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Editorial

Reimagining Medical Care in Assisted Living

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The increasing medical complexity of assisted living (AL) residents[1] in the context of variable regulatory oversight and an ill-defined role for physicians[2,3] suggests the need to rethink our current approach to delivering medical care in AL. We believe that a structured and accountable medical staff, led by a medical director, has the potential to accommodate to the changing needs of AL residents and ensure high-quality care. Recognizing the limited evidence base to support our recommendations, the proposed model must be empirically tested so as to inform new policy and practice standards.

Proposal 1: All residents, whenever possible, should be seen on site by primary care providers in concert with nursing staff employed by the AL community

Several issues surfaced during the COVID-19 pandemic that argue strongly for providing on-site, dedicated medical care in AL. Residents of AL were often unable to be transported to their outside primary care provider when the community had active COVID cases in staff or residents. Although telemedicine allowed continued contact with providers and to a certain degree may have ensured continuity of care, it was intended to be an adjunct rather than a replacement for the provision of hands-on care. Rounding as a team is invaluable given the ability to observe the living environment firsthand as well as benefiting from the nurse's intimate knowledge of current medications, function, nutritional intake, and dementia-related behaviors. One on-site medical practice demonstrated a relationship between on-site care with the timely diagnosis and treatment of chronic conditions such as depression and dementia.[4,5] When providers can attend to residents in their "home," such assessment may mitigate the need for evaluation in the emergency room. Studies of community-based home care, although not quite analogous, have demonstrated reductions in mortality and nursing home admissions.[6]

Greater involvement of medical providers in AL, with more frequent and predictable rounding schedules, would theoretically allow more timely evaluation of residents with an acute change in condition. The findings of decreased hospitalizations in nursing homes cared for by SNFists lend credence to this argument.[7] In a study of 22 AL communities served by a single group of primary care physicians, a protocol involving timely consultation between paramedics and physicians resulted in a decision to forgo ED transfer in 553 of a total of 840 falls over a 43-month period.[8]

Enhanced communication with nurses and families is another potential by-product of on-site coordinated care. Indeed, for more than 15 years, resident's families and AL staff have talked about challenges contacting off-site primary care providers, and that when they do, the conversation often seems rushed.[9] Depending on availability, visits may alternate between the physician and nurse practitioner (NP) or physician assistant (PA). Given the extent of comorbidity and complexity in many AL residents, an examination every 3 to 4 months seems reasonable. Residents, of course, should be attended to as soon as possible after an acute change in condition, which is more likely when on-site care is available.

Proposal 2: AL communities should be staffed by medical providers (physicians/NPs/PAs) who are both committed to and experienced in post-acute and long-term care (PA/LTC)

Given that medical provider commitment, competence, and medical staff organization have been proposed as links to quality in nursing homes,[10] this conceptual framework may perhaps apply equally to AL. Limiting the number of medical staff caring for the residents in a given AL community to those with experience in PA/LTC settings (ie, a closed staff model) ensures a minimum level of competence while also facilitating communication with AL staff and integration of the clinician into the general culture of the community.[11] A reasonably sized patient cohort ensures greater efficiency and is likely to be associated with more frequent and predictable rounding schedules. In addition, meaningful engagement with the medical director (raised next as the third proposal) is generally facilitated when there are a limited number of medical providers, as is participation in quality improvement programs and the establishment of cross coverage between attendings. There is a need to grow this specialty; however, compared to SNFists (n = 6857 physicians, NPs, and PAs), there are only a limited number of AL specialists (n = 601), who are more likely to be female, generalists, and foreign trained.[12,13] AL physicians are equally distributed between the specialities of internal medicine and family medicine.[14]

Proposal 3: Establish an AL medical director position

Akin to the nursing home medical director, the AL medical director would be assigned the task of developing policies and procedures relevant to the delivery of medical care. Standardization of practice would potentially include frequency and content of medical visits, documentation, as well as guidelines related to pharmacologic and

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nonpharmacologic management of common conditions. Examples include infection control, advance directives, and management of dementia with behavioral manifestations. Standardization of care would hopefully avoid what was commonly observed during the pandemic, namely, the administration of ineffective and potentially harmful "COVID cocktails."[15]

The medical director would also be tasked with setting credentialing standards, thus ensuring a minimum level of competency and the acceptance of established medical care guidelines. The medical director would attend regular meetings with the executive director and nursing leadership to ensure ongoing communication and participation, when appropriate, in addressing issues affecting resident care. There must also be a collective agreement regarding the establishment of quality metrics for the medical staff. Ideally, the medical director would also have a role in staff education. The medical director position must be fairly compensated financially and with mutually agreed on expectations (ie, 24/7 availability) and accountability.

There also is a potential valuable role for the medical director to work cooperatively with other local health care entities such as hospitals and health departments in representing the needs of AL residents.

Next Steps

We acknowledge that the proposals outlined above will likely be controversial, especially given a paucity of empiric evidence supporting our suggested framework as well as payment and regulatory models that may not incentivize on-site committed medical providers.[16] Although the proposed model may raise fears about overmedicalization and a move toward nursing home–like practice, the need for a blending of the medical and social models seems inevitable.[1,17]

Additionally, it may be difficult to apply a one-size-fits-all approach to AL when there is tremendous variability among AL communities. For example, there may be less of a need for a medical director in a small house model vs a larger community. The affordability of a medical director may also be an issue for smaller settings or those that are resource constrained. The number of hours per month devoted to medical direction, based on needs and expectations, as well as compensation (ie, salaried vs fee for service) will likely vary considerably in AL, much as it does in nursing homes.

While we have proposed on-site, regularly scheduled rounding, communities with limited nursing personnel may find it challenging to set aside other critical duties to accommodate the medical provider. This is a particular concern given that only slightly more than half of AL communities have licensed care providers on site.[18] Further, on-site care does not fit with every provider's practice model (even among geriatricians), and setting such expectations may lessen provider autonomy.

Although we believe that a closed staff model delivers superior care, with some confirmatory evidence now emerging in the nursing home setting,[12] definitive evidence is lacking in AL. Given that some residents prefer to keep their existing primary care physician when they transition to AL, there is an arguable benefit to continuity of care. Residents and families may not appreciate the potential differences in care related to accessibility and competence of the medical provider, and beyond that may not be willing to pay extra for such. A lack of integration between physician-based electronic medical records and those maintained by AL communities poses yet another obstacle to seamless communication between multidisciplinary team members.[19]

Although we strongly believe that our proposals will improve care in AL, we desperately need proof of concept. It is unlikely that we will have randomized controlled studies available anytime soon to test our hypotheses, so we must encourage everything from descriptive and case-controlled studies to evidence gleaned from quasi-experimental trials. Defining the optimum physician-to-resident ratio, frequency of visits or the cost effectiveness of employing committed and engaged providers are but a few of the issues that desperately need answers. It is also critically important that a medical provider database be developed that includes both AL and nursing homes. It is virtually impossible in 2021 to identify and characterize nursing home medical directors, let alone attending physicians, NPs, and PAs practicing in PA/LTC settings. Without such basic demographic information, it will be extremely difficult to advance any research agenda.

In comparing provider quality and related outcomes, it is imperative that we develop metrics that are clinician (physician/NP/PA) centric. Such measures, currently in development,[20] can then be added to the quality standards supported by industry leaders such as Argentum.[21] Ultimately, a determination will need to be made as regards the responsibility for setting medical standards in AL. Should we rely on professional organizations or use the nursing home as a model where the federal government sets standards applicable in all jurisdictions? Alternatively, and especially if we believe that the current system does not require fixing, should we continue to rely on the state based regulatory framework that ensures continued widespread variability? Future research will hopefully shed light on these critical questions.

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