The Emerging Practice of Integrated Care In Assisted Living

Preamble

This report is written for assisted living (AL) organizations inclined to address the medical needs of their residents. Specifically, it provides a blueprint for implementing the “integrated model” of care, in whole or part. We believe that addressing the medical needs of AL residents adds value to AL communities; the “integrated model” is one way to address those needs, without incurring onerous federal regulation, or additional liabilities. 1,2,3,5

We recognize that state regulations, clinician availability, corporate culture, and several other factors pose limitations in the way a given AL community addresses the health care needs of its residents, or implements the model we outline. Such diversity is healthy, and consistent with the way the AL industry has evolved in meeting the needs of an aging U.S. population.4

It is important to note that the effects of the interventions we recommend must be verified by data. AL communities should use this data to demonstrate to hospitals, health care systems, or other organizations striving to provide higher-value care, the improvements in clinical outcomes and resource consumption expected from onsite medical services.

This paper use the term “physician” or “clinician” to include a variety of “advanced care providers.” More recently, the term “non-physician practitioners” (“NPPs”) has been used to refer to these clinicians, particularly in CMS documents. These clinicians include nurse practitioners (“NPs”), especially those with additional training in adult and geriatric medicine, and physician assistants (“PAs”). They represent an increasingly important component of the health care workforce, especially when combined with physician leadership and supervision.

Introduction and Purpose

Assisted living (AL) has become an important housing option for older individuals needing support with activities of daily living (ADLs), or some degree of cognitive impairment. Currently, around one million Americans live in some type of senior living community, and that number is expected to double by the year 2030. 6,7 This paper is intended as a guide for communities committed to implementing the integrated model of care, as one way to meet the medical needs of its residents.
AL communities can play an increasingly important role in the post-acute space, but only if they can provide higher value care compared to rehab hospitals or skilled nursing facilities (SNFs). To compete with those institutional settings, AL communities must demonstrate the ability to improve outcomes, and reduce both costs and readmission of patients recently discharged from the acute care hospital.

To provide higher value care, AL providers must address the medical needs of their residents, which will require them to embrace the “integrated” model of care, as a complement to the “hospitality” or “social” model. In addition to competing more effectively for referrals in the post-acute space, that evolution should also increase residents’ average length of stay (LOS), reduce their turnover, and improve facility occupancy.

**The Challenge, and the Path Forward**

AL residents are often frail, medically complex, and need help with one or more basic activities of daily living (ADLs). Although the health care needs of AL residents have intensified – become increasingly complex – over the last several decades, the AL industry in many parts of the country has been slow to address those needs.

The AL industry evolved in part as a reaction against the institutional characteristics and cost profile of SNFs. As such, AL communities historically emphasized “social” and “hospitality” services, which emphasizes life-style improvements, person-centered care, hotel-type services, and freedom of choice, with the addition of 24-hour staffing, assistance with ADLs, communal dining, social activities, and medication administration. Many also provide transportation to medical appointments and cultural events. As valuable as these services are, they do not specifically address the residents’ medical needs, including their mental health needs.

Aging-in-place is a goal of increasing interest to today’s aging population. Older adults prefer living in their own home, or a home-like environment, up until and including the end-of-life. They do not want to spend their last days or weeks in a hospital or nursing home. The opportunity and challenge for AL communities is to make this possible.

Presumably, AL communities that meet the medical needs of their residents will experience less resident turnover, currently running roughly 50% annually, and improved facility occupancy. The most common reason for resident turnover is health-related, including the need to transition to a more comprehensive level of care. Death adds another 33% to the turnover rate.

Many AL residents are among the top 5% of Medicare beneficiaries that account for nearly 55% of Medicare expenditures (see figure 1). By addressing the health care needs of this high-cost patient population, AL providers should be able to significantly reduce costs by reducing unnecessary emergency room visits, hospitalizations, and 30-day
readmissions; in short, they could become key components of a high-value delivery system. Where costs are greatest, one has the best opportunity for cost reduction.\textsuperscript{1,3,6,7,12,13,14,15,16,17}

However, some AL practices increase costs rather than reduce them. For example, AL personnel traditionally respond to falls and minor changes in mental status by reflexively sending residents to the emergency room. Typically, this is due to the lack of availability or responsiveness of personnel with the skills to determine whether transport to the emergency room is appropriate, or the resident can safely remain in the community. It is further fueled by an understandable desire to reduce facility liability.

The integrated model of care allows AL providers to address their residents’ health care needs, without incurring additional liabilities or onerous federal regulations. The “integrated model” calls for AL communities to collaborate with dedicated, competent physicians willing to provide medical care onsite in the community. They would also take responsibility of coordinating all health care services, communicating with family and facility caregivers, and leading a multidisciplinary health care team. Our approach does not require AL personnel to engage in activities beyond their scope of practice, or prohibited by state law. It shifts responsibility and liability to health care personnel with the appropriate clinical skills, training and liability insurance to provide medical services.
It frees AL employees to operate within their domain of expertise, and continue their focus on social and support services.

**Barriers to Better Access**

**Transportation:**

The first step in evolving to the integrated model of care, is ensuring that residents have adequate access to medical services. Currently, access is impaired by the need for residents to travel from where they live to where services are provided. This requires the community, or a family member, to transport them; either way, the expense and inconvenience are substantial. To ensure good access, AL communities ideally should establish relationships with “care partners” willing to provide primary care and skilled services onsite in the community. Onsite care effectively overcomes many barriers to access, and improves coordination of care. Unfortunately, such care partners are rarely available in many areas of the country, which may require the AL community to explore alternative approaches to reducing barriers and improving care coordination.

Even when transportation to outpatient care is available, a patient’s physical and/or mental impairment can make doctor appointments difficult. Those challenges can limit visit frequency, and pressure clinicians to provide a great deal of care over the phone. Medical advice provided over the phone increases liabilities, but eliminates payment.

Clinicians who see AL residents are expected to review and sign the paperwork required of AL communities to comply with state regulations. This typically requires additional uncompensated time. Medicare recent decision to pay for “chronic care management” should improve compensation for such services; however, most practice are still learning how to document and bill for those services.

**Payments and Paperwork:**

Most AL residents are insured by traditional Medicare, or a Medicare Advantage Plan (MAP). Low income or disabled residents may also qualify for Medicaid, in which case they are referred to as “dually eligible” for both Medicare and Medicaid. Residents who are insured by “traditional” Medicare may also have a Medicare supplemental insurance plan (“Medigap”) to pay for some or all of Medicare’s annual deductible, and its 20% co-pay.

The number of medical practices which accept Medicare or Medicaid is shrinking, which further impairs access to care for AL residents in some communities. The result is that many AL residents are seen less frequently than warranted by the complexity of their problems.
Complex elderly patients pose a special challenge for most clinicians. Compared to the
typical primary care patient, these patients require more time and more services, and a
greater emphasis on coordination of care. These factors limit the number of patients that
can be effectively seen in a day. They provide a disincentive for practices to
accommodate this population, particularly those which need a high volume of patients to
remain profitable in the face of escalating overhead and poor reimbursement for primary
care services.

The clinical challenges of managing complex patients, combined with Medicare’s
payment limitations and paperwork requirements, conspire to limit access to care for AL
residents. This often results in a disproportionate amount of care being provided in the
emergency room or acute-care hospital, making it more expensive and disjointed than it
ought to be.

**Resources and Relationships:**

To attract health care partners willing to provide onsite care, communities will need to
develop the supports that will make these arrangements attractive. At a minimum, this
would involve providing clinicians with the medication administration record (MAR) and
plan of care (POC), and assistance with scheduling visits. Depending on the
administrative support available from the provider’s own practice, AL personnel may be
called on to transcribe orders, arrange consults, or fulfill other administrative functions.
The community may be asked to provide space where clinicians can speak on the phone
or document the medical record in private. It may also be asked to provide space where
patients can be seen for services like podiatry, ophthalmology, and dentistry, which
cannot be provided cost-efficiently in the patients’ own room.

The strategy of collaborating with external organizations to provide needed onsite
services is often referred to as “contract management.” It has become increasingly popular
in hospitals, where administrators strive to achieve excellence in a wide range of
disparate services, from the cafeteria, to the imaging service and the delivery room. AL
administrators face a similar challenge. The experience of hospitals suggests that
managers can exercise as much or more control by contracting with specialized service
providers, rather than trying to be provide services through their own employees.
Contractors who fail to fulfill their promises or obligations can be given feedback, and
ultimately replaced if they fail to respond.

The provision of medical care onsite to AL residents does not require a formal contract
between the facility and provider. Rooted in the AL industry’s commitment to resident
choice, most states codify the right of residents to choose their own provider. Even if a
facility has a medical director, it must preserve the residents’ right to choose a different
provider as their PCP.
State Laws and Regulations:

In contrast to SNFs, which are regulated by federal law and guidelines, AL communities are regulated by the states. Even if AL employees have the training or background to provide skilled services, state law may prevent them from operating according to their abilities or licensure within the assisted living setting. Regulations governing the services AL employees can provide vary from state to state, and will affect a community’s strategy for addressing the medical needs of their residents.

Effectively addressing the health care needs of complex geriatric patients requires a multidisciplinary team approach. The following services are important components of the integrated model of care, and reflect the interdisciplinary nature of geriatrics.
- **Primary Medical Care**: Provided by competent, dedicated MDs, DOs, or a non-physician practitioners (NPPs), particularly those skilled in managing complex patients.

- **Home Health Agency Services**: PT, OT, Speech Therapy; Nursing; Social workers; mental health nursing services.

- **Home Care Services**: Companions or “sitters” who provide non-skilled services, such as support with executive or basic ADL; not paid for by Medicare.

- **Ancillary Services**: Laboratory Testing; Medical Imaging; Respiratory Therapy.

- **Durable Medical Equipment**: Wheelchairs; Walkers; Oxygen; Support Surfaces; Transfer Mechanisms; diabetic shoes; etc.

- **End-of-life Care**: Hospice; Palliative Care; Primary Care

- **Transitions of Care**: Coordination Of Care for Emergency Room Visits, Hospital Admissions, and Hospital Discharge to Poste-Acute Care

- **Medication Management**: Medication Administration and Reconciliation of all Prescribed Medication, especially when there’s a care transition.

**Primary Care**

Primary care is best provided onsite in the patient’s own environment, by clinicians experienced in managing complex geriatric patients.\(^8,17\) Such clinicians should also understand the compliance requirements, peculiarities, and limitations of AL communities. Ideally, strategies for addressing mental health and cognitive issues would be integrated into primary care services, or at least coordinated with them. Of particular importance are the issues associated with depression and dementia because those diagnoses are so prevalent among AL residents. Best practices call for managing mental health issues with the minimum necessary use of psychotropic medication.\(^18,19,20,21,22\)

For optimal continuity of care, primary care services are best provided onsite, ideally by the same clinician, or at least by the same practice, using the same medical record. The overarching goal should be “proactive primary care,” which means actively managing clinical problems, so they never become clinical and financial crises, requiring treatment in the emergency department or hospital.

**Ancillary Services**

These services include laboratory tests and medical imaging. To optimize access, both services should be provided onsite, except for MRs and CTs. All such services should be
ordered by a clinician, whose compensation does not vary with the volume of services, and who therefore ensures that all tests and procedures are medically necessary.

**Home Health Agency (HHA) Services:**

These services consist of physical and occupational therapy, skilled nursing, speech therapy, social services, and psychiatric nursing. Not all services are provided by all HHAs, and a given HHAs may vary over time in the services it can provide. As is the case with ancillary services, HHA services should be ordered by clinicians who are independent of the agency, and have no vested interest in the volume of services.

HHA services are readily available in most areas, including states which require a certificate of need (CON) for such services. Typically, AL communities designate a “preferred provider” for those services, and the clinician works with that agency.¹³,²²

Within policy limits, HHA services are paid for by Medicare, Medicare Advantage Plans (“MAPs”), or Medicaid, but only when ordered by a clinician. The clinician must certify that the services are medically necessary, and the patient is homebound. The clinician’s order must meet stringent documentation requirements, which include a face-to-face visit by the certifying clinician, within strict time limits of when services are ordered.

Over the last several years, Medicare’s documentation requirements have become increasingly strict. Payment for HHA services are often denied if all documentation and certification requirements are not met.

**Home Care Services**

In contrast to HHA service, Home Care services are paid for out-of-pocket, except when paid for by long-term care insurance, or sometimes by Medicaid. They encompass a wide range of services, generally provided by a “companion” or “sitter,” to help with shopping, transportation, checkbook balancing, or other executive-type activities. Services may be purchased by the hour, day or week, and minimums often apply. These services can be valuable “add-ons” for a person who has increased need that cannot be met entirely by the assisted living staff.

**Durable Medical Equipment (DME)**

Insurers have imposed increasingly strict requirements on DME orders, to ensure that items ordered are medically reasonable and necessary. Durable medical equipment includes everything from diabetic shoes, to wheelchairs, walkers, and power mobility devices. Support surfaces, oxygen, and hospital beds are also considered DME.
Clinicians must complete detailed forms to certify medical necessity, and verify that the patient and environment are suited to the use of the equipment. AL communities can simplify their residents’ access to DME by entering into an agreement with a local provider to deliver supplies onsite in a timely manner.

End-of-life care

It is important to document and honor patient preferences with respect to end-of-life care. The documentation must be accessible in the patient’s medical record, facility chart, or ideally both. If a resident is Do Not Resuscitate (DNR), that status must be displayed prominently in the resident’s room.

Most states have a legally-binding form for documenting end-of-life preferences in a more granular manner than previously encouraged. These forms are generally referred to by the acronym MOST or POLST, which stands for “Medical Orders for Scope of Treatment,” or “Physician Orders for Life-Sustaining Treatment.”

In this era of “patient centeredness,” AL staff should abide by a resident’s wishes. There are situations where patient preferences clash with corporate policy, such as the threshold for calling 911 following a fall or a change in mental status. Conflict between patient preferences and organizational protocols create dilemmas for community personnel.

The timeframe covered by the term “end-of-life” means different things to different people. Hospice agencies require a clinician to certify that the patient is expected to live 6 months or less. Nonetheless, the average tenure in hospice can vary from several days to well over a year. Some patients even “graduate” from hospice. The term “pre-hospice care” has been recently coined to designate the point where death is “in sight,” but for cultural or other reasons, hospice is not involved in the patient’s care.21

End-of-life care is intended to be “palliative” as opposed to curative. The goal is to keep patients as pain free and comfortable as possible, not to “fix” the medical problem. Although such services are often provided in an inpatient setting, increasingly they are provided on an outpatient basis. Palliative care reduces transfers to the emergency department, hospital, or nursing home. End-of-life care may involve emotional and religious components, and in some instances, bereavement services for the survivors. Hospice is paid on a per diem basis by Medicare Part A; reimbursement can vary depending on the intensity of services.

Transitions of Care

The first care transition occurs when a person moves into an AL community from a private residence. The “right” time to make that transition depends on myriad individual
and environment factors, including the patient’s need for support with ADLs, the extent of cognitive impairment, the presence of behavioral problems, and the risk of elopement. The needs and preferences of the individual should be weighed against the resources, safety and support services available in the home environment, compared with the resources, safety, and support services provided in the AL community.

The above determinations should be made by a person who has no incentive to increase AL occupancy; otherwise, there would be a mismatch between resident needs and the community’s ability to provide care.

Unnecessary transfer of residents to the emergency department, hospital or nursing home contribute to the high cost of care. Such transfers also disrupt the patient’s or family’s routine, and could become a source of conflict with the AL facility. Contrary to common belief, unnecessary transfers may increase a resident’s risk for untoward events, and liability of the AL community.

Patients generally prefer to avoid unnecessary transfers to an emergency department, hospital, or nursing home, unless they have a problem that can be treated only in that type of setting. Collaboration between primary care clinicians and emergency medical services (EMS) can help reduce unnecessary transports to the emergency department; however, the financial incentive for EMS to transport patients is compelling. Combined with protocols intended to minimize AL liabilities, these incentives encourage rather than reduce emergency department referrals.

**Medication Management**

Medication reconciliation is the key to avoiding medication administration errors and the untoward events they can cause. This service is particularly important following transitions between the AL community and the hospital, ER, or SNF, where medication regimens are most likely to change. Effective medication management also involves reconciling the medication prescribed by primary care providers, ER or hospital personnel, and by specialists involved in the patient’s care.

Many AL communities contract with an “extended care pharmacy” to minimize medication errors, streamline access to newly prescribed medications, and identify opportunities to improve medication management, particularly by the use of information technology.

**Conclusion**

AL providers can address the health care needs of their residents without assuming additional responsibilities and liabilities. The approach outlined in this report – the “integrated model” of care – advocates for AL communities to collaborate with health
care organizations willing to provide services onsite in the community. That strategy does not require AL personnel to directly provide medical services, or engage in activities which may be beyond their scope of practice, licensure, or that which is permitted by state law. It instead places responsibility on the providers of medical services, where it belongs, and therefore should not increase liability of the AL community.

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