A Day in the Life of an Assisted Living Physician

Alec Pruchnicki, MD

The full-time assisted living facility physician is rare. However, as more assisted living facilities move from a social model to one that includes health care as a key component, this unique species is likely to become more common.

I am one of the rare breed of full-time AL physicians. What follows here is an account of a "typical" day for me. Perhaps this can serve as an example to others about how physicians can be involved effectively in ALFs.

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The Facility...

The facility where I work is Lott Assisted Living Facility (formerly the DeSales ALF), a 126-bed, 14-story building overlooking Central Park in New York City. Lott was opened in September 2000 by a local nonprofit community-based housing corporation in response to a proposal from New York State to use Medicaid funds to pay for ALF fees. This is an attempt to decrease unnecessary expensive nursing home placements.

The overall reimbursement was one-half of the rate for nursing homes, with occasional adjustments for acuity, and was to include room and board, meals, personal care, and medication dispensing. Because these board services go beyond a typical ALF, we actually are considered an assisted living *program.* Virtually all of our residents are Medicare enrollees, and about 85-90% also have Medicaid. In addition to Medicare, the other 10-15% pay privately or have private insurance, Medigap policies, or Medicare HMOs.

The facility has a working relationship with St. Vincent's Hospital in New York City to help encourage admissions between the two settings. This not only benefits the two facilities but it also ensure a seamless continuum of care for patients.

Since ALFs are not set up for medical practice, you may have to compromise on your exam room and office space; and you probably will have to bring your own staff to help you.

Lott has a Wellness Center, where medications are monitored and dispensed to about half of the residents, with the other half self-medicating. The center is staffed by one or two nurses (LPNs) from 7 a.m. to 11 p.m. seven days a week. These nurses, in turn, are supervised by a clinical care coordinator who is a RN. A commercial off-site pharmacy delivers medications for all residents several times daily.

Outside vendors come in to draw blood once a week and perform simple x-rays, EKGs, and ultrasound testing during the week. About two-thirds of Lott's residents use me as their primary care physician; and the rest have outside physicians who they see off-site at the doctors' offices. Rarely, a private physician will make a house call at a resident's apartment. Residents with outside physicians still see me occasionally for emergencies or convenience.

My Training and My Work...

My own training is in internal medicine, and I completed a geriatrics fellowship at UCLA. My clinical experience includes a variety of outpatient, hospital, and nursing home settings, including a Program of All-Inclusive Care for the Elderly (PACE) site and another ALF.

My typical work week is Monday through Friday, nine to five. Additionally, I sometimes have teaching duties at St. Vincent's; and I attend some geriatrics or medicine grand rounds at the hospital. At Lott, I also teach medical students, geriatric nurse practitioner students, geriatric fellows, and an occasional resident.

I am part of a seven-physician section of geriatrics in the hospital's department of medicine; and I have on-call responsibilities (weekend hospital rounds) about every seven weeks or so. When I am not on call, the other members of the

group cover me. All of my patients are admitted to the service of a single hospitalist in the geriatrics section, so I never go to the hospital except when I am on call.

My Day...

My work day starts at about 9 a.m., with the first half-hour usually spent returning calls, checking the physicians' communication book the nurses keep, and handling paperwork and prescription renewals. For the next few hours, I see residents and go to "Morning Report," a meeting that involves staff from administration, finance, recreation, transportation, nursing, and social work. Topics of discussion include medical, nursing, social, or other problems residents are having and what we can do to resolve them promptly and prevent them from recurring in the future. This meeting usually lasts about an hour.

I use the lunch hour—when residents and staff are eating—to catch up on paperwork and medical reading. Then, I spend the rest of the day seeing residents. Except when there are emergencies, my day ends at about five.

I usually see six to eight residents every day, with the average new admission visit lasting about 90 minutes and follow-up visits lasting about 30. Most of the follow-ups are scheduled, but about one-fourth are walk-ins, emergencies, or incidents (mostly falls).

I want to emphasize here that a visit in an ALF is more involved and time-consuming than an office visit. For one thing, staff are not there simply to help the physician. They have many other duties, so "rounding up" residents, charts, and paperwork often takes longer. Also, because residents live right there, they may leave and come back later if I am behind or busy; so the "next patient" isn't necessarily waiting right there when I am ready for him or her. All of these challenges can make the day a little longer.

My Viewpoint...

As a geriatrician, I really enjoy practicing at the facility. The residents have a wide variety of geriatric syndromes, and the pathology is challenging. Helping residents to maintain their levels of functioning and independence and preventing their conditions from deteriorating can keep them from having to move to a nursing facility; so care in this setting is very rewarding. I also teach some medical students, and I am able to enlighten them about the benefits and joys of a practice that involves geriatrics and assisted living.

If I were to eliminate teaching, the Morning Report, and other administrative work and limit my hours, the practice could become more efficient. However, it also would be less academic and less enjoyable.

The finances are challenging. St. Vincent's contracts with the facility for both my office space and staff time, and I operate on a shoestring. Any private office would have more extensive support services and resources than I have. But my low overhead enables my admissions and billing for individual visits to cover my salary and benefits; and this keeps St. Vincent's satisfied.

Speaking of billing, the fact that so many of my residents are enrolled in straight Medicare and Medicaid, paperwork is relatively simple. If 90% of my residents were enrolled in a variety of Medicare HMOs, administrative costs and time easily could make the practice go into the red. In fact, when the Medicare prescription drug benefit goes into effect next year, there is a distinct possibility that this red is in my future. Of course, if I were to eliminate teaching, the Morning Report, and other administrative work and limit my hours, the practice could become more efficient. However, it also would be less academic and less enjoyable.

My Lessons...

There are a few lessons here for other physicians who are considering work in ALFs. Since these facilities are not set up for medical practice, you may have to compromise on your exam room and office space; and you probably will have to bring your own staff to help you (even if you just bring a non-professional to help you track down and retrieve residents). Otherwise, your days could be very long and frustrating.

As for hospitals, the business model that resulted in my hiring and placement may be practical for others as well. It can result in increasing hospital admissions while enabling the provision of quality medical care to a fragile population.

Opportunities—as well as need—for physicians in assisted living are growing. Perhaps the time will come when physicians are common and valued full-time presences in ALFs and not a rare species. ALC

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