AGS Position Statement on Assisted Living

More seniors reside in assisted living facilities than skilled nursing facilities this year; and this industry growth likely will continue. The combination of this trend and the lack of regulation overseeing this care setting led the American Geriatrics Society to develop a position statement on ALFs. This statement should serve as a resource for residents, providers, and policymakers. It also offers a foundation to ensure that facilities and the practitioners and staff that work with them meet resident expectations and provide adequate and appropriate resources.

The position statement also is meant to guide the industry from a hospitality to more of a medical focus. This is necessary as consumers expect the ability to age in place and to have their needs met and their safety protected as their acuity increases and they become more frail. With this statement, AGS hopes to help ensure that assisted living facilities are willing and able to care for seniors as they age and their care and support needs grow.

Background

The American Geriatrics Society (AGS) believes that Assisted Living Facilities (ALF) can offer seniors an environment that could enhance their health status over other possible living arrangements. This Position Statement is to provide policymakers, administrators, health care professionals, and consumers with guidance for achieving optimum outcomes with regards to ALFs.

Positions

The following principles are essential to realizing the potential benefits of ALFs.

1. ALFs have a responsibility to provide complete information to prospective residents to assure that an appropriate match is made between resident and facility.

Rationale: Consumers of ALFs need to have detailed information regarding the services provided and any associated costs. In contrast to nursing facilities whose primary payors are the states through Medicaid, ALF payors tend to be the residents themselves. As a result, ALFs are subject to less state and federal regulation and are more affected by market pressures. In order for consumers to make optimal decisions, ALFs need to disclose fully the services provided, the limitations of their facility, how much functional decline they can handle effectively, and especially the criteria residents must continue to meet to remain in the ALF. In addition, the staffing levels and expertise should be discussed with all potential ALF residents.

Reference

1. Hawes C, Phillips C, Rose M. (2000) *High Service or High Privacy Assisted Living Facilities, their Residents and Staff: Results from a National Survey.* Miriam Rose, Myers Research Institute. U.S Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy (ASPE) and Research Triangle Institute, November.

2. Residents entering an ALF should have a baseline evaluation, completed within 30 days of their admission, of their physical, medical and psycho-social needs, and a detailed review of all medications, prescription, non-prescription, herbal and other remedies, completed by a qualified, licensed practitioner experienced in the care of older adults. This culturally sensitive evaluation should be the basis for the development of a care plan that indicates resident physical and psycho-social 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 and is willing to accommodate as well as the responsibility of the resident/family.

Rationale: A resident's move to assisted living is a critical life change event. This event offers a special opportunity for a comprehensive review of the resident's health and social needs. This move to an ALF often signals some medical, cognitive or functional need for the senior, which makes a comprehensive assessment all the more crucial at this transition of care. It also offers the opportunity to provide optimum interventions

designed to maintain independence and prevent pre-existing conditions from deteriorating.

3. ALF staff should be knowledgeable and skilled in carrying out important components of geriatric care, including, but not limited to, safe medication administration, falls prevention, incontinence care, communication techniques, dementia care, skin care, and able to recognize the changes that can signal acute illness, delirium, and depression.

Rationale: Staffing levels and expertise do vary between ALFs. In a 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%) 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. Staff should be knowledgeable regarding safe medication administration, falls prevention, incontinence care, communication techniques, dementia care, skin care, and recognition of the changes that can signal acute illness/delirium.

References

1. Phillips, Munoz, Sherman et al (2003) *Effects of Facility Characteristics on Departures from Assisted Living: Results from a National Study.* Gerontologist 42 (5) 690-696.

2. *Ambulatory Geriatric Clinical Care and Services Position Statement.* Developed by the AGS Health Care Systems Committee and approved May 2000 by the AGS Board of Directors. Journal of the American Geriatrics Society, 48:845-846, 2000.

4. A primary care provider (includes geriatric nurse practitioners as well as physicians) experienced in geriatrics care should be available within each ALF to help direct staff in optimizing outcomes for each resident.

Rationale: The benefit of clinical leadership within LTC facilities was noted in 1978 in *JAGS* and later supported by a 1993 AGS position statement on the Physician's Role in the Long-Term Care Facility, which illustrated the importance of this involvement. This benefit is true in all long-term care facilities, including ALFs, extended care units, skilled nursing facilities, intermediate care facilities, and residential units caring for frail residents. More recently the work of the Assisted Living Workgroup highlighted the link between these clinical services and outcome for ALF residents.

A comprehensive system of care is able to accommodate seniors with varied needs as they traverse through different levels of health and function in their aging lifetime.

Reference

1. Ingman SR, Lawson IR, Carbon D. (1978) *Medical Direction in Long-term Care.* JAGS 26(4);157-66. Assisted Living Workgroup Report to US Senate Special Committee on Aging 2003. www.aahsa.org/alw.htm.

5. ALFs need to become aligned with other facilities, providers and systems of care to produce optimum outcomes for seniors.

Rationale: A comprehensive system of care is able to accommodate seniors with varied needs as they traverse through different levels of health and function in their aging lifetime. Key to coordination of care is communication at each transition of care.

References

1. Improving the Quality of Transitional Care for Persons with Complex Care Needs *Position Statement.* Developed by the AGS Health Care Systems Committee and approved May 2002 by the AGS Board of Directors. The American Geriatrics Society, New York, NY.

6. ALF resources need to be within the reach of those living in rural and low-income communities.

Rationale: The lack of non-institutional, long-term care services in many rural areas may explain why residents of nursing homes in rural areas tend to be younger and less disabled than their urban counterparts. Part of this can be accomplished with continued funding of the 1915[c] Home and Community Based Services waiver program to provide needed services. The 1915[c] Home and Community Based Services waiver is the primary Medicaid funding vehicle for low-income persons requiring assisted living services.

Reference

1. Spector, W., et al, (1996) *Appropriate placement of nursing home residents in lower levels of care.* The Millbank Quarterly. 74: 139-160.

Credits

American Geriatrics Society and approved by the AGS Board of Directors in May 2004. Written by the AGS Health Care Systems Committee, with special thanks to Drs. Richard Stefanacci, Leslie Wooldridge and Kenneth Brummel-Smith. AGS, The Empire State Building, 350 Fifth Avenue, Suite 801 New York, NY 10118. ALC

The Subtext of the AGS Assisted Living Facilities Position Statement: **The Frail or Failing Older Adult**

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The task set forth for the operators of assisted living facilities is complicated and challenging. They must set up homes for aging Americans who are used to personal independence but simultaneously are medically, cognitively, and functionally diverse. While it may seem a monumental task to define and identify the important components of the systems of care and support needed for this heterogeneous population, the pivotal piece to establishing systems of care at an ALF is the identification of the frail or vulnerable elder.

The importance of identifying the frail or failing older adult cannot be overemphasized. In general terms, the aging population is at greater risk for hospitalization, hospital readmission, need for long term care, and mortality. But the ALF resident represents a particularly large population of frail or potentially frail older adults. More than half of ALF residents are 85 years old or older, 25% have moderate to severe cognitive impairment, 51% require assistance with bathing, 77% require medication assistance and 33% are incontinent of urine according to one national study.[1] This recurrent theme of advanced age and cognitive and physical functional decline speaks to an operational definition of frailty, defines the systems of screening and care that must be available and ongoing in an ALF, and helps ALF owners and operators define a cut-off point of "too frail" for them to provide the type and quality of care necessary for residents who require transfer to a nursing or other facility.

But how do we define or identify failure to thrive in the aging patient population? And what is a frail or vulnerable older adult? One must first look at human aging and the components that add to the heterogeneity of the process.

Human aging is a complex process that is affected by aging physiology with decline in organ functioning, decline in functional reserve, and the accumulation of multiple medical co-morbid conditions and the medications designed to treat these conditions. While decline in individual organ systems is a key part of aging, it is not just this physiological functioning that is required for survival but a mix of biological, psychological, and social functioning.

A more comprehensive view of aging is represented in the model of functional reserve. Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) are the most common measures of functional reserve and represent one important measure of frailty in medical studies. The ability to bathe, dress, transfer, toilet, and eat (ADLs) and ability to use the phone, travel, shop, prepare meals, do housework, take medications, and manage money (IADLs) require more than physiological or organ functioning and reserve to compensate for a stressor such as an illness. The ADLs and IADLs require a certain level of biopsychosocial functioning. It is with aging that reserve in all these areas may decline. The screening of the older adult, therefore, needs to take into account not just the medical co-morbidities, medications, and degree of organ decline (including a cognitive screen) but also evaluation of functional status (test of mobility, ADLs, and IADLs) and a psychosocial screen.

Attempts to define frailty have included defining frailty as a clinical syndrome. One such epidemiological view by Fried and colleagues defines the frail syndrome with three or more of the following criteria: unintentional weight loss (10 pounds over the past year), self-reported exhaustion, weakness (grip strength), slow walking speed, and low physical activity.[2] This definition actually may describe a more extreme end of failing often termed as failure-to-thrive. This clinical syndrome definition is not inclusive enough for the much larger numbers of potentially at-risk older adults who are admitted to ALFs.

Other definitions of frailty attempt to define a phenotype of frailty. These definitions include older adults with baseline vulnerability who have unstable or changing disabilities and are at higher risk for adverse outcomes.[3] This prototypical frail older adult then would have the features of advanced age, multiple medical co-morbidities, suspected cognitive or functional impairments, and psychosocial issues. One could argue that age alone could be reason enough for initiating a screen for frailty, considering the strong association of functional decline with age. If difficulty with ADLs occurs in approximately 26% of the population age 75-84 and in > 50% of the 85 and older population, using an age criteria of 70-75 and older is a reasonable place to start a comprehensive screening protocol to identify frailty in an ALF.

The model screen for a complex frail or failing older adult is the comprehensive geriatric assessment (CGA) used and studied in both the outpatient and hospital settings.[4,5] In addition to screening for medical conditions and medication use as part of the routine medical history, the CGA assesses cognition and functional status (ADLs, IADLs). Screens for hearing and visual impairments, depression, and mobility, as well as a detailed psychosocial history, usually are included.

Ongoing screening should occur at regular intervals and when the ALF resident is failing. This failing may be in the form of unexplained weight loss, falls or balance problems, and/or confusion. Any change or suspected change in cognitive or functional status in an ALF resident would trigger such re-evaluation. One comprehensive model of screening developed for use in an ALF is the Maryland Assisted Living Functional Assessment (MALFA).[6] This model for assessment ties into specific systems of care and support determined by the plan of care established from the (MALFA) assessment tool.

Finally, screening for frailty of the older adult at the point of ALF admission and throughout the years that the resident continues to reside at a given ALF would be the recommended standard. It is only with the appropriate supports keyed into this fragile portion of the aging population that independence is maintained, ensuring a better quality of life and forestalling the need for nursing home placement

Equally important is to recognize the failing elder who requires more supports than a given ALF can provide. Setting up policies addressing when it will be necessary to move residents to higher care levels and explaining these to residents and families at admission will minimize misunderstanding, frustration, and even unnecessary litigation. Such policies also empower the ALF staff to follow a set of guidelines to aid in the decision for increasing care levels or transfers for the failing resident.

References

1. Hawes C, Phillips C, Rose M. *High service or high privacy assisted living facilities, their residents and staff: Results from a national survey*. Miriam Rose, Myers Research Institute. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning, and Evaluation, Office of Disability, Aging, and the Long-Term Care Policy (ASPE) and Research Triangle, November 2000.
2. Fried L, Tangen CM, Walston J et al. Frailty in older adults: evidence for a phenotype. *J Gerontol Medical Sciences* 2001; 56A(3): M146-M156.
3. Rockwood K, Hogan DB, MacKnight C. Conceptualisation and measurement of frailty in elderly people. *Drugs Aging* 2000; 17(4): 295-302.
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