



Assisted Living Communities and Medical Care Providers: Establishing Proactive Relationships

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ABSTRACT

Assisted living communities (ALCs) are a major residential setting for older adults with 35,000 ALCs housing over one million seniors. This paper addresses medical care in ALCs focusing on the proactive development of relationships between ALCs and residents' medical providers. Based on interviews with medical providers, the paper describes the organization and delivery of medical care in ALCs. In light of the medical needs of residents and limited provider involvement, the need for ALCs to proactively engage medical providers is advocated. The paper identifies key medical providers to approach and outlines areas to address including: communication between ALCs and providers, medication management, and medical records. The development of a medical provider education packet is described.

Assisted living communities (ALCs) have rapidly become a major residential setting for older adults in the U.S. In 2002, up to 35,000 ALCs housed a resident population exceeding one million older adults (Hawes, Phillips, & Rose, 2000). Projections call for an increase in this population of over 20 percent in the next decade (Golant, 2004). In most cases, the move into an ALC signals some type of decline on a physical, cognitive, and/or functional level and the need for a more supportive environment. The health status of this population remains quite heterogeneous, with up to 80 percent reporting difficulty with some activities of daily living (Hawes et al., 2000) and the majority making significant use of health services. ALCs vary on several key dimensions including size, unit type, staffing levels and qualifications, admission/retention criteria, level and range of services, and philosophy, as well as cost. Within this context of heterogeneity, the provision of appropriate medical care and oversight represents a common challenge facing both ALCs and primary medical care providers.

This paper addresses the issue of medical care in assisted living with a focus on the proactive development and maintenance of relationships between ALCs, their residents, and medical care providers. It begins by reviewing industrywide ALC resident acuity levels, health status, and healthcare utilization rates. Based on ethnographic interviews with medical providers funded through two National Institute on Aging studies, it describes the typical organization of medical care in ALCs, particularly the relationship to community-based medical providers (e.g., physicians, nurse practitioners, physician assistants). In light of the medical care needs of ALC residents and the limited medical provider involvement, the need for ALCs to proactively engage medical providers is advocated. The paper identifies key medical providers to approach and outlines areas to address including: communication between the ALC and provider, medication management, and medical records. The development of a medical provider education packet, which introduces an

ALC and its services and limitations to a resident's medical care provider, is described. The paper concludes by discussing the opportunities and challenges presented by proactively engaging the medical care providers of ALC residents.

OVERVIEW OF ALC RESIDENT HEALTH STATUS, UTILIZATION, AND MEDICAL CARE PROVIDERS

Overall Resident Acuity, Functional Status, and Health Service Use

The difficulty in defining ALCs and the lack of nationally drawn AL samples make accurate demographic and health status description of the ALC population challenging. Hawes et al. (2000) report the results of one nonrandom, national sample (N=184,558) with the average age of residents as 84.5 years, 78.6 percent female and over 95 percent white. Comparable results are reported by Zimmerman et al. (2003) from a multi-state random sample of ALC residents (N=2,058) whose composition averaged 84.1 years, 75.6 percent female, and 91.9 percent white. In summary, the ALC resident population is predominantly the oldest-old (~85 years old), female, and white.

Challenges also exist regarding an accurate description of the health status of ALC residents. In the national sample by Hawes et al. (2000), fully 40 percent of residents describe their self-rated health as fair or poor in contrast to the just over 25 percent who rate their health as very good or excellent. This relatively negative perception of health status among ALC residents may be accompanied by an increased level of contact with healthcare providers and the healthcare system (Hawes et al., 1995). In general, ALC residents are characterized as having higher health status than traditional nursing home (NH) residents. However, there are reports of increasing acuity among ALC residents, which make distinguishing between ALC and NH populations more difficult (Manard & Cameron, 1997).

Regarding activities of daily living (ADLs), studies suggest a very broad range from 20 percent and up to 80 percent of residents having ADL impairment that requires assistance or supervision (Zimmerman et al., 2003; Hawes et al., 2000; Phillips, Holan, Sherman, Spector, & Hawes, 2005; National Center for Assisted Living, 2001). Assistance with at least one ADL (locomotion, transfer, eating, bathing, toileting, grooming) appears to be common. More assistance is required by residents for Instrumental Activities of Daily Living (IADLs) including managing medications, shopping, and dealing with finances.

In terms of cognitive status, Hawes et al. (2000) report 27 percent of residents had moderate or severe cognitive impairment. Similarly, Zimmerman et al. (2003) report residents with cognitive impairment ranging from 23 to 42 percent. Thus, while the majority of residents do not have a dementia diagnosis, a significant percentage have some degree of cognitive impairment. In terms of medical care, cognitive impairment has been associated with negative attitudes and lower satisfaction among healthcare workers (Schumacher, 2000).

As noted above, the acuity of residents has steadily been increasing to the point that the distinction between ALC and NH environments can be difficult to make due to the overlap of some resident populations. The prevalence of chronic health conditions among residents is substantial; however, this may be anticipated given the advanced age of residents. Regarding specific health conditions, rates of heart conditions (e.g., congestive heart failure, myocardial infarctions, angina, arrhythmias) among ALC residents range from 38 to 49 percent (Zimmerman et al., 2003). Urinary incontinence is present for about 33 percent of residents (Hawes et al., 2000). In addition, falls among residents are common with 37 percent experiencing a fall within the past year (Hawes et al., 2000).

Given the advanced age and number of health conditions among ALC residents, it is not surprising that their health services utilization rates are high

compared to the general population. Approximately 24 percent of residents reported an emergency department visit during the preceding 12 months and 32 percent had an overnight stay in a hospital distinct from any emergency room visit (Hawes et al., 2000; Phillips et al., 2005). It is noteworthy that these rates are both higher than those of the general older adult population and surprisingly higher than for NH residents.

In summary, ALC residents often rate their health poorly, experience a range of serious chronic comorbidities, and tend to utilize acute care services at rates higher than both the general elderly and NH populations (Phillips et al., 2005). Nonetheless, the ALC is considered a “community-based” setting that is juxtaposed against a healthcare system oriented to rapidly discharging patients from the acute care environment and back into the community setting. Consequently, community-based primary medical care providers (e.g., physicians, nurse practitioners, physician assistants) will remain the primary source of ongoing healthcare for the ALC population.

Typical Relationship Patterns Between ALCs and Residents' Medical Providers

As noted above, ALCs and their residents generally rely on community-based providers to manage their substantial healthcare needs and health service use. Despite this widespread practice, in the author's experience, ALCs and medical providers do not routinely interact regarding the care of ALC residents. One reason may be that most medical care providers classify patients living in ALCs as community-dwelling individuals, and, therefore, may not make any special efforts to engage the ALCs in the patient's care and treatment planning. Conversely, medical providers might also erroneously assume that ALCs are medical communities staffed with higher levels of medically trained persons than is generally the case. At the same time, some ALCs appear to mistakenly interpret a “social model of care” as one that discourages the ALC's involvement

with any medical providers due to concerns about medicalization, staff time constraints, and cost issues. With some notable exceptions (e.g., physicians or nurse practitioners who see patients on-site in the ALC), the extent of ALC contact with community-based medical providers, in some instances, may be as limited as exchanging prescription refill requests with physicians. Although much needed systematic research on medical care in ALCs is currently lacking, anecdotal evidence suggests benign nonengagement with medical providers may be the norm between many ALCs and community-based medical providers.

THE CASE FOR PROACTIVE ENGAGEMENT WITH MEDICAL CARE PROVIDERS

To explore the issue of ALC/medical provider interactions, this paper draws on preliminary research from two qualitative NIA-funded research studies on ALCs, (1) "Transitions from Assisted Living," Eckert, P.I., R01-AG019345 and (2) "Physician Practice in Assisted Living," Eckert and Schumacher, Co-P.I.s, R01-AG019345-S1, which are part of the ongoing Collaborative Studies of Long-Term Care (CS-LTC).

The "Transitions from Assisted Living" study data included background and organizational information on four ALCs that participated in an ethnographic research project on resident transitions (see Schumacher, Eckert, Zimmerman, Carder, & Wright, 2005; Mead, Eckert, Zimmerman, & Schumacher, in press, for additional methodological and analytic information). These ALCs included two small, private ALCs (6–8 units), one midsize ALC (60 units), and one large, purpose-built, corporate ALC (120 units).

This paper primarily utilizes data from the "Physician Practice in Assisted Living" study, which has conducted in-depth interviews with nine community-based medical providers who have patients living in ALCs. These medical providers included

six physicians and one nurse practitioner who had patients living in the above noted "Transitions from Assisted Living" study communities, as well as two physicians with ALC experience not related to the noted study. Interviews were taped (15–40 minutes) and transcribed verbatim into 120 pages of narrative with identifiers removed or pseudonyms used. A research team of three doctoral-level social scientists and one geriatrician reviewed the interview transcripts and developed preliminary coding categories and themes for analysis.

Analytically, initial examination of the interviews lead to the first raw sort of responses, corresponding to what many ethnographers call "working through" their data ("first-level coding") (Miles & Huberman, 1994); that is, asking of the data, "What's here" or "What topics?" and then sorting it into large-level categories which represent potential large ("rough") codes. As Mischler (1986) and many others have pointed out, our goal was to identify categories that were generated from meanings inherent in the data themselves. In addition, the analysis team looked for "pattern saturation" related to the emerging themes to verify the existence of a theme (Bertaux & Bertaux-Wiame, 1981). Finally, since an important aspect of these interviews was to provide an occasion for medical providers to speak about their experiences, a key aspect of the analysis was to also permit their statements to stand for themselves, applying interpretation or clarification only when the utterance was unclear. Thus, representative quotes supporting identified themes are presented verbatim in Tables 1–9.

Diversity of Medical Providers' ALC Knowledge and Attitudes

In light of the well-documented heterogeneity of ALCs, it is not surprising that medical providers have an equally diverse range of knowledge and attitudes regarding them. The broad definition of ALCs and the industry's exceptionally rapid expansion in some geographic areas make it difficult for busy clinicians to simply have awareness of all of the

ALCs licensed in their area. The sheer density and diversity of ALCs in a medical provider's catchment area makes it unrealistic that a provider would have knowledge regarding the existence, let alone the services, of most of the communities. Consequently, medical providers' knowledge of communities is likely to be limited and incomplete, perhaps based on as little as a single patient's comments about a community. Although research to date has not systematically assessed medical providers' general knowledge of the scope and services of ALCs, based on anecdotal evidence, providers demonstrate relatively little specific knowledge about the ALCs and services in their area.

Such a lack of knowledge and awareness regarding ALCs is somewhat alarming, since older adults and their families frequently seek and follow the recommendations from medical providers regarding the need for an individual to transfer from an independent living situation to a more supportive environment like assisted living. Although some states' regulations require a physician or other healthcare provider's assessment prior to admitting a new resident to an ALC, this does not necessarily translate into provider knowledge of ALCs. Consequently, medical providers may be in a difficult position since information regarding individual ALCs and their services may not be easily available or accessible to them and they are being asked for guidance. The result is that, in many cases, medical providers are being called upon to provide information about ALCs that they simply do not have and do not know how to get.

Overall, interviews with medical providers suggest that they hold diverse attitudes regarding the quality of ALCs and their ability to care for older adults. Based on analysis of the interviews, **Table 1** illustrates a representative range of medical provider attitudes beginning with a neutral or unaware opinion of ALCs. The absence of an opinion by medical providers represents a clear opportunity for ALCs to proactively reach out and educate providers regarding their benefits and services. Beyond these neutral

Table 1. Diversity of Medical Provider Attitudes Toward Assisted Living Communities (ALCs)

Neutral or Unaware of ALCs:

Medical Provider: "I have no opinion [about the ALC] because I have no idea how the facility is."

Positive Comments/Attitudes:

Medical Provider: "I usually think of it [ALC] as a positive because I think a lot of these patients need some assistance with medications and just—food is a big deal for a lot of these older patients."

Medical Provider: "I've been very happy with ALCs. I think, the fewer the residents...the more personal the care."

Medical Provider: "I think that the smaller ones tend to be better."

Negative Comments/Attitudes:

Medical Provider [As related by ethnographer]: When asked if the physician knows of any exemplars of medical care in AL, he said flatly he doesn't know of any, adding that "the cost pressures are against it."

Medical Provider: "I think the biggest problem is the level of care they're supposed to be providing. That is, what they are licensed and approved to provide and what they're actually doing or capable of doing."

Medical Provider: "Same issues. The ALC can't provide [care]. Someone shouldn't be there.... It was a lot of neglect and medical problems that would come up because of poor care and poor follow-up."

Medical Provider: "Of course, I virtually never recommend large, institutional ALCs. I have nothing nice to say about them. Hardly anybody of mine [patients] ends up there having been sent by me."

attitudes, positive attitudes toward ALCs among medical providers were articulated based on the perception that ALCs may have a keen awareness and

can closely monitor a resident's health status. It was suggested that such 24-hour surveillance by trained staff is beyond the level of observation a family could be expected to provide in the community.

At the opposite end of the spectrum, some medical providers articulated strongly negative attitudes toward ALCs related to perceptions of grossly inadequate care and monitoring of residents. Larger communities (e.g., eight units and over) were frequently associated with perceptions of poor quality and negativity as well as the impression they accept residents whose medical needs exceeded their caregiving abilities. Larger ALCs may need to respond to such negative perceptions by proactively addressing the concerns articulated by medical providers. In summary, medical providers report lack specific knowledge about ALCs in their area and appear to hold decidedly mixed attitudes about the quality of medical care available in ALCs, particularly in larger communities.

In this context of limited medical provider knowledge and diversity of attitudes toward ALCs, it is not clear the ALC industry is taking the initiative to respond to the information needs and attitudes held by local medical providers. A possible reason for the absence of ALC proactivity is that the industry promotes itself as guided by a "social model" of care, which explicitly rejects medicalization and a "medical model" of care that is typical of nursing homes. However, a narrow interpretation of the social model of care can contribute to the creation of a false dichotomy between the social and medical care models in ALCs. Clearly, while ALCs may primarily promote a social model of care focused on resident autonomy, the fundamental need to coordinate high-quality medical services cannot be marginalized. Whether it is medication management, blood pressure monitoring, or assessment of cognitive function, ALCs must incorporate some elements of a medical model into their overall operations. Rejecting the fundamental attributes of the medical model (e.g., primary focus on the older per-

son's disease and limitations) cannot translate into the rejection of medical needs of AL residents, especially in communities that promote aging in place or that offer nursing-home level of care as do those that are certified to accept Medicaid clients under states' 1915(c) waivers. While some ALCs do successfully care for high health acuity residents and maintain a focus on resident autonomy, others may use the rejection of the medical model as justification for their lack of engagement with residents' medical providers.

The Need for ALCs to Proactively Establish Relationships With Medical Providers

Despite concerns about medicalization and the challenge of engaging medical providers, high-quality ALCs will take the initiative to proactively establish these relationships. Medical providers

Table 2. Medical Provider Lack of Engagement

Medical Provider: "I tell people if they are moving their parents in town, and they want me to be their doctor...[and] they're going out to those assisted living places, they have to come here [office]."

Medical Provider: "I haven't had too much contact with the facility. I think the family is very attentive. They usually send me little letters and things.... Her big health problem is her dementia."

Medical Provider: "Well, the family seems happy, so I'm assuming that she's being cared for well. She seems, you know, well-groomed and fairly content when I see her, so I assume she is well cared for."

Interviewer: Have you had contact with the family or the facility? Medical Provider: "Not the facility at all. The family once in while calls me for a prescription."

report the expectation that their patients and the ALCs will contact them if necessary. However, a general lack of engagement or contact with ALCs is described by medical providers as seen in **Table 2**.

Proactively addressing this lack of engagement could be as simple as a letter of introduction sent to the residents' medical providers upon admission. A following section, Developing a Medical Provider Education Packet, describes key elements of such a strategy. Regardless of the approach, it remains clear that ALC providers will need to be the ones to initiate contact since experience indicates most medical providers are not oriented to independently contacting or engaging a patient's ALC. Nonetheless, all stakeholders, including ALCs, medical providers, and importantly ALC residents stand to benefit from any increased engagement and communication between ALCs and medical providers.

KEY MEDICAL CARE PROVIDERS AND SUBSTANTIVE AREAS TO ADDRESS

Due to the array of medical providers and specialists potentially associated with the care of an older adult and the inherent difficulty of contacting them, approaching them may seem an overwhelming task for ALC managers. However, considering almost one-third of ALC residents will experience an overnight hospitalization (Phillips et al., 2005) and almost all will have an outpatient medical provider visit, it may actually be overwhelming to not consider approaching a resident's medical care provider. To reiterate, by "approach provider," what will be suggested in Developing a Medical Provider Education Packet ranges from a letter of introduction summarizing specific ALC-provided services, to providing ongoing monitoring and follow-up information for the provider (e.g., blood pressures), to jointly reviewing/developing comprehensive care and service plans.

Initially, any proactivity with resident's medical care providers begins with the resident and the resi-

dent's family. Thus, concretely, as part of the move-in process, residents can be asked to provide the name and contact information both for their personal health-related contact person (e.g., spouse, adult child) and their primary medical care provider's name, location, and contact information. At this time, the resident's permission should be obtained to contact the medical care provider in order to inform them about his/her patient's new ALC living environment and about the services the ALC does and does not provide.

Relationships With Primary Care Provider

Due to the central role that primary care providers play in the U.S. healthcare system, ALCs should strive to develop a relationship with their residents' primary care physicians or physician extenders (e.g., nurse practitioners, physician assistants). This contact can enhance the ability of an ALC to maximize a resident's functional status and contribute to his/her ability to age in place, which is mutually advantageous to the ALC and the resident. Furthermore, an active ALC relationship with its residents' primary care providers is supported by the fundamental best practices of geriatric medicine, which encourage open dialogue between patient and medical provider regarding medical decision making

Table 3. Frequency of Medical Provider Contact with AL Residents

Medical Provider: "I probably see them less frequently because they're having day-to-day contact with someone else who is keeping an eye on them. I mean some of my patients that are at home, I see them every month.... I have to see them more frequently."
 Medical Provider: "Yeah, we probably end up dragging them back to the office on a more frequent basis. You might see the ALC person on a more regular basis."

Table 4. Medical Provider – ALC Communication Issues

Medical Provider: “I think they should contact me and update me. They never contacted me. Probably they are in touch with the family, but never with me.”

Medical Provider: “And again, that’s not consistent. Some care providers you have to go chasing around the ALC to try to give you an answer. But she’s an exception. She’s a very good one.”

Medical Provider: “One ALC I went to only had an aide there [and]...all the patients were moderate- to late-stage dementia, so they weren’t communicative. The care manager was never at the facility. I always had to call her and when I called her, even though my date was on the calendar, she would always act surprised. ‘Oh, you’re there today?’ She would never come to visit with me. So that’s a complete contrast to Sally, who was always on-site, always ready with updated information.”

Medical Provider: “The ALC said that one of our doctors had been mean to them and that is all they would focus on. The ALC would page us six times, and every time we’d call back we would never get through to the person who was supposedly paging us.”

Table 5. Development of Medical Provider Relationship

Medical Provider: “I had a lot to learn. I remember early on, at facility 01, one of the nurses saying, ‘The doctor has to stop writing nursing home orders in our ALC.’ And that started a dialogue.... I would say we had a mutual learning curve and there were some things that I needed to adjust in the way I was approaching things, but there were also things that if they were really going to take these frail, medically complex people, they also had to bend a little and figure out. So, it was new to both of us.”

Medical Provider: “I just went to people’s apartments, rooms, and made visits with domiciliary care code billing. Most of the people who were coming in from the community retained their community-based physicians, but about half of the people moving in were being dislodged from somewhere else—to be near adult children who lived in that neighborhood—and then the staff would say, ‘Well, we have a doctor and she comes here. She’ll make a visit here. You know, she is a geriatrician’...so very quickly, I had about half the population in AL.”

(Chen, Brown, Archibald, Aliotta, & Fox, 2000). Substantively, in addition to extensive discussion regarding medication management and reporting, ALCs can work with individual primary care providers to develop and implement resident-focused care, treatment, and rehabilitation plans.

The interview data here indicate an older adult’s residence in an ALC may influence the relationship with a primary care provider in terms of the frequency a medical provider schedules visits with a patient. **Table 3** presents conflicting statements from two medical providers indicating ALC residence motivating both more frequent and less

frequent scheduling of medical appointments. Additional research is necessary to systematically assess the relationship between AL residence and medical service utilization.

The development of a relationship with medical providers also involves a focus on communication between ALCs and medical providers. Medical providers report a desire to be contacted by ALCs to be updated on the status of their patients as seen in **Table 4**. Medical providers expect to be able to interact easily with knowledgeable ALC staff regarding the health status and history of their patients. Several medical providers relate frustrating experiences seeking information from ALC staff members.

Also, as with any healthy relationship, development

and growth in the relationship should be anticipated. **Table 5** notes the reflections of a medical provider who felt she had a lot to learn about ALCs, particularly the types of appropriate and inappropriate clinical orders that can be written for ALCs.

As part of the development of the relationship, there are a number of substantive areas repeatedly identified in the interviews with medical providers that an ALC may wish to particularly focus on in order to maximize the value of the contact. These areas include medications management, monitoring/observation of residents, and medical records/documentation.

Medication Management Procedures

Managing, administering, and documenting medications for AL residents remains a significant challenge for ALCs. Clear and current communication with medical providers regarding the management of medications is essential. Although states vary on the regulatory requirements for staff training on medication administration, all care staff should be trained to recognize common side effects related to basic geriatric medications (e.g., blood

pressure medications, cardiac medication, dementia medications). In the event of a medication difficulty, any staff person should be able to quickly initiate a protocol for contacting the prescribing physician for instructions regarding proper administration or adverse events. In addition, accurate and up-to-date documentation of medication records is essential to maintain patient safety. Interviews with medical providers revealed frustration with selected ALCs for their lack of timely documentation of medications a resident may be taking.

Monitoring and Observation of ALC Residents

Beyond acute situations, the documentation and monitoring of residents' health status by the ALC can help medical providers improve their management of chronic health conditions for older adults. Longitudinal information may be particularly useful in evaluating the efficacy of a specific medication therapy or the care plan for an individual. Detailed and accurate information about side effects experienced by residents could be documented and communicated to medical providers to help inform their overall care planning.

In the interviews, medical providers report both frustrations with poor oversight as well as praise for the attentiveness in ALCs as seen in **Table 7**.

Medical Records/Documentation of Health Status

The availability of accurate information and documentation regarding an ALC resident's health status longitudinally is critical to a medical provider's accurate differential diagnosis of conditions. For example, in the case of a resident's confused mental status, documentation of the patient's baseline cognitive status is essential to determining whether the current incident is an acute condition like delirium, or part of a chronic condition like Alzheimer's dementia. ALCs can provide accurate, timely, longitudinal data about a patient's health condition, which can be invaluable to the medical provider's

Table 6. Medication Management Issues

Medical Provider: "Well, usually I get a list from them of the monthly list of medications. For some reason, I'm not getting that for this patient."

Medical Provider: "They don't take seriously sending people out with a current list of what [medications] they're on."

Medical Provider: "If the medicine isn't given, who finds out? How soon do they find out? Do you understand if you don't give this medicine it could be a life-threatening problem, as opposed to their constipation medicine? I have my own set of standards that I think that they should offer. When you are not going to give the medicine that's dangerous, you need to tell the nurse, so the nurse can call us."

Table 7. Monitoring/Observation of ALC Residents

Medical Provider: "ALCs always generate a lot of acute admissions to hospitals because something didn't get noted earlier."
Medical Provider: "My sense is that the facilities with significant resident loads...do not pay the kind of salaries to attract staff that's adequate to deliver care."
Medical Provider [As related by ethnographer]: The lack of supervision of ALC residents is a major issue for physicians. If he sees a patient and writes an order for a mammogram or other preventative services, it likely will not get followed up on. The ALC transfers responsibility to patient and family. If no family exists, or is uninvolved, it doesn't get done. ALCs justify this by saying, "We're not medical model and we informed the family. Our responsibility ends there."
Medical Provider [Regarding small ALCs]: "It's more common sense. They usually know the people they're taking care of better. They still, to this day, will usually call you when there is a more subtle change along the lines of a family member raising concern."
Medical Provider: "They are usually very responsive. They communicate well her concerns. They are able to intervene. They're able to monitor her changes in her status, whether physical or emotional. They are quick in picking up any significant changes."

management and care plan. This information should be available in ALC medical records.

Medical providers articulated the need for medical records or documentation in ALCs. In **Table 8**, they report variability with how some ALCs handle medical records and the inadequacy of records in some ALCs. In addition, a frequently overlooked aspect of medical records is their availability and transportability. Medical records are of no use to the

Table 8. Medical Records/Documentation in ALCs

Medical Provider: "People who needed more medical monitoring and should have had a chart and not—you know, the lack of a chart."
Medical Provider: "Some of the facilities ask me for a 'visit note.' Some don't and some of their regulations are catching up with them. So now, people who never asked me to chart in their charts before are now asking me to chart in their charts."
Medical Provider [As related by ethnographer]: Medical records in ALCs are nonexistent except for medication records. If medical records exist, they are poorly documented and almost never transferred with a patient in an acute healthcare situation. The medical records that exist may be in the physician's office with no way to get hold of them in a crisis. Essentially, there is no communication between the facility and physician.

medical provider if the ALC has no system for transferring the information in a timely fashion. Overall, the heterogeneity of ALCs and lack of standard regulations has resulted in idiosyncratic medical record-keeping systems created by each ALC. Medical providers could benefit from the existence of an easily transferable medical record that could travel with an ALC resident in the event of an acute situation. Such documentation would also be useful in the office setting if the records could also travel with the resident. Conceptually, Coleman (2003) describes the need for such documents in the midst of older adults' transitions between various health-care facilities. These ideas extend directly into the realm of ALCs.

Relationship With Emergency Department Providers and Emergency Medical Services

While establishing a relationship with the resident's primary care providers is paramount, the

Table 9. Benefits of Proactive Engagement With Medical Providers

Medical Provider: “Well, they [ALCs] always sent someone with her and that’s always a source of so much useful information. You can almost look through their eyes as to what’s going on at the facility. It’s like making a house call. You don’t realize what’s going on until you make one.”

Medical Provider: “I like it because I can—if the staff is right—I can create an atmosphere where I’ve got great lines of communication. I’ve got the eyes in the community that I need that I may not have in somebody’s house. You know, the daughter may not want to tell me the truth. The daughter may want me to think something so that we don’t put Mother some place. Or the patient may tell the daughter something that’s not right, so she can keep her drivers license.”

Medical Provider: “Well, the staff, the medical technicians, the nurses, the receptionist, and everybody comes to me if there is something going on, so I hear six different flavors of the same story. And everybody learns when you see something funny. The nurses need to know so that they can tell the medical provider so they can fix it. So it builds into a community caring for these people, not just ‘Come to the office [and] tell me what you want to tell me. In fact, you’ve been on the floor four times in the last week.’ I have a lady who had fallen, I don’t know how many times in a week. I heard it from the two gossipy women at the next table, who told the physical therapist, who came over to say she was on the floor five times last week. The lady who told me I’m sure is reliable. So I was able to call over and talk to the lady and say, ‘Look, you know somebody said this stuff. I think you’d better make an appointment.’”

Medical Provider: “The ALC has the best physical therapist that I have ever worked with and many of the families are willing to pay privately because he is just a magician as far as interacting with these people, motivating them, getting them up and moving. [Also], the wellness nurse, [it’s] a joy to work with her...and even the care staff.”

ALC’s reliance on the local emergency medical 911 system and its emergency departments (EDs) highlights it as another key stakeholder for proactive engagement. Particularly in light of the chronic overcrowding experienced in local EDs, contacting directors of emergency medical systems and departments can be a useful strategy to improve the utilization of these services. These providers may have guidelines on the appropriate use of their services. Overall, the inappropriate use of these resources leads to unnecessary resident transfers, hospitalizations, patient/family stress, and excess costs (Petersen, Burstin, O’Neil, Orav, & Brennan, 1998).

Proactively engaging emergency medical providers can result in more efficient and justified transfers of residents to the acute care setting. Emergency medical providers can identify core medical information (e.g., vital signs, medications, medical history) ALCs could collect and send with residents that would be

valuable to the emergency department’s assessment, diagnosis, and treatment plan. For example, baseline information on physical functioning would be extremely valuable to emergency personnel as they attempt to assess the impact of a fall on an older adult patient. Additionally, emergency medical providers may have a preferred format for receiving transfer information regarding a patient so that it can be seamlessly incorporated in the hospital’s medical record. In light of these potential benefits, it is likely emergency medical providers would welcome such proactive contact with ALCs.

BENEFITS OF PROACTIVE ENGAGEMENT WITH MEDICAL PROVIDERS

Medical providers report numerous benefits associated with their interactions with ALCs regarding

their patients. As illustrated in **Table 9**, the strongest theme is the clinical value of information regarding a resident's longitudinal health status and functional ability reliably communication by ALCs. Such information, from a range of sources in the ALC, can be used to address the healthcare needs of residents that may not typically emerge in a routine encounter between patient and medical provider (e.g., depressive symptomatology, lack of energy, falls). Interactions with residents' medical providers also may raise the providers' awareness of ALC staff and resources (e.g., physical therapist, nutritionist, dementia care unit) available to the residents. Ideally, these ALC services could be integrated into the medical provider's care plan for the resident.

DEVELOPING A MEDICAL PROVIDER EDUCATION PACKET

As illustrated above, ALCs should realize that the vast majority of medical providers report having little or no direct knowledge about ALCs in their practice area. An "education packet" is a tangible way for ALCs to respond to the information needs reported by medical providers. Such a packet needs to be focused and concise in order to be read. Ideally, its content focuses on information that will help the medical provider understand the scope of the ALC and its relevant services for patient care planning.

As noted in the section on key medical care providers, move-in meetings with new residents and families typically is a time to document medical provider contact information. It represents an ideal time to obtain the resident's permission to send a "medical provider education packet" directly to his/her medical provider. Alternatively, the packets could be distributed to ALC residents upon moving in with instructions to take the packet to their next medical appointment.

Based on consideration of the themes emerging from the medical provider interviews/analysis and the author's knowledge of ALC operations, an outline of a proposed medical provider education packet

is described below as one concrete way for ALCs to proactively engage medical providers. The organization of the education packet depends on the depth desired (e.g., introductory letter vs. packet of information). The next section briefly highlights key points for the education packet including the overview, resident care plans and documentation, and medication issues.

Overview of ALC (Size/Location, Staffing, and Health Services)

Since each ALC is unique in its mission, size, staffing, and constellation of services, the medical provider education packet should communicate this information in some form. For example, a cover page could concisely introduce the ALC by describing the location, number of units, and a general description of services for residents. Next, the key goal of the materials should be to identify the range of health-related services that are offered by the ALC. In particular, the level, availability, and organization of the nursing staff are essential to clarify for the medical provider. For example, does the ACL employ licensed, registered nurses 24-7 or on a more limited schedule? The introductory material should clearly identify the health-related contact person at the ACL including the name and title, as well as his/her contact information. It is also important to let the medical provider know who to call regarding the condition of their patient. In smaller communities this person may be the manager/owner while in larger communities a nurse may be the appropriate healthcare contact person. Additionally, a specific section of the materials should review relevant medically related services and information (e.g., nutrition services, medication management and monitoring, blood pressure monitoring, exercise services, medical record keeping, health-related policies). It is also useful to articulate the ALCs discharge policies, that is, how decisions are made to transfer residents out of the community.

Resident Care Plan and Updates

As part of the education packet, ALCs may want to include a copy or summary of the care plan developed for the resident. Medical providers may have comments or suggestions regarding the care plan. Knowledge of elements of the care plan may be useful to the provider during their medical appointments with the resident. As a follow-up to the care plan, ALCs may elect to send periodic care plan updates regarding functional status information to the medical provider. These efforts will assist in the continued engagement with the provider. As part of this communication, ALCs may wish to develop a standardized form, which documents a resident's care plan, health status, and functional status information. In this way, information communicated to the medical provider can easily be added to the resident's medical record in the medical provider's office.

Medication Issues

As noted in the section on Key Medical Care Providers, medication issues in most ALCs represent a source of continuing contact with medical providers, ranging from prescription refills and monitoring efficacy to reporting side effects and adverse drug reactions. A dedicated section of the education packet should address how the ALC handles medications, including issues like: ordering, administering, monitoring, changing, and reporting adverse reactions to medications. In general, medical providers report a lack of knowledge regarding how medications are handled in ALCs. Medication-related issues remain a consistent theme in interviews with medical providers, ALC residents, families, and staff (Sloane, Zimmerman, Brown, Ives & Walsh, 2002). As such, medical providers should be engaged on the topic of medications beginning with the first contact ALCs have with medical providers.

In summary, an education packet represents an opportunity to initiate a dialogue with residents' medical providers. The three substantive areas suggested (ALC overview of services, resident care plan,

and medication issues) are core issue to address with medical providers. However, they do not exhaust the range of information ideally to be exchanged.

ENGAGING MEDICAL CARE PROVIDERS: OPPORTUNITIES FOR ALCs

Overall, ALCs offer a supportive and autonomous environment for older adults that, ideally, can be a synergistic resource for their residents' medical care providers. However, unless medical care providers are aware of the services offered by ALCs, including specific resident care plans, such information cannot be incorporated into the medical provider's care plan. While additional empirical research is necessary to establish how ALCs and medical providers can most effectively work together, a number of benefits to such a relationship can be suggested based on the author's experience.

First, improving the coordination between ALCs and healthcare providers has the potential to improve the functional status of residents/patients. Evidence from the Program of All-Inclusive Care of the Elderly (PACE) communities suggests that supportive environments have the potential to contribute to maintaining or improving the functional status of individuals (Lee, Eng, & Fox, 1998). Second, the systematic resident-monitoring ability of a supportive ALC environment has the potential to identify and address residents' health issues earlier in their course. Addressing residents' health issues earlier may avoid their exacerbation and the need for hospitalization or the need for skilled nursing care. For example, the increased monitoring of a diabetic older adult may lead to improved control of his/her condition and avoidance of hospitalization. Third, a coordinated effort with medical providers can improve the overall health quality of life of residents. A good working relationship with a medical provider can help to recognize and identify symptoms and manage them more effectively over the course of a condition. In this way, appropriate interventions

may be implemented well before a crisis occurs.

Beyond the benefits for the residents of ALCs, proactively engaging medical providers makes business and marketing sense since relationships with providers may be beneficial in several additional ways. Most importantly, the resident may receive better care and service from the ALC as well as from the medical provider because of this coordinated engagement. This orientation can contribute to improved functional status of the resident which, in turn, may allow the resident to remain in the ALC for a longer period of time, thereby stabilizing its census. Another indirect marketing benefit is that medical providers are frequently involved in the decision for a resident to move into an ALC. Medical providers who appreciate the quality of services provided to their patients may be more likely to recommend the ALC to a patient and family who may be considering a future move into an ALC.

CONCLUSIONS

ALCs will continue to provide an essential component of care to older, frail adults. However, rising acuity levels among residents has necessitated additional health-related support and services for residents including the provision of appropriate levels of medical care, monitoring, management, and/or oversight. In this context, proactively establishing and maintaining relationships with the residents' medical care providers represents an important resource that is consistent with a rich "social model" of care and can positively contribute to the health status and quality of life for ALC residents. Engagement with medical care providers can include professionals like personal physicians, specialist physicians, physician extenders, allied health professionals, and hospice staff, as well as key personnel in the emergency medical health system. The suggested use of a standardized "medical provider education packet" to initiate contact with providers may be an efficient way for both ALC providers and medical professionals to begin their relationship.

However, such a proposed innovation should be systematically evaluated by research prior to widespread implementation. It should also be noted that results from the current study are considered preliminary and illustrative since it was limited by the relatively small sample sizes of both ALCs and medical providers. Future research regarding medical care in assisted living is called for in order to better elucidate the relationship between ALCs and community-based medical providers.

In conclusion, in pursuit of high-quality care for residents of ALCs, key medical care communication domains include: overall communication patterns/preferences, medication management issues, health monitoring information, and medical records/documentation. A written medical provider education packet sent to residents' primary care providers upon entry into an ALC is one concrete way suggested to efficiently initiate this engagement. Ultimately, the potential benefits of establishing proactive relationships with medical care providers include the coordination of care for residents and potentially less health service use due to earlier intervention, improved functional status, and higher overall quality of life. Nonetheless, realistically, the responsibility for initiating contact with the medical care providers of residents will continue to lie with the ALC. At the same time, the benefits of such engagement will be enjoyed by the resident, the ALC, and the medical care provider.

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