Be Well in AL:
A Coalition to Promote Medical and Mental Health Care in Assisted Living

Launch Webinar Hosted by UNC, AMDA, and CEAL

Overview

Topic	Presenter
Rationale and aims of the Be Well in AL Coalition	Sheryl Zimmerman
Perspectives	
Center for Excellence in Assisted Living (CEAL)	Lindsay Schwartz
Society for Post-Acute Care and Long-Term Medicine (AMDA)	Barbara Resnick
American Assisted Living Nurses Association (AALNA)	Margo Kunze
Alzheimer's Association	Douglas Pace
Providers (Evergreen Estates)	Pat Giorgio
Advocates (California Advocates for Nursing Home Reform)	Tony Chicotel
Next steps in joining the coalition, discussion, Q & A	Everyone

Insert comments and questions for discussion in the chat box throughout the presentation

Why a Coalition?

Rationale

JAMDA

journal homepage: www.jamda.com

Special Article

The Imperative to Reimagine Assisted Living

Check for updates

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Summative Point

“Stakeholders agree -- and vehemently so -- that today’s assisted living is not as intended in the past, and must be reimagined for the future.”

Five Areas for Change, Twenty Potential Solutions

Area	Potential Solution
Models	• Promote consumer education using common definitions and including important details • Endorse standardized reporting • Decouple services from housing • Evaluate models in reference to person-centeredness • Consider quality measures that address social and health components
Regulation	• Create regulations in partnership with stakeholders and review them regularly • Encourage and evaluate quality improvement initiatives • Examine outcomes related to regulations
Financing	• Limit unnecessary new construction • Diversify housing options and modify services to lower costs • Provide tax incentives and public subsidies • Develop partnerships • Expand Medicaid coverage
Residents	• Coordinate health care consistent with resident acuity • Train all staff on dementia care practices • Reconsider segregated dementia care • Prepare for increased resident diversity
Nurse and direct care workforce	• Embrace strategies being recommended in nursing homes • Address training needs specific to assisted living • Establish acuity-based staffing recommendations

Where to Start?

Area	Potential Solution
Models	• Promote consumer education using common definitions and including important details • Endorse standardized reporting • Decouple services from housing • Evaluate models in reference to person-centeredness • Consider quality measures that address social and health components
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Why Start with Residents?

WHO LIVES THERE

"Nursing home residents from a decade ago"

- Increased acuity (> 50% have hypertension, depression; ≈ 33% have COPD, diabetes)

Alzheimer's disease and other dementias are prevalent

- 70% cognitive impairment; 42% moderate/severe dementia

Assisted living is the largest provider of residential long-term care in the country, including for persons with dementia

WHAT ASSISTED LIVING IS

Residential nature and philosophy

- "Social" (psychosocial) focus; not a health care setting

National variability

- Size ranges from 4 to 499 beds (average is 33)
- State regulated with 350 policy approaches (e.g., building type, scope of care)

WHO WORKS THERE

Limited medical and nursing provider presence

- Half (46%) do not have RN/LPN
- Few have primary care onsite

Limited direct care staffing; minimal training

- < 40% of states specify minimum staffing ratios
- Only 25% require staff to have at least 11 hours training

Medical/Mental Health Care in Assisted Living

CONCERNS

Regarding care

- Infection prevention, medication use, poor communication with staff when change in condition occurs

Regarding outcomes

- Acute and chronic conditions, falls, depression, emergency department visits, hospitalization

EVOLUTION (absent data)

Increase in nursing presence

Some integrated medical care

CHALLENGES

No guidance regarding optimal structures and processes of care

- Recognizing variability in staffing, medical records, training, regulation, services

Concern that AL not become too medicalized

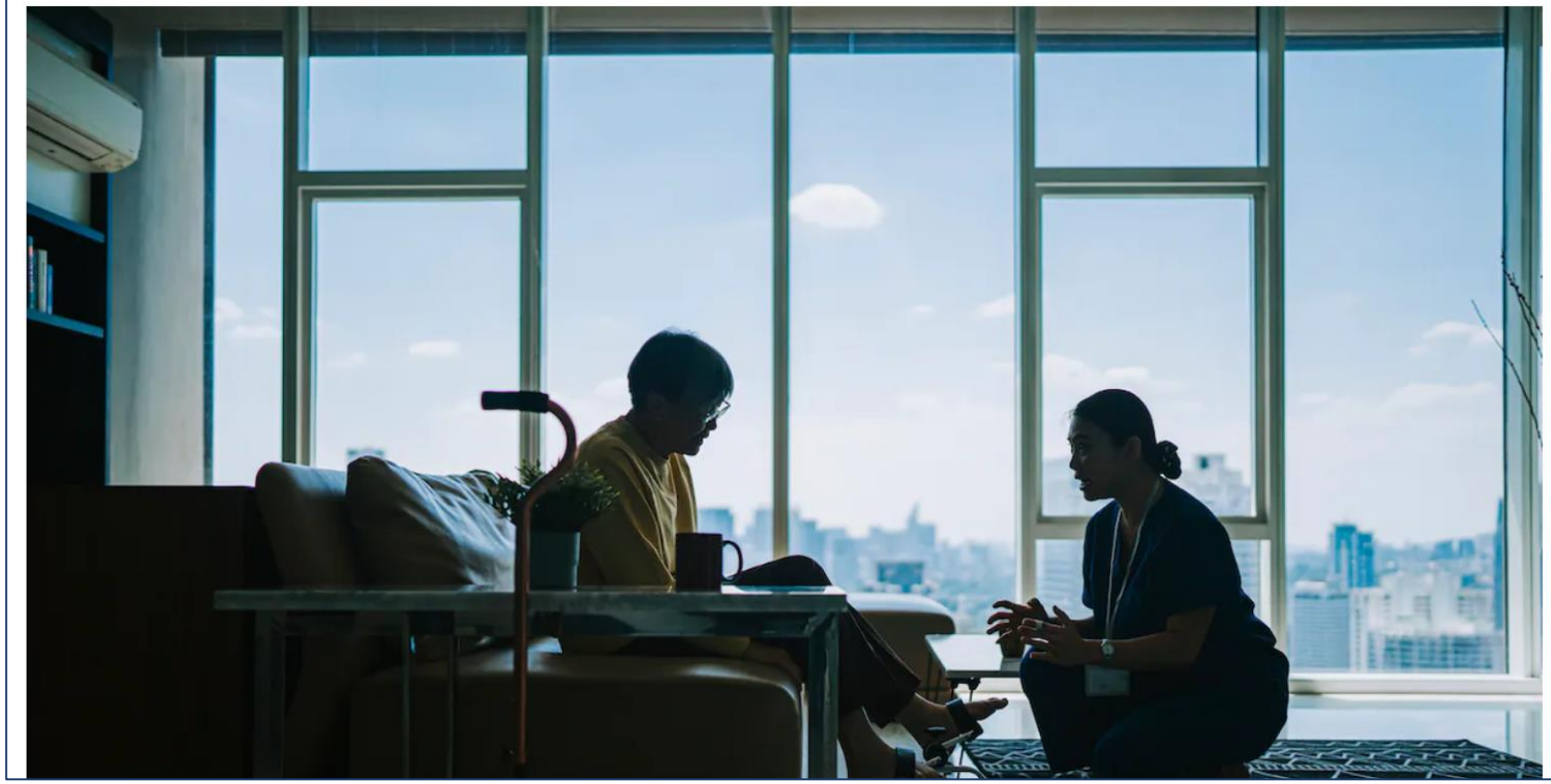
- Erosion of original intent, call for federal oversight, increased cost, reduced accessibility

The Washington Post
Democracy Dies in Darkness

Assisted living too often fails older, sicker residents, report says

By Judith Graham

December 3, 2022 at 7:07 a.m. EST



Select Comments (of more than 490 comments)

- *"There's no consistent assisted living definition. Saying 'assisted living' is like saying 'hotel' -- it could be a small roadside dump, it could be a five-star luxury establishment."*

- *"I've found that the term 'assisted living' means different things in different states. In PA (where my husband's grandmother lived), a person in assisted living would receive help with their activities of daily living like dressing and toileting. In MA, where we now live and where my mother-in-law moved to be closer to us, people in assisted living were expected to be able to do those same activities of daily living with no help. This caused us no end of hell."*

- *"My mother benefitted from assisted living for several years. I think it improved her health and wellbeing. But as her health deteriorated, she needs far more care than she's getting. She went to a SNF, but Medicare threw her out, so she's 100% bedbound in assisted living and requires an aide to feed her. It's horrible. The facility and staff really aren't equipped to deal with a bedbound person, but there's nowhere else to go."*


The Washington Post

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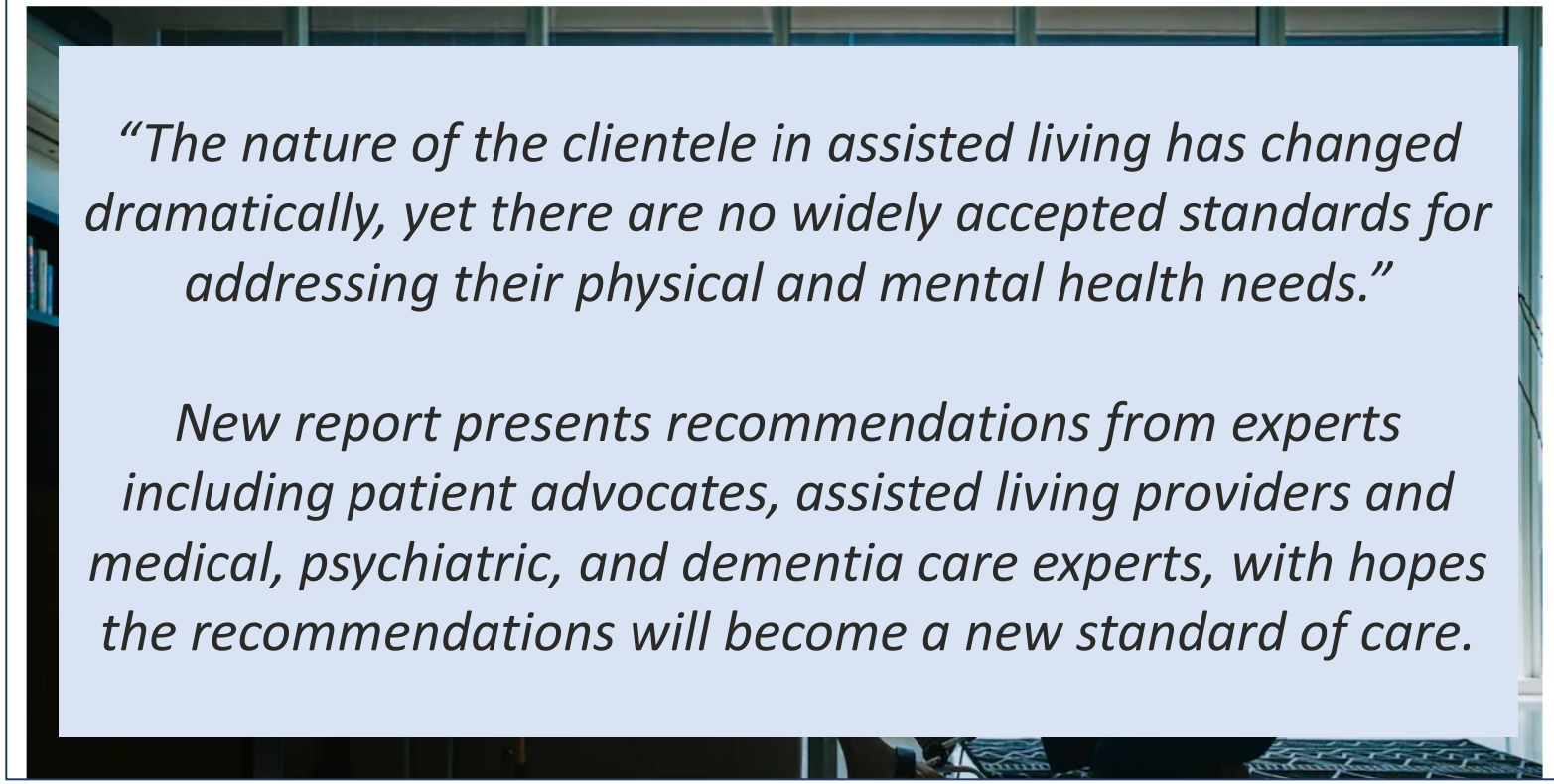

"The nature of the clientele in assisted living has changed dramatically, yet there are no widely accepted standards for addressing their physical and mental health needs."

New report presents recommendations from experts including patient advocates, assisted living providers and medical, psychiatric, and dementia care experts, with hopes the recommendations will become a new standard of care.

Publication

JAMA Network | Open

Consensus Statement | Geriatrics

Recommendations for Medical and Mental Health Care in Assisted Living Based on an Expert Delphi Consensus Panel

A Consensus Statement

Sheryl Zimmerman, PhD; Philip D. Sloane, MD, MPH; Christopher J. Wretman, PhD; Kevin Cao, BS; Johanna Silbersack, MSW; Paula Carder, PhD; Kali S. Thomas, PhD; Josh Allen, RN; Kim Butrum, RN, MS; Tony Chicotel, JD, MPP; Pat Giorgio, MPS; Mauro Hernandez, PhD; Helen Kales, MD; Paul Katz, MD; Juliet Holt Klinger, MA; Margo Kunze, RN; Christopher Laxton, CAE; Vicki McNealley, PhD, MN, RN; Suzanne Meeks, PhD; Kevin O'Neil, MD; Douglas Pace, NHA; Barbara Resnick, PhD, RN; Lindsay Schwartz, PhD; Dallas Seitz, MD, PhD; Lori Smetanka, JD; Kimberly Van Haitsma, PhD

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Expert and Diverse Panelists

Josh Allen RN, Allen Flores Consulting Group, Searcy, AR
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Pat Giorgio MPS, Evergreen Estates, Cedar Rapids, IA
Mauro Hernandez PhD, Hearth & Truss, Wilsonville, OR
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Margo Kunze RN, American Assisted Living Nurse Association, Belmar, NJ
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Kevin O'Neil MD, ALG Senior, Hickory, NC
Douglas Pace NHA, Alzheimer's Association, Chicago, IL
Barbara Resnick PhD, RN, University of Maryland School of Nursing, Baltimore, MD
Lindsay Schwartz PhD, American Health Care Association/National Center for Assisted Living, Washington, DC
Dallas Seitz MD PhD, Hotchkiss Brain Institute, University of Calgary, Calgary, Alberta, Canada
Lori Smetanka JD, National Consumer Voice for Quality Long-Term Care, Washington, DC
Kimberly Van Haitsma PhD, College of Nursing, The Pennsylvania State University, University Park, PA

Item Development and Rating

(1) Compiled items of potential importance to medical and mental health care

- Review of literature, regulations, community guidelines; advisory panel; input of panelists
- Created 183 items, grouped into six categories (e.g., staff/staff training/ policies/practices)

(2) Round 1: Panelists anonymously rated items in importance and feasibility

Importance to quality of care (rated 1-9; items scored ≥ 7 are considered important)

- Extent to which the item is expected to significantly affect quality of care outcomes if implemented, considering the extent of expected need and expected magnitude of benefit

Feasibility (rated 0-2, none/some/all)

- Extent to which the item is feasible for/can potentially be implemented in no, some, or all communities, based on factors such as variable case-mix, location, or other considerations, in the context of today's environment

(3) Round 2 and follow-up: Panelists rated reworded items and commented on others (e.g., use of metrics/cut-points); met to discuss final results

(4) Compiled items according to established importance cut-points and consensus (≥ 75% agreement)

Example Rating Sheet (Select Items of 183 in Six Categories)

- **Importance to Quality of Care:** significantly affects care outcomes based on extent of need and benefit
- **Feasibility:** Can be implemented in no/some/all communities based on case-mix, location, other considerations

	Importance to Quality of Care Rate 1-9	Feasibility None	Some	All
Community demographics/administration				
Has memory care unit/designated dementia beds	☐	◯	◯	◯
Staffing and staff training				
Has LPN/LVN available on-site	☐	◯	◯	◯
Nursing and related services				
Provides physical therapy on-site	☐	◯	◯	◯
Resident assessment and care planning				
Conducts a formal cognitive assessment	☐	◯	◯	◯
Policies and practices				
Advance care discussions occur and are documented	☐	◯	◯	◯
Medical and mental health clinicians and care				
Has some medical care provided on-site	☐	◯	◯	◯

RECOMMENDATIONS

A total of 43 items achieved consensus as important to quality of care outcomes

Handout

Recommendations for Medical and Mental Health Care in Assisted Living Based on an Expert Delphi Consensus Panel: A Consensus Statement

Distributed by Be Well in AL: A Coalition to Promote Medical and Mental Health Care in Assisted Living

Items Achieving Consensus as Important to Quality of Care Outcomes
Staffing and Staff Training
Training for any staff on person-centered care
Direct care worker-to-resident ratio
Staff training for dementia/mental illness
Training on side effects of drug treatments for staff who administer medications
Health care supervisor training and knowledge
Training for any staff on infection prevention and control
Percent of direct care workers who are not contract staff
Training for any staff on end-of-life care/advance care planning
Percent of direct care workers who are full-time
Has RN available on-site
Has LPN/LVN available on-site
Nursing and Related Services
Provision of routine toenail care on-site
Administration of influenza vaccines on-site
Provision of physical therapy on-site
Provision of insulin injections on-site
Blood sugar testing on-site
AL staff schedule residents' medical and mental health care visits
Provision of occupational therapy on-site
Obtainment of weight for all residents at least monthly on-site
Administration of breathing/nebulizer treatments on-site
Resident Assessment and Care Planning
Resident present during assessment/care planning
Conducts a formal cognitive assessment as part of resident assessment
Nurse present during assessment/care planning
Uses a formal assessment tool for cognition
Conducts a standardized assessment to determine cause when a resident is agitated
Certified nursing assistant/personal care aide present during assessment/care planning
Uses other formal assessment tools (other than for cognition)
Conducts as needed formal resident care or service plan meeting
Family present during assessment/care planning
Health care supervisor present during assessment/care planning
Policies and Practices
Has a policy/procedure regarding aggressive or other behaviors
Informs a responsible party when an emergency department visit occurs
Discussions about advance directives occur for all residents and are documented
Records health information in chart
Has a policy/procedure regarding expression of suicidal thoughts
Informs a responsible party when change in status
If resident cannot respond, family provides consent for new antipsychotic or opioid
Informs a responsible party when a medication is changed
If resident is able to respond, resident provides consent for new antipsychotic or opioid
Has a program or policy related to gradual dose reduction for psychotropic medications
Medical and Mental Health Clinicians and Care
All off-site medical or mental health visits include post-visit notes with findings
Has any medical care provided on-site
Has any mental health care provided on-site

Expert Consensus Recommendations (11 of 43)

Staffing & Staff Training	Importance Mean (SD)	Percent Agree Importance ≥ 7.0	Feasibility Mean (SD)
Training for any staff on person-centered care	8.89 (0.32)	100.0	2.89 (0.32)
Direct care worker-to-resident ratio	8.68 (0.58)	100.0	2.84 (0.37)
Staff training for dementia/mental illness	8.54 (0.55)	96.5	2.74 (0.42)
Training on side effects of drugs for staff who administer medications	8.53 (0.84)	94.7	2.89 (0.32)
Health care supervisor training and knowledge	8.49 (0.78)	97.4	2.74 (0.45)
Training for any staff on infection prevention and control	8.42 (1.12)	94.7	2.95 (0.23)
Percent of direct care workers who are NOT contract staff	8.21 (1.23)	94.7	2.47 (0.51)
Training for any staff on end-of-life care/advance care planning	8.16 (1.12)	89.5	2.74 (0.45)
Percent of direct care workers who are full-time	7.95 (1.18)	84.2	2.68 (0.48)
Has RN available on-site	7.95 (1.54)	84.2	2.11 (0.32)
Has LPN/LVN available on-site	7.89 (1.20)	78.9	2.32 (0.48)

Note: Importance scored 1 (least) through 9 (most); feasibility scored 1 (none), 2 (some), and 3 (all) communities.

Expert Consensus Recommendations (11 of 43)

Staffing & Staff Training	Importance Mean (SD)	Percent Agree Importance ≥ 7.0	Feasibility Mean (SD)
Direct care worker-to-resident ratio	8.68 (0.58)	100.0	2.84 (0.37)
Should be acuity-driven, related to care needs, evidence-based			
Is need for further research			
Percent of direct care workers who are NOT contract staff	8.21 (1.23)	94.7	2.47 (0.51)
Must recognize staffing challenges/employment conditions			
Percent of direct care workers who are full-time	7.95 (1.18)	84.2	2.68 (0.48)
Staff split shifts to be home with their children			
Both need further research			

Note: Importance scored 1 (least) through 9 (most); feasibility scored 1 (none), 2 (some), and 3 (all) communities.

Expert Consensus Recommendations (9 of 43)

Nursing & Related Services	Importance Mean (SD)	Percent Agree Importance ≥ 7.0	Feasibility Mean (SD)
Provision of routine toenail care on-site	8.16 (1.17)	89.5	2.58 (0.51)
Administration of influenza vaccines on-site	8.05 (1.54)	84.2	2.63 (0.50)
Provision of physical therapy on-site	7.94 (1.16)	88.9	2.26 (0.45)
Provision of insulin injections on-site	7.89 (2.13)	84.2	2.47 (0.51)
Blood sugar testing on-site	7.84 (1.38)	84.2	2.61 (0.50)
AL staff schedule residents' medical and mental health care visits	7.74 (1.73)	78.9	2.53 (0.51)
Provision of occupational therapy on-site	7.73 (1.19)	84.2	2.16 (0.37)
Obtainment of weight for all residents at least monthly on-site	7.58 (2.48)	78.9	2.74 (0.56)
Administration of breathing/nebulizer treatments on-site	7.42 (1.92)	78.9	2.26 (0.56)

Note: Importance scored 1 (least) through 9 (most); feasibility scored 1 (none), 2 (some), and 3 (all) communities.

Expert Consensus Recommendations (10 of 43)

Resident Assessment & Care Planning	Importance Mean (SD)	Percent Agree Importance ≥ 7.0	Feasibility Mean (SD)
Resident present during assessment/care planning	8.32 (1.16)	94.7	2.74 (0.45)
Conducts formal cognitive assessment as part of resident assessment	8.32 (1.11)	84.2	2.74 (0.45)
Nurse present during assessment/care planning	8.05 (1.31)	89.5	2.47 (0.51)
Uses a formal assessment tool for cognition	8.00 (1.53)	84.2	2.63 (0.50)
Conducts standardized assessment to determine cause of agitation	8.00 (1.89)	89.5	2.53 (0.61)
Personal care aide present during assessment/care planning	7.79 (2.04)	84.2	2.68 (0.48)
Other formal assessment tools are used (other than for cognition)	7.63 (1.40)	81.1	2.74 (0.38)
Conducts as needed formal resident care or service plan meeting	7.63 (2.36)	78.9	2.95 (0.23)
Family present during assessment/care planning	7.58 (1.61)	78.9	2.53 (0.51)
Health care supervisor present during assessment/care planning	7.58 (1.77)	78.9	2.47 (0.51)

Note: Importance scored 1 (least) through 9 (most); feasibility scored 1 (none), 2 (some), and 3 (all) communities.

Expert Consensus Recommendations (10 of 43)

Policies & Practices	Importance Mean (SD)	Percent Agree Importance ≥ 7.0	Feasibility Mean (SD)
Has a policy/procedure regarding aggressive or other behaviors	8.68 (0.58)	100.0	2.79 (0.42)
Informs responsible party if emergency department visit occurs	8.67 (0.59)	100.0	2.88 (0.33)
Discussions about advance directives occur and are documented	8.65 (0.70)	100.0	2.94 (0.24)
Records health information in chart	8.43 (0.74)	94.7	2.86 (0.29)
Has a policy/procedure regarding expression of suicidal thoughts	8.32 (1.06)	94.7	2.67 (0.49)
Informs a responsible party when change in status	8.16 (1.20)	91.2	2.84 (0.34)
If resident cannot, family provides consent for antipsychotic or opioid	8.00 (1.41)	88.2	2.88 (0.33)
Informs a responsible party when a medication is changed	7.74 (1.33)	84.2	2.67 (0.49)
If resident can respond, provides consent for antipsychotic or opioid	7.65 (2.32)	82.4	2.82 (0.53)
Has a program/policy for gradual dose reduction for psychotropics	7.21 (2.32)	78.9	2.50 (0.51)

Note: Importance scored 1 (least) through 9 (most); feasibility scored 1 (none), 2 (some), and 3 (all) communities.

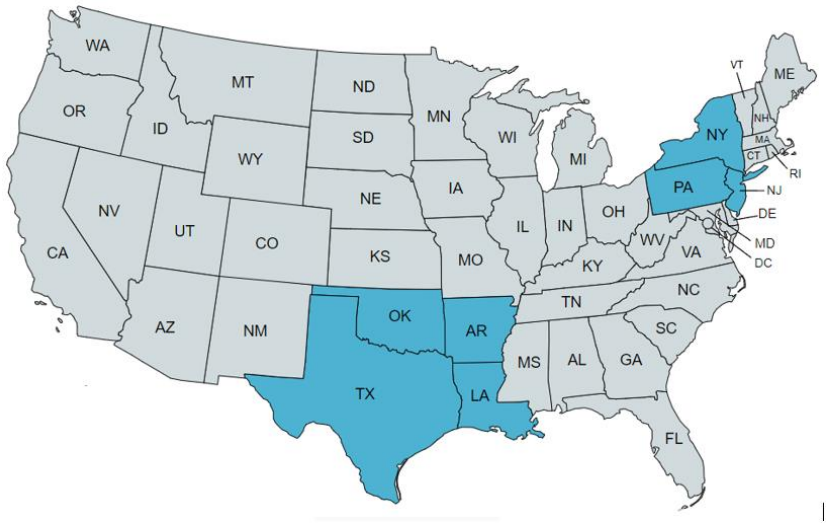
Expert Consensus Recommendations (3 of 43)

Medical/Mental Health Clinicians & Care	Importance Mean (SD)	Percent Agree Importance ≥ 7.0	Feasibility Mean (SD)
All off-site medical/mental health visits include post-visit notes	8.59 (0.62)	100.0	2.82 (0.39)
Has any medical care provided on-site	7.84 (1.57)	89.5	2.22 (0.43)
Has any mental health care provided on-site	7.42 (1.89)	78.9	2.22 (0.43)

Note: Importance scored 1 (least) through 9 (most); feasibility scored 1 (none), 2 (some), and 3 (all) communities.

Actual Feasibility: Medical and Mental Health Care in Practice

- **250 communities across seven states (AR, LA, OK, TX; NJ, NY, PA) participating in a study of dementia, medical, and mental health care in assisted living**
  - Communities selected to represent the state
  - Data available for 26 of 43 items, from 151-250 communities
  - **77% of items were practiced in ≥ three-quarters of communities (including all nursing/related services items)**
    - Least common
      - *Having a program/policy for gradual dose reduction for psychotropic medications* (44%)
      - *Conducting as needed care plan meetings* (11%)



OBSERVATIONS

Recommendations Embrace Four Key Components

Tenets of Assisted Living

(Person-centered care, quality of life, aging in place)

- Training on person-centered care/advance care planning
- Conduct care plan meetings as needed, attended by resident and direct care worker
- Discuss and document advance directives

Primary Provider of Dementia Care

- Training on dementia
- Conduct formal cognitive assessments for agitation
- Have policies to manage behaviors, including gradual dose reduction program for psychotropic medications
- Involve responsible party when change in status occurs

Pragmatism and Diversity

- Three quarters of items were rated 2.5 in terms of feasibility (some/all), and were in practice in at least three-quarters of communities
- Two items were not practiced in at least half of communities: conduct as needed formal assessments, have a program for gradual dose reduction

Workforce Needs

- RN or LPN onsite
- Medical and mental health care onsite
- Need for data related to direct care workers (optimal staffing ratios based on resident acuity; how best to employ part-time and contract staff)

EFFECT CHANGE IN PRACTICE AND POLICY:

The Be Well in AL Coalition

Aim, Methods, and Next Steps of the Coalition

AIM

Develop a diverse national coalition to effect change in assisted living practice and policy based on evidence and best practices

METHODS

- Launch with the medical and mental health care recommendations
- Convene two action-oriented roundtables: operational, policy
- Include policy-makers; owners/operators; professional, provider, health care and advocacy organizations; residents and family members; researchers; others
- Develop products (e.g., information briefs, toolkits)
- Spread the word and *effect change*

NEXT STEPS

- Roundtable leaders are being solicited; e-mail Alicia Graf (Agraf@paltc.org)
- Zoom registration links will be provided for participation in roundtables

Perspectives

Center for Excellence in Assisted Living (CEAL)	Lindsay Schwartz
Society for Post-Acute Care and Long-Term Medicine (AMDA)	Barbara Resnick
American Assisted Living Nurses Association (AALNA)	Margo Kunze
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