Examining the Physician’s Role With Assisted Living Residents

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In response to the rapid growth of the assisted living (AL) residents, this article considers the resulting range of roles, opportunities, and challenges physicians may face as increasing numbers of their older adult patients choose residence in AL facilities. The problem is framed by providing an overview of the AL industry and reviewing AL resident demographics and health status characteristics. The discussion section examines the pervasive involvement of physicians with AL residents, reviews professional position statements on health care in AL, and reviews the emerging AL-focused clinical literature. In conclusion, the paper proposes key elements of a research agenda including establishing baseline physician-AL activity levels, physician collaboration with mid-level practitioners, and exploring physician involvement in chronic care and health promotion in AL. (J Am Med Dir Assoc 2006; 7: 377–382)

Keywords: Assisted living; medical care; physicians

Over the past 2 decades, assisted living (AL) communities have emerged as a major supportive residential setting as part of the long-term care continuum. In 2002, approximately 35,000 AL facilities housed nearly 1 million older adults. Estimates project an additional 20% increase in the AL population by the year 2010, surpassing the nursing home (NH) population. In the midst of this rapid growth, the physician’s role in AL care has remained largely undefined, due in part to the AL industry’s strong promotion of a social model of care sharply distinguished from medical models of care. Therefore, how physicians respond to and interact with this rapidly growing patient population has remained largely unexplored. For example, physicians may treat AL residents similarly to their other community-dwelling older adults (eg, requiring office visits, interacting with only the patient, off-site diagnostic testing, and so forth) maintaining the status quo. In contrast, some physicians may recognize the unique care needs of AL residents and modify their health care delivery efforts/planning (eg, make AL facility home visits, employ physician extenders, collaborate with AL facilities) as well as incorporating the available supportive services of some AL facilities (eg, medication management and monitoring, vital sign monitoring, health promotion/wellness, on-site physical therapy, and so forth). Currently, community-based physicians caring for residents of AL facilities have few resources available to inform them about the AL population and the range of potential roles physicians can take with their patients living in AL.

SIGNIFICANCE OF THE PROBLEM

Assisted Living Industry Characteristics

One challenge for physicians is the significant heterogeneity of AL facilities, which is reflected by their multiplicity of names including sheltered housing, domiciliary care, small board and care homes, intermediate care housing, adult foster care, congregate care, and assisted living. In many ways, AL residents resemble NH residents in terms of acuity, activities of daily living (ADL) impairment, and cognitive impairment. However, ALs are nonmedical community-based living arrangements that are not licensed as NHs. In general, they house 3 or more unrelated adults; provide shelter (room), food (board), and 24-hour supervision or protective oversight or personal care services in some ADLs; and can respond to unscheduled needs for assistance. Conceptually, AL facilities are considered intermediate between home and NH care. They differ from NHs in many ways, including lower costs, fewer professional caregivers, and the important fact that regulation is undertaken on the state, not federal, level. Consequently, AL is highly varied, with a number of factors that may affect residents’ function and independence. Based on national data, most facilities have fewer than 10 beds, but some are as large as 1400 beds; some
Assisted Living Resident Characteristics

Beyond basic demographics, establishing accurate functional and health status descriptions of the AL population is challenging owing to the difficulty in defining the scope of AL facilities and the lack of nationally drawn AL samples. Hawes et al report the results of one national AL sample (N = 184,558) with the average age of AL residents as 84.5 years, 78.6% female, and over 95% white. Similar results are reported by Zimmerman et al (2003) from a multistate sample of AL residents (N = 2058) whose composition averaged 84.1 years, 75.6% female, and 91.9% white. Overall, the AL resident population is predominantly composed of the oldest-old (approximately 85 years old) and is female and white. Regarding ADLs, studies suggest up to 81% of AL residents have ADL impairments and require assistance or supervision. Thus, assistance with at least one ADL (locomotion, transfer, eating, bathing, toileting, grooming) is common. In terms of health status, fully 40% of AL residents describe their self-rated health as fair or poor in contrast to the just over 25% who rate their health as very good or excellent. This relatively negative perception of health status among AL residents may be accompanied by an increased level of contact with health care providers and the health care system. AL residents are generally characterized as having higher health status than traditional NH residents. However, there are reports of increasing acuity among AL residents, which makes distinguishing between AL and NH populations more difficult. Finally, in terms of cognitive status, Hawes et al report 27% of AL residents had moderate or severe cognitive impairment while Zimmerman et al report AL residents with cognitive impairment ranging from 23% to 42%. Thus, while the majority of AL residents are not cognitively impaired, a significant percentage live in AL with some degree of cognitive impairment.

The prevalence of chronic health conditions among AL residents is substantial; however, this may be anticipated given the advanced age of AL residents. Regarding specific health conditions, rates of heart conditions (eg, congestive heart failure, myocardial infarctions, angina, arrhythmias) among AL residents range from 38% to 49%. Urinary incontinence is present for about 33% of AL residents. In addition, falls among AL residents are common with 37% experiencing a fall within the past year. Approximately 24% of AL residents reported an emergency department visit during the preceding 12 months and 32% had an overnight stay in a hospital distinct from any emergency room visit. It is noteworthy that these rates are both higher than those of the general elderly population and surprisingly higher than for NH residents. In summary, AL residents commonly require some ADL assistance, tend to rate their health poorly, and use acute care services at rates higher than both the general elderly and NH populations. At the same time, AL remains a community-based residential setting interacting with a health care system that is oriented to rapidly discharging patients from the acute care environment and back into the community setting. Consequently, AL residents and facility staff will continue to rely on community physician providers as the primary contact for ongoing health care needs.

DISCUSSION

Physician Involvement With Assisted Living Residents

In the midst of the rapid, documented growth of AL facilities and the resident population, the specific nature of health care delivery by physicians to AL residents remains largely unknown. Absent any empirical evidence, the assumption remains that physicians treat AL residents similarly to their older adult patients living independently in the community. Yet, in light of reports on AL residents’ lower health status and significant morbidities it is likely that AL residents have substantially more contact and involvement with their personal physicians than comparable independently living older adults. Also, beyond providing health care services to AL residents, physicians are frequently involved in the preceding AL placement decision-making processes with patients and family. They are typically asked to provide guidance on the need, timing, availability, and quality of AL facilities. However, emerging research indicates that physicians are uncomfortable in this advisory role because of their limited, detailed knowledge of local AL facilities and services.

Although the precise involvement of physicians with AL residents has not been examined empirically, organizationally, as illustrated in Figure 1, physicians have significant involvement with AL residents particularly involving transitions among various environments and health care settings, including home, AL, hospitals, skilled nursing facilities, and nursing homes. The involvement of physicians is ubiquitous as they may be expected to mediate residents’ transitions between a variety of settings based both on regulation and practice. For example, physicians are frequently consulted for guidance or validation of the initial decision to move into AL. In some states AL regulations require a physician’s authorization for admission to an AL facility. Transition from the AL setting to a hospital involves an admitting physician as does the dis-
charge of the older adult for return to the AL, a NH, or the home environment. Clearly, physicians play a critical role in health care delivery to AL residents on multiple levels.

Moving beyond the overall involvement of physicians with AL residents, the substantive delivery of care can differ significantly from the physician care provided to older adults living independently at home in the community, as seen as in Table 1. These delivery considerations include the location of care, medical records, medication management, patient management, treatment services, and communication issues. In some cases, the AL environment has the potential to offer a physician a robust level of health-related support and services not generally available in the independent community setting. However, the tremendous heterogeneity of AL facilities makes such generalization difficult.

Numerous implications emerge from the above, setting differences in terms of quality of care, the timeliness of services, communication patterns between staff and physicians, and the role of the physician in service delivery. As AL continues its rapid evolution, it will be increasingly important to consider the physician’s involvement and role regarding AL residents.

**Physician Professional Association Guidelines on Assisted Living**

Nationally, at least 2 professional physician associations have recently issued position statements addressing AL facilities. Statements in 2004 by the American Medical Directors Association (AMDA) and in 2005 by the American Geriatrics Society (AGS) acknowledge the increasing acuity level of residents and advocate for greater involvement of physicians in care planning and collaboration with AL facilities guided by the fundamentals of geriatric medicine. These position statements include a strong emphasis on focus on physicians’ involvement in the organizational/structural aspects of care in AL facilities addressing issues such as medical directorships, development of facilities’ health-related policies and procedures, staff training and evaluation, and collaborative arrangements with other providers. However, the statements provide comparatively little concrete guidance regarding the proactive role individual physicians may play in delivering care to their specific patients who reside in AL. For example, community physicians could be encouraged to proactively contact a patient’s AL facility to assess the facility’s medical and health promotion services (ie, medication monitoring, medical records, physical therapy) that could be incorporated into a comprehensive care plan. Another innovative approach to AL care involves providing some level of physician services on-site in AL. Physician professional organizations can provide leadership and disseminate practice-oriented resources to community physicians treating patients living in AL.

### Table 1. Comparison of Physician-related Consideration in Assisted Living

<table>
<thead>
<tr>
<th>Location of care</th>
<th>Patient Living at Home in the Community</th>
<th>Patient Living in Assisted Living Facility</th>
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<tr>
<td>Medical record</td>
<td>Not available at home</td>
<td>Physician office or potentially AL facility office/AL residence.</td>
</tr>
<tr>
<td>Medication management</td>
<td>Unsupervised</td>
<td>Potential for on-going medical charting of vital signs, monitoring, behavior/mood, etc. by AL facility staff including RNs.</td>
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<tr>
<td>Patient management and diagnostic testing</td>
<td>Patient is responsible for transportation and compliance with diagnostic testing recommendations.</td>
<td>Potential for on-site availability of diagnostic testing, imaging, blood work, screenings, and other diagnostic testing. Potential for on-site transportation services.</td>
</tr>
<tr>
<td>Treatment services</td>
<td>Fragmented services coordinated through home health agencies and visiting nurses.</td>
<td>Potential for on-site services including nursing care, mental health treatment, pharmacy, physical therapy, podiatry, and nutrition and diet, as well as traditional home health services.</td>
</tr>
<tr>
<td>Communication</td>
<td>Directly with patient and/or designated caregiver.</td>
<td>Directly with patient and/or caregiver and possibly with AL facility staff.</td>
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Beyond the AMDA and AGS statements, related documents and guidelines that may inform physicians’ delivery of care to AL residents include the Assisted Living Work Group Report and the AGS position statement titled “Improving the quality of transitional care for persons with complex care needs.” The AGS statement is particularly relevant to the AL setting because of the frequent need to transfer residents. This guideline defines transitional care as “as a set of actions designed to ensure the coordination and continuity of health-care as patients transfer between different locations or different levels of care within the same location.” Although patients with complex problems and needs experience heightened vulnerability during transfers, the systems of care often fail to ensure that the essential elements of patient care are met. As the AGS statement notes, our existing health care system is rife with failures to communicate patient care plans from one set of caregivers to those in the new setting, since care and practice settings often “operate as ‘silos,’ without knowledge of the problems addressed, services provided, medications prescribed or preferences expressed in the previous setting.”

Despite ample evidence that discharge planning and transitional care are problematic, the topic has received little attention in the academic, health policy, and clinical arenas.

Clinically Oriented Literature Regarding Assisted Living

Despite the described high levels of involvement of physicians with AL residents, the focused empirical clinical literature on the topic is quite modest. A review of the literature reveals just 2 book chapters that have substantively addressed the issue of physicians and medical care in AL. The first chapter by Cacchione and Morely presents an extended case example of primary care in AL and notes 2 models of providing care in AL including (1) a standard model of requiring residents to go to the physician’s office for visits; and, a contrasting model of (2) a model that brings the primary care team to the facility to assess and treat residents in their own environment. The second chapter by Sligh and Vicioso addresses the broader issue of medical care problems in AL and has a short section dedicated to the physician’s role in AL including notably some time management guidelines for physicians. Beyond these 2 book chapters, the literature has been relatively silent regarding physician care in AL. It is encouraging that a new peer-reviewed journal, Assisted Living Consult, has begun to publish brief articles dedicated to addressing clinical issues associated with health professionals’ delivery of care to AL community residents.

Turning to the dedicated clinical literature examining AL residents’ and physicians’ clinical care, relatively little appears on a Medline search. The available clinical literature on AL generally falls into 2 major domains including (1) mental health issues, and (2) medications. These domains are consistent with the broad clinical literature on geriatric populations; however, most of the AL articles do address the unique features of the AL setting that may interact with the clinical issue.

Mental Health Issues

To begin, by far the largest number of articles focus on the issue of cognitive impairment in AL including its prevalence, underrecognition, management, and role in admission and discharge decisions. Increasing attention is being given to the recognition and treatment of depression in AL facilities and addressing issues of overall psychological well-being. Cohen et al address the issue of the physician’s role in the treatment of mental health problems in AL.

Medication Issues

The issue of medications in AL has received increasing attention from stakeholders in AL. The use and regulatory oversight of unlicensed caregivers to administer medications as well as the training of these personnel has been an area of continued debate. At the same time, inappropriate prescribing and underprescribing for AL residents has been identified as an increasing problem. Clinical pharmacists have provided some resources through the American Society of Consultant Pharmacists that issued a report “Medication Management in Assisted Living.”

At the state level, medication administration is frequently under the supervision of a delegated nurse or other licensed professional who is responsible for maintaining records. The literature has just begun to examine the issue of medications in AL in any systematic way.

Beyond the topics of mental health and medications, general clinical issues in AL have received only indirect attention including falls, health promotion/physical activity, incontinence, and end-of-life care. Overall, the dedicated clinical literature involving physicians and AL residents is exceedingly small in light of the numbers of AL residents and documented health care needs. Consequently, clinicians working with residents of AL facilities have little empirically based information to guide clinical decision making in these settings.

CONCLUSIONS

Physicians have a critical role to play in the care of AL residents. To date, this role has not been well articulated or systematically examined. While the heterogeneity of AL facilities, services, and residents will require flexibility in the physician’s role, the AL setting represents a significant opportunity for physicians to contribute to optimizing AL residents’ health status and quality of life. In an effort to further stimulate clinically relevant AL research, this article concludes with a list of 5 research areas in responding to the above-identified gaps.

Establishing Baseline and Range of Physician Activity

To date, no systematic studies of physician behavior, practice, or clinical activity with AL residents have been published. It is only recently that major professional associations and the literature have begun to address the organizational role of physicians’ care in AL. Research describing the baseline range of physician activity and involvement in the care of...
AL residents would be valuable for planning and policy development. In the absence of data regarding physicians and AL facilities, it is difficult to assess how well or poorly services are being delivered to residents of AL facilities. There remains a need to document how care to AL residents by physicians is structured in terms of its intensity, location, duration, and scope.

Examining Collaboration With Mid-Level Practitioners

Mid-level practitioners (eg, geriatric nurse practitioners, physician assistants) provide substantial and effective care in many geriatric and long-term care (LTC) settings. As an LTC setting, AL facilities represent an ideal setting for these practitioners since they may have the flexibility to make on-site home visits to AL facilities to implement care plans that incorporate specific features of the AL environment to support the care plan. Mid-level practitioners have the advantage of being independent licensed care providers who can partner or collaborate with physicians to provide better overall care in AL. Recent research regarding the role of geriatric nurse practitioners in NHs has been quite promising; however, such research needs to be extended to AL.

Extending Chronic Care and Health Promotion

In many ways, AL facilities represent an exceptional opportunity for the treatment and management of chronic care conditions in a supportive structured environment. Although AL facilities vary greatly in terms of the resources available for supporting chronic care and health promotion activities, the AL resident population has the potential to benefit enormously from the introduction of such programs. Research into the efficacy of disease management, health promotion, and the integration of physician direction of such care plans represents an exciting area and opportunity to impact AL residents’ overall quality of life.

Sponsoring NIH/AHRQ/IOM/Alzheimer’s Association Clinical Care Conferences

The need exists for stimulating, organizing, and disseminating information through national conferences on AL and clinical care. Programs and conferences sponsored by major health organizations like the National Institutes of Health, the Agency for Healthcare Research and Quality (AHRQ), and the Institute of Medicine (IOM) would be a natural linkage to develop more knowledge about the role of physician care in AL. Such conferences could focus attention on developing best practices in AL and focus energy on this area.

Capitalizing on Current Knowledge

Exploring physician care in AL should first capitalize on the research conducted in broadly related settings including programs for all-inclusive care of the elderly, geriatric evaluation and management programs, and physician practice nursing homes. Although each of these settings is significantly different from AL facilities, they may offer important insights into how physicians can most effectively deliver care to residents of AL facilities. For example, the Alzheimer’s Association has been very active in supporting the delivery of high-quality services in AL and its efforts have resulted in a recent volume that addresses the issue of health care for persons with dementia across a variety of settings.

Mirroring the national growth of AL living environments, physicians can anticipate increasing numbers of their patients to reside in AL facilities. The physician’s role of delivering care to residents of AL facilities will undoubtedly continue to expand and change. Fueled by the tremendous heterogeneity of both patients/residents and AL facilities, physicians will be challenged to reexamine the structure and process of their ubiquitous role in providing care to AL residents. New models of care delivery may emerge in response to the complex relationships inherent in AL, including patient/resident, family members, AL staff, and physicians. Ideally AL communities can offer physicians unique resources and information that can substantially enhance the delivery of care to older patients ultimately resulting in higher quality of life and extended aging in place. The key is to focus broader attention on examining the role of physicians in delivering care to residents of AL.

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REFERENCES


