfers so that issues such as medication reconciliation and medication management can be reviewed and updated as needed by the PCP.

For the PCP

1. A PCP who follows patients in an ALF should attempt to understand the facility's medication policies and clinical capabilities and limitations. This could be accomplished by meeting or otherwise communicating with the administrator, operator, and clinical staff.

2. A PCP should try to support his/her AL patients by helping and encouraging the facility to accommodate their wishes and preferences, to the extent possible.

3. A PCP with patients at an ALF should find out who to contact to provide medical orders and other clinical instructions, e.g., monitoring BP, weight, labs, etc. The PCP should also identify who at the facility will notify them about problems with their patients.

4. A PCP should discuss/describe for resident/family and key staff at ALF (without violating physician-patient confidences) the likely trajectory of the resident's illness/condition(s).

5. A PCP should be aware of the facility policy regarding the resident who is contemplating a negotiated risk agreement (NRA). PCP must know when this is occurring so s/he can make a determination if the medical plan of care might be in jeopardy (e.g. diabetic consuming Mars bars…) – and PCP is at risk of malpractice.

Summary

The purpose of this white paper is to help physicians provide optimal care to AL residents, consistent with applicable standards of practice. The bond between a physician and his/her patient transcends time and place. Physicians need ample detailed information about their patients in order to make appropriate clinical decisions. This is equally true in all settings, including Assisted Living.

ALFs need to have clear policies about the extent of the capabilities which they provide to PCPs caring for their residents. ALFs should also inform physicians, as well as residents, families, and their own staff about any limitations or rules that may affect the physician's ability to promote certain approaches on behalf of their patients.
The great variability among ALFs nationwide is bound to affect these efforts. State and federal regulations may be required to make such activities more uniform and predictable.

We also strongly recommend that AMDA form a core committee of qualified individuals (including nurses in AL care) to expand upon these stated recommendations and to lay a foundation upon which education, research, and new developments can be shared with our members and those of other related organizations. We could take as a model the manner in which our home care section emerged as a separate entity.

References:

1) American Medical Directors Association. Position Statement on Assisted Living, Position Statement D04, 2004.
2) American Geriatrics Society, JAGS 2005;53:536-7.
3) John G. Schumacher, Ph.D, The Assisted Living Residents: Who Are the Residents? What Do They Need? The Assisted Living Industry: Power Point Presentation, American Medical Directors Association, AL Clinical Practice Guidelines Summit, Washington, DC., October 24, 2006.
4) McNabney et al. The Spectrum of Medical Illness and Medication Use Among Residents of Assisted Living Facilities in Central Maryland. JAMDA 2008;9:558-564.
5) Levenson SA. Assisted Living: Shall we learn from history or repeat it? JAMDA 2008;9:539-541.
6) J. Schumacher. Examining the Physician's Role with Assisted Living Residents. JAMDA 2006;7:377-382.
7) Schumacher, J. et al. Physician Care in Assisted Living: A Qualitative Study. JAMDA 2005;6:34-45.
8) Vance, J. Proceedings of the AMDA Assisted Living Consensus Conference Washington, D.C. October 24, 2006. J Am Med Dir Assoc 2008; 9:378-382.

FISCAL NOTE:

RESOLUTION RESULTS: Passed.