Using the Maryland Assisted Living Functional Assessment to Establish a Plan of Care

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Comprehensive assessments of assisted living facility residents can make a tremendous difference in terms of recognizing and addressing diseases and illnesses early, as well as keeping these individuals safe from falls, fractures, and other injuries. However, such assessments may be time-consuming and/or conducted in a hit or miss way. Recently, a tool has been tested in Maryland that could become a valuable and important resource for facilities nationwide. That instrument is the subject of this original research article.

Background

Assisted living housing generally is described as any group home-like residential program with the capacity to care for people with disabilities on an as-needed basis.[1,2] The Centers for Medicare and Medicaid Services (CMS) defines assisted living as "a type of living arrangement in which personal care services such as meals, housekeeping, transportation, and assistance with activities of daily living (ADLs) are available as needed to people who still live on their own in a residential facility."

The Assisted Living Workgroup, a government-convened congregate of AL stakeholders, established a more comprehensive definition of assisted living that was intended to be consumer oriented and consumer friendly.[3] Suggesting that AL's goal is to help older adults receive the care they need in a home-like setting and in a way that promotes dignity and independence, the group defined assisted living as a state-regulated and -monitored residential long term care option.

ALFs vary and can range from a small home with one resident to larger facilities with 100 or more living units. The types and levels of care provided with regard to health, social, or recreational activities; options regarding personal freedom; and policies regarding admission of residents with deficits in ADLs or those who exhibit behavioral problems likewise vary across facilities.[4,5]

There are federal laws that impact assisted living; however, oversight of assisted living occurs at the state level. The varying laws and regulations affecting these settings

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have created a diverse and fluid operating environment for providers and a mix of terminology, settings, and available services. The National Center for Assisted Living (NCAL) developed a comprehensive source that provides a state-by-state review of requirements.[6]

State Guidelines for AL Resident Assessment

State guidelines for assisted living address several areas.[7] Admission assessment guidelines vary significantly across the states, although each state typically requires that facilities establish some type of evaluation or plan of care. Some states recommend the completion of a specific assessment form. Other states mandate that the assessment form used to evaluate residents be approved at the state level, while still others do not specify what needs to be included in the assessment.

The MALFA Tool

Maryland is one of those states that recommend facilities complete a specific assessment form. Toward that end, a group of practitioners developed the Maryland Assisted Living Functional Assessment (MALFA) tool.[8] The MALFA is comprised of seven sub-categories:

- Monitoring of medical illnesses and conditions (MI)
- Monitoring of cognitive impairments, substance abuse, and psychiatric illnesses (CI)
- Performing treatments for physical/medical conditions (PROBMAN)
- Medication management (MEDMAN)
- Assistance with activities of daily living (ADL)
- Management of high risk situations both physical (eg, impaired hearing and vision) and psychosocial (eg, impaired judgment, isolation) (RISKMAN)
- Management of problematic behavior such as resistance to care, or wandering (MANTOTAL).

The total score for all seven sections ranges from 0 to 115.

There is no published evidence of reliability and validity of this tool, although studies currently are ongoing. MALFA's purpose is to help nursing staff in facilities collect essential information about each resident with regard to his or her physical, functional, and psychosocial needs. In so doing, it is anticipated that an optimal level of care would be determined and the information would be used to develop an appropriate plan of care. Ultimately, use of the MALFA should help maintain the function, health, and quality of life of the resident, and assure that the resident remains in the least restrictive level of care for the longest period of time.

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Scoring of the MALFA determines the level of care necessary for each resident. In fact, the level of care reflects the complexity of the services needed to optimally meet the resident's needs:

- Level 1 is a low level of care and may involve providing occasional assistance in accessing and coordinating health services and interventions, providing occasional supervision, assistance, support, setup, or reminders with some but not all daily activities, and assisting the resident with taking medication or coordinating access to necessary medication and treatment.
- Level 2 is a moderate level of care and might involve providing or ensuring access to necessary health services, providing or ensuring substantial support with some but not all ADLs or minimal support with any number of ADLs, and providing or ensuring assistance with taking medication or administering necessary medication and treatment (including monitoring medication and treatment effects/outcomes).
- Level 3 is a high level of care that might include providing or ensuring ongoing access to and coordination of comprehensive health services and interventions, providing or ensuring comprehensive support as frequently as needed to compensate for any number of ADL deficits, and providing or ensuring assistance with taking medication to administer necessary medication and treatment.

Scores simply are tallied in each of the seven sections and then combined to calculate the total score. Level 1 is advised for a total score of 0 to 25, level 2 for a score of 26 to 50, and 51 or higher for level 3.

MALFA in Action

The MALFA takes a nurse evaluator approximately 30 to 60 minutes to complete and provides a wealth of information about the individual's care needs on areas particularly relevant to nursing, such as medication management and safety. The assessment tool was used in a single site that admitted approximately 80 residents over a five-year period.

In the first year, the facility noted a need for increased help managing cognitive impairment and

psychiatric illnesses, medication management, and management of behavioral problems. Over the first two years, the tool helped identify an increased need for assistance with medication management and ADL performance. Interestingly, these functional declines over time are similar to what is found in the trajectory of older adults living in nursing home settings.[9,10] In this instance, the average length of stay in the ALF was 1.4 years. During a five-year period, close to 50% of the residents who moved into the facility were moved to a nursing home; and nearly 50% died.

What is not well addressed in ALFs is how information from the baseline assessment using the MALFA can influence care and care planning for residents. Moreover, the care plans implemented in ALFs actually may be focused on providing care services. Staff and clinicians, in turn, may focus on resident needs (eg, bathing, dressing, or medication administration/assistance), rather than optimizing underlying function and capability. In reality, this care philosophy may exacerbate cognitive as well as physical decline. Identification of safety concerns, for example, may result in limiting a resident's physical activity (ie, keeping him or her in a safe environment where there may be less room to ambulate freely). At the same time, providing too much assistance with bathing and dressing actually may exacerbate functional decline.

However well-meaning the intentions of facility staff, caregivers, and others, assessments that misinterpret resident needs clearly can do more harm than good. Admission assessments of residents in assisted living are intended to help form a "blueprint" for each resident, but these only work when they enable an effective plan.[11,12] Ideally, the comprehensive descriptive findings from assessment tools such as the MALFA can be used to establish an appropriate and individualized care plan for each resident.

This plan of care should incorporate a restorative care philosophy aimed at helping the individual obtain and maintain his or her highest level of function. The goals for each resident should focus on maintaining and improving MALFA scores so that the individual can remain within an assisted living level of care, as defined by state guidelines. Take the case of one resident, Mrs. D., as detailed in Table 1.

Mrs. D.'s Story

Mrs. D. was an 83-year-old white female admitted to the ALF with a baseline MALFA score of 66. She was unable to manage her own medications independently. She was at risk for harming herself due to excessive alcohol use. In fact, contributing to her transfer into the ALF was her habit of drinking at least four glasses of wine daily; and her family was unable to change this behavior.

The ALF should clearly indicate the specific elements of the care plan that the ALF will meet, as well as the responsibility of the resident/family.

In addition to a history of alcohol abuse, Mrs. D. also had experienced a stroke with no evidence of dense hemiparesis but some functional changes associated with balance. She also had hyponatremia secondary to alcohol abuse, osteoarthritis, and a history of a gastrointestinal bleed (also likely associated with alcohol abuse), and anemia.

She had multiple falls prior to admission into the ALF; and although she ambulated independently with a walker, she spent most of her day in the bed or sitting on her couch. She needed assistance with bathing and dressing and a lot of encouragement to even get up out of bed during the day. She refused to go to the dining room or to engage in any of the activities offered within the facility. Her only social interaction was frequent visits from her son and his family.

After her initial assessment, a plan of care was established to wean her off drinking by removing all alcoholic beverages in her home and working closely with her family to prevent them from providing her with alcohol. Medical intervention was implemented to avoid withdrawal, and facility staff worked to increase daily structure. Mrs. D. received help from a nursing assistant to complete personal care, and she was encouraged to ambulate to the dining room for lunch and dinner. Nonetheless, she was not interested or willing to participate in facility activities, and she continued to return to bed frequently throughout the day. However, as noted in her annual follow-up assessment, her score on the MALFA decreased from 66 to 22, largely by decreasing her risks for harming herself or others.

Harmonizing Assessments and Care Plans

ALFs were developed to provide a homelike environment, independence, autonomy, and privacy for older individuals. To truly allow these individuals to "age in place," however, aggressive care planning and treatment implementation may be needed to optimize function across all areas. Unfortunately, it is not currently clear how these assessments are being utilized.

Table 1.
Case Example of Use of the MALFA to Optimize Outcomes of Care in Assisted Living Facilities

Case Description:	Mrs. D. was an 83-year-old white female with a known history of alcohol abuse, stroke with no evidence of dense hemiparesis but some functional changes associated with balance, hyponatremia secondary to alcohol abuse, osteoarthritis, and a history of a gastrointestinal bleed also likely associated with alcohol abuse, and anemia. She needed supervision and encouragement to engage in personal care activities, and generally stayed in her room, ate meals by herself, and aside from visits from her son had no other social interactions. She drank approximately four glasses of wine daily, with drinking starting at lunch time.
MALFA	Baseline Scores on the MALFA MI: 5 CI: 8 MEDMAN: 8 RISKMAN: 11 ADL: 18 TMAN: 14 PROBMAN: 2 Total MALFA: 66 Level of care: 3
Care Planning Focus	Decreasing risky behaviors particularly her resistance to care, identified in the MALFA, isolation, and alcohol abuse. Improving functional independence Addressing psychiatric illness and the depression underlying the long history of alcohol abuse.
Intervention Implemented	Working closely with the family (to stop bringing in alcohol), the primary health care provider, and the resident goals were set to eliminate alcohol use following a move in to the facility. This was done with careful drug withdrawal interventions and careful monitoring. Encouragement of personal care activities under guided supervision. A daily life structure reinforced and maintained by daily interactions with care providers. Increased social interaction by going to at least two meals in the dining room daily.
Results	Mrs. D. was helped to stop all alcohol intake and this significantly helped improve her physical, functional, and cognitive status. Moreover, many of her problematic behaviors were eliminated (such as resistance to care). In addition, she enjoyed the interactions with the nursing assistance daily, and went to two meals in the dining room, and engaged with other residents during these time periods. With daily verbal encouragement and set up she was able to complete her own personal bathing and dressing, requiring supervision for safety. Her scores at the end of her first year of living in the assisted living facility changed as follows: MI: 5 CI: 0 MEDMAN: 8 RISKMAN: 2 ADL: 7 TMAN: 0 PROBMAN: 0 Total MALFA: 22 Level of care: 1

There is a tendency for the assessment information to be used to plan for services, ie, assistance with bathing and dressing and medication administered. This is in contrast to utilizing the information to consider how interventions can be implemented to help individuals safely and effectively engage in activities at their highest level of independence.

Nursing assistants providing care in ALFs have a very limited period of time in which to complete an activity (eg, to help with bathing, dressing, walking to the dining room). Consequently, there is an even greater risk in the ALF setting to complete tasks for the resident rather than encouraging self-care with appropriate support, encouragement, and monitoring. Implementing care that focuses on a restorative care philosophy of care is crucial to prevent the subsequent decline that is exacerbated by disuse.

The American Geriatrics Society (AGS) position statement on assisted living suggests that residents entering an ALF should have a baseline evaluation—completed within 30 days of their admission—of their physical, medical, and psychosocial needs and a detailed review of all medications, prescription, nonprescription, herbal, and other remedies. The AGS recommends that this be completed by a qualified, licensed practitioner experienced in the care of older adults. This evaluation also should be culturally sensitive and serve as the basis for the development of a care plan that indicates resident physical and psychosocial needs, along with resident preferences for treatment and strategies for meeting identified needs. This care plan should be available to the resident and to the ALF staff. The ALF should clearly indicate, preferably prior to admission, the specific elements of the care plan that the ALF will meet as well as the responsibility of the resident/family.

A resident's move to assisted living is a critical life change. This offers a special opportunity for a comprehensive review of the resident's health and social needs, as well as an opportunity to make significant changes as seen in the case of Mrs. D. The move into an ALF often is associated with a medical, cognitive, social, or functional crisis for the older adult; and the comprehensive assessment is crucial to understanding the individual in a way that helps optimize care. It also provides an opportunity to implement interventions designed to maintain independence and prevent pre-existing conditions from deteriorating.

This level of assessment and interventions requires that ALF staff be knowledgeable and skilled in carrying out important components of geriatric care including—but not limited to—safe medication administration, fall prevention, incontinence care, communication techniques, dementia care, and skin care. Staff also must be able to recognize changes that can signal acute illness, delirium, and depression. Most important, a facility must incorporate a restorative care philosophy in which residents are helped to engage in functional activities and exercise at their highest level.

Unfortunately, staffing levels and expertise vary considerably from one ALF to another. In one national study of ALFs, 40% reported having full time registered nurse staff, 55% had a registered nurse either full or part time, and 71% had a registered nurse or licensed practical nurse on staff full or part time. About half (52%) of these facilities used outside agencies to supply registered or licensed practical nurses. Staff working onsite should be sufficient in numbers and experience to meet the ongoing needs of the residents at all times. Assessments such as the MALFA can help maximize staff efforts and enable them to make the best use of their time with individual residents.

Conclusion

If fully and accurately utilized, the MALFA could become an important resource for ALFs nationwide to help them identify what deficits residents have with regard to personal care activities and associated risks involved with activities and daily life. This tool also could help guide the health care team toward areas in which the resident can be helped to optimize function, safety, and overall quality of life. This can enable health care providers to truly be able to help ALF residents age in place. ALC

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