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# Revisiting the Role of Physicians in Assisted Living and Residential Care Settings

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# Revisiting the Role of Physicians in Assisted Living and Residential Care Settings

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## Abstract

As the United States population ages, a higher share of adults is likely to use long-term services and supports. This change increases physicians' need for information about assisted living and residential care (AL/RC) settings, which provide supportive care and housing to older adults. Unlike skilled nursing facilities, states regulate AL/RC settings through varying licensure requirements enforced by state agencies, resulting in differences in the availability of medical and nursing services. Where some settings provide limited skilled nursing care, in others, residents rely on resident care coordinators, or their own physicians to oversee chronic conditions, medications, and treatments. The following narrative review describes key processes of care where physicians may interact with AL/RC operators, staff, and residents, including care planning, managing Alzheimer's disease and related conditions, medication management, and end-of-life planning. Communication and collaboration between physicians and AL/RC operators are a crucial component of care management.

## Keywords

assisted living, residential care, long-term services and supports, primary care physicians

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## Introduction

Demand for geriatric clinical practitioners and long-term care services will accompany increases in the older adult (65+) population (Alzheimer's Association, 2020; Thach & Wiener, 2018). System changes, including a recent national shift toward interdisciplinary primary care teams (American Hospital Association, 2013; Engel et al., 2016; Young et al., 2011) and community-based care expansion (e.g., assisted living) rather than skilled nursing facilities (SNF) has implications for older adults' care management (Cornell et al., 2020; Silver et al., 2018). Nationally, 29,000 assisted living and residential care (AL/RC) settings licensed for four or more adults serve over 800,000 residents, compared to 15,600 SNFs that serve 1.3 million residents. AL/RC residents have significant health and personal care needs as described in Figures 1 and 2 (Khatutsky et al., 2016; Harris-Kojetin et al., 2019).

Physicians serve an essential role as part of the healthcare team providing clinical oversight and care to AL/RC residents. Physician roles in AL/RC may include clinical services consultant, interprofessional care team member, medical director, geriatric care manager (Stall, 2009; Stone, 2006). States' AL/RC regulations vaguely

specify physicians' involvement in AL/RC residents' care processes (e.g., resident evaluations upon move-in and for retention, medication administration and review, hospice orders) (National Center for Assisted Living [NCAL], 2019).

There is a significant need for physicians to understand the contexts where their patients live, especially given the coronavirus pandemic, which disproportionately affects older adults in congregate care settings (Dosa et al., 2020). Though they provide housing and health services to older adults, AL/RC settings have largely been left out of the coronavirus conversation (Zimmerman et al., 2020). A combination of third-party services, direct care staff, and family caregivers provide care and social support are now limited by precautions to mitigate the spread of coronavirus (Dobbs et al., 2020; Young & Fick, 2020). Social isolation, loneliness, delirium, dementia

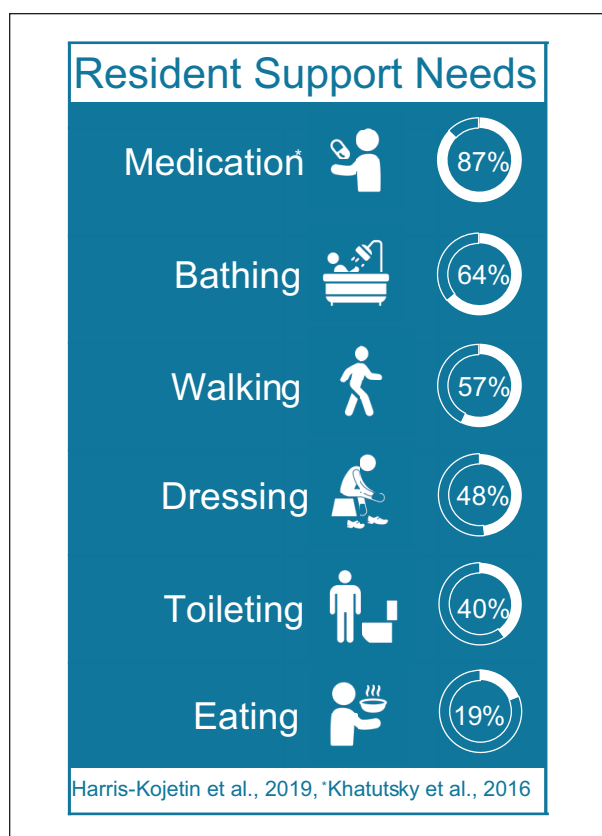
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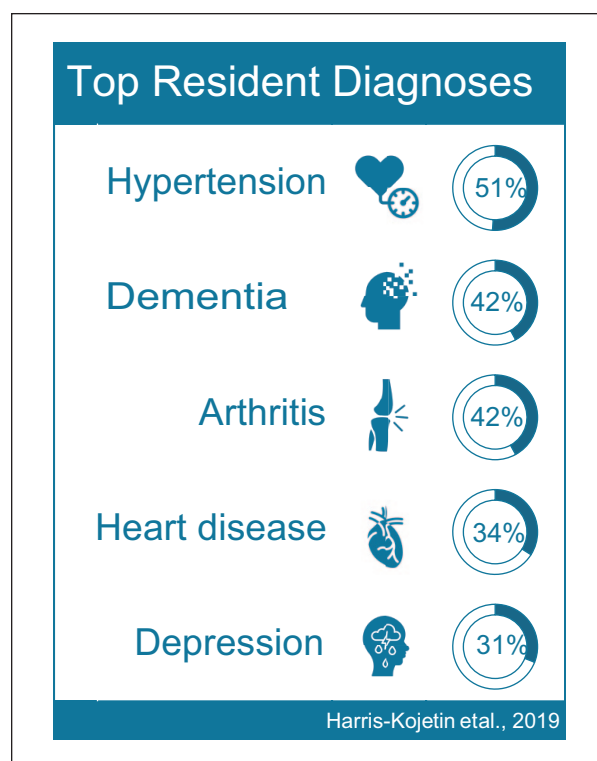
**Figure 1.** Prevalence of AL/RC resident support needs. Note. Data from National Study of Long Term Care Providers (NSLTCP) and National Study of Residential Care Facilities (NSRCF).

management, medication administration, and effects of the coronavirus pandemic on caregivers of residents all intersect with the overall health and wellbeing of AL/RC residents (Brooke & Jackson, 2020; Brown et al., 2020; O’Hanlon & Inouye, 2020). Infection control requirements in AL/RC might not be as robust as in other care settings; 31 states have AL/RC regulations for infection control (Bucy et al, 2020).

There are four main reasons to highlight physicians’ roles in AL/RC settings. First, 16% of adults over 65 and 40% of adults over 85 need long-term health-related support due to significant cognitive and physical impairments (Johnson, 2017). Second, there are not enough clinicians with geriatric training to meet this demand (Warshaw & Bragg, 2016). Third, older adults and their families often seek physician advice regarding physical or cognitive decline, and care transitions (Hamdy, 2015; Holt, 2017; Oh & Rabins, 2019; Sedhom & Barile, 2017). Lastly, there is a lack of consensus on physicians’ roles related to clinical oversight given the interdisciplinary nature of healthcare teams in AL/RC (Katz et al., 2018; Resnick et al., 2018).

## Methods

We used a narrative review to identify key topics of research and themes in physicians’ roles in AL/RC



**Figure 2.** Most prevalent chronic health conditions among AL/RC residents. Note. Data from NSLTCP.

(Grant & Booth, 2009; Green et al., 2006). We limited this review to studies published after 2003, when a comprehensive report including recommendations regarding physicians’ roles in medication management and service plan development, among others, was presented to the U.S. Senate Special Committee on Aging (Assisted Living Workgroup, 2003). In fall 2019, we queried Google Scholar using the boolean search: all-in-title: physician OR physicians OR physician’s AND “assisted living” OR “residential care.” This approach returned 20 publications, of which 14 were peer-reviewed journal articles; we reviewed these for relevance, identifying seven papers that directly address physician roles and perspectives on care delivery in AL/RC in the U.S. (Katz et al., 2018; Nyrop et al., 2011, 2012; Resnick et al., 2018; Schumacher et al., 2005; Schumacher, 2006; Sloane et al., 2011).

## Physician Roles in Assisted Living/ Residential Care Settings

The identified studies highlighted topics of communication, perceptions of staff, care delivery, and assessment. According to one study, physicians trust AL/RC staff less than SNF staff, raising concerns regarding AL/RC staff reliability when taking orders over the phone (Schumacher et al., 2005). Others observed disagreement between physicians and AL/RC staff over treatment plans and physician frustrations regarding

**Table 1.** Key Points and Recommendations for Physicians with Patients in AL/RC.**AL/RC settings**

State regulatory approaches are unique; states may have more than one AL/RC type  
 Learn about AL/RC in your state, and bordering states, if relevant  
 Reliance on paraprofessional staff, nurse availability varies  
 Physicians are care convoy members

**Care planning and communication**

Evaluation/assessment informs the care plan  
 Develop communication plans with AL/RC staff  
 Identify residents' preferences and key staff contacts

**Care transitions**

Move-in and move-out may require physician input  
 Use communication plans to track care transitions/changes in condition  
 Consider telemedicine options to facilitate in-place assessment and care

**People living with dementia**

Recognize dementia versus delirium  
 Identify underlying causes of behavioral expressions  
 Prioritize nonpharmacologic strategies  
 Know psychotropic medication risks

**Medication management**

Frequently review medications and treatment orders  
 Consider:  
 Potential drug-induced delirium  
 Untreated pain  
 Unrecognized sleep disorders  
 Anticholinergic effects  
 Use clear, specific language in medication and treatment parameters

**End-of-life care**

Third-party services including hospice may require physician orders  
 Discuss advance care planning with patients and families

unexplained additional paperwork, including multiple faxes and signed orders (Schumacher et al., 2005; Schumacher, 2006; Sloane et al., 2011). Two studies suggest miscommunication with AL/RC staff regarding responsibility for residents' fall risk assessments (Nyrop et al., 2011, 2012). Based on these studies, literature cited in these studies, and states' AL/RC regulatory summaries (Carder et al., 2015; National Center for Assisted Living [NCAL], 2019), we discuss topics summarized in Table 1 as relevant for physicians with patients living in AL/RC settings.

**AL/RC Settings, Their Residents, and Staff**

In the U.S., AL/RC settings vary due to different state regulations, development and finance models, consumer demands, and resident makeup (Armstrong et al., 2016; Carder et al., 2015; Cornell et al., in press; Grabowski et al., 2012; Trinkoff, 2020). Proponents of AL/RC settings promote the social model of care and home-like environment that supports resident choice through community operations (Brown Wilson, 2007; Carder, 2002; Carder & Hernandez, 2004; Kane & Wilson, 1993). Providers must balance these person-centered values with operations, regulatory oversight, and health care provider goals of safety and

beneficence (Calkins & Brush, 2016; Kapp, 1997; Morgan, 2009; O'Dwyer, 2013).

Each state regulates AL/RC differently, using state-specific terminology (e.g., assisted living facility, residential care facility, community residence, personal care home, dementia care units) to license operators (Carder et al., 2015). Nationally, the average capacity of AL/RC settings is 35 beds, ranging from small homes, with a capacity for fewer than ten residents, to apartment buildings housing hundreds (Harris-Kojetin et al., 2019). Additionally, 23% of AL/RC settings offer dementia care units with 40 states regulating a special license or certification for dementia care (Cornell et al., in press; Harris-Kojetin et al., 2019). In the U.S., one in five AL/RC settings reported policies allowing for admission of residents needing ongoing skilled nursing services (20%), four out of five allowed for residents with needs including assistance with incontinence (82%), daily monitoring of blood sugar levels or insulin (81%), half allowed residents with assistance with cognitive impairment (55%), and one-third allowed residents in need of two-person or Hoyer lift transfer (33%) (Han et al., 2017).

Staff mix within AL/RC settings can include registered nurses (RNs), licensed professional/vocational nurses (LPN/LVNs), certified nursing assistants (CNAs), certified medication aides (CMAs), unlicensed direct

care workers, and administrators. Thirty-eight states require RNs or LPN/LVNs to provide or supervise care (Beeber et al., 2018; Rome et al., 2019). Administrators are responsible for all AL/RC operations, such as staffing, resident care provision, and regulatory compliance. Compared to SNFs, fewer states require AL/RC administrator licensure (Carder et al., 2015; Dys et al., 2020; National Center for Assisted Living NCAL, 2019). The majority of the workforce in AL/RC settings are paraprofessionals. In comparison to SNFs, a larger proportion of these staff identify as men and have completed college (Kelly et al., 2020). They provide an average of 2.27 care hours per resident per day compared to licensed and registered nurses 0.2 hours (Harris-Kojetin et al., 2019). Sixteen state agencies require minimum staffing ratios, while most states specify “sufficient” staff be present to address residents’ needs (Carder et al., 2016). Currently, there is no standard measure of “sufficient” staffing (Zimmerman et al., 2016).

### *Care Planning and Communication Among Physicians, Families, Residents, and Staff*

AL/RC settings develop care plans for each resident. An admission assessment can inform the care plan, as can communication between the AL/RC setting and the resident’s physician after a change in condition. Care plans can promote role clarity among the care team by emphasizing participatory decision making and care coordination (Burt et al., 2014). Care plan requirements vary from state to state, but generally, they describe resident needs and preferences and corresponding health and social services (Unwin et al., 2019). Residences may require a physician to conduct the pre-admission assessment which can include medication review and clinical assessment for fall risk, physical and cognitive decline, and behavioral symptoms (National Center for Assisted Living [NCAL], 2019).

Unless an AL/RC setting employs or contracts a healthcare professional, individual residents’ physicians provide oversight and input on medical care provided offsite and onsite. Examples of the former include visits to specialists and admission to hospitals or acute care rehabilitation centers. Physicians also prescribe treatments delivered by AL/RC staff (e.g., medications), and third-party providers (e.g., hospice and home health care services). Interprofessional collaboration in care provision within AL/RC settings varies. A South Carolina-based study found administrators of freestanding AL/RCs were less likely than those co-located with a memory care unit to use a multidisciplinary team approach (Kelsey et al., 2010).

Research suggests physician offices may benefit from established communication procedures and parameters for AL/RC patient treatment. Examples include identifying a consistent person in the physician office to receive and triage messages from AL/RC staff, co-creating a protocol with the AL/RC setting or

family members regarding necessary information for residents’ records, and developing specific medication parameters for paraprofessional staff to implement (Burt et al., 2014; Tjia et al., 2009; Winn et al., 2004). States post information for consumers about requirements for AL/RC scope of practice, staffing, and health services that can be used by physician offices to clarify responsibilities.

As of 2016, one-quarter of AL/RC settings (26%) reported using electronic health records (EHR) compared to 79% of physicians (Caffrey et al., 2020; Rao et al., 2019). Settings using EHRs reported greater health information exchange with physicians and pharmacies compared to their non-EHR counterparts (Caffrey et al., 2020). One Florida-based study found AL settings primarily used EHR for tracking resident demographics and medication lists (Holup et al., 2014). AL/RC EHR use may be less familiar to physicians who are accustomed to an integrated EHR for clinical decision making and information sharing with other providers (Munchhof et al., 2020; Rao et al., 2019).

In the AL/RC context, physicians are one member of an interdisciplinary care network, or “convoy,” comprising family, friends, AL/RC staff, therapists, and pharmacists (Kemp et al., 2018, 2019). Families provide a source of socioemotional support and financial and medical oversight for AL/RC residents (Gaugler & Kane, 2007). Families report wanting improved communication regarding healthcare needs, including whether to send their relatives to the emergency department or complete advance directives (Sharpp & Young, 2015).

Transport to medical appointments can be a challenge for residents, who rely on family, caregivers, or formal transportation services (Eby et al., 2017; Wolf & Jenkins, 2014). Telemedicine consults with AL/RC operators, care teams, or virtual appointments may be useful, especially in patients living with dementia, cognitive impairment, and mobility limitations (Daniel et al., 2015). Teleconferencing may also benefit physicians via consults with geriatric, older adult behavioral health, or dementia care specialists (Bennett et al., 2018; Catic et al., 2014; Oh & Rabins, 2019; Tso et al., 2016).

### *Resident Transitions Into, During, and From AL/RC Care*

Cognitive decline and dementia progression can lead to numerous care transitions, which are associated with declines in health and quality of life for people living with dementia (PLWD) and their caregivers (Chyr et al., 2020; Ryman et al., 2018). Older adults and their families may seek advice from their physicians as they decide whether to move into an AL/RC (Alzheimer’s Association, 2020; Chen et al., 2008; Reinardy & Kane, 2003). One study reported significant caregiver distress at the lack of information or engagement from physicians in anticipating future needs and transitions for their loved ones with dementia (Liken, 2001).



Although AL/RC residents typically want to age in place, a move-out might become necessary if their care needs exceed the level of care the residence is licensed to provide (Ball et al., 2004; Chapin & Dobbs-Kepper, 2001; Munroe & Guihan, 2005). Residents may transfer to a dementia care unit co-located on the same property, offsite, a SNF, or another care setting (Shippee, 2009). Other transitions during residents' tenure in AL/RC may include hospitalizations or treatment in acute care rehabilitation centers (Berish et al., 2018). A qualitative study of AL/RC and SNF residents and their families found that few received information about reasons for hospital admissions, had limited contact with physicians during hospitalization, and expressed uncertainty about treatments and discharge planning (Toles et al., 2012). Standardized communication and care planning, inter-professional cooperation, and person-centered, dementia-competent care can mitigate the negative effects of these potential transitions (Hirschman & Hodgson, 2018). Older adults' engagement in decisions to move into AL/RC and transition or discharge during their stay is unclear (Chen et al., 2008; Mead et al., 2005; Shippee, 2009). Evidence-informed practice promotes involving both families and residents using clear, direct communication at every stage of care transition regardless of the destination (Jackson et al., 2016).

### *Managing Alzheimer's Disease and Related Disorders (ADRD)*

AL/RC settings increasingly provide care to PLWD. Dementia-specific settings typically have controlled egress to prevent residents from exiting the building (except in emergency), dementia-specific staff training, increased staffing levels, or additional cognitive assessments, though specific requirements vary by state (Carder et al., 2016). Physicians play an important role in dementia diagnosis and management (Hamdy, 2015). The prevalence of residents with an ADRD diagnosis in AL/RC varies by state from 24% in Minnesota to 47% in North Carolina (Thomas, Belanger, et al., 2020). Dementia is associated with behavioral expressions, such as agitation, anxiety, depression, delusions, irritability, and sleeplessness (Ismail et al., 2016; Lyketsos, 2007; Roth & Brunton, 2019). One multistate study reported one-third of AL/RC residents expressed one or more behaviors (e.g., physical/verbal aggression, wandering, resistance to care) at least once a week (Gruber-Baldini et al., 2004). However, nearly all PLWD experience behavioral expressions (Lyketsos et al., 2002; Zimmerman et al., 2014).

Treatment decisions should be driven by the multiple possible causes of residents' behavioral expressions (Lancôt et al., 2017). When residents express behaviors, they may be communicating some unmet need (e.g., hunger, pain, or using the bathroom) (Cohen-Mansfield et al., 2015; Gaugler et al., 2005; Smith & Buckwalter, 2005). Insomnia, especially common

among older adults with cognitive impairment, may also result in preventable agitation or stress that manifests as behaviors (Hamdy et al., 2018). PLWD may experience delirium, often characterized by acute changes in focus or attention, hallucinations, and disruption to sleep-wake cycles as opposed to gradual cognitive decline (Morandi et al., 2017). If clinically managing a resident with behavioral expressions, physicians can reinforce treatment plans that emphasize identifying underlying causes. For example, the Antecedent-Behavior-Consequence (ABC), Needs-Driven Dementia Compromised Behavior (NDB), and Describe, Investigate, Create, Evaluate (DICE) models frame identification of preceding and underlying factors that result in behaviors and provide guidance on person-centered interventions (Algase et al., 1996; Kales et al., 2014; Volicer & Hurley, 2003).

### *Medication Management*

Assistance with medication administration is a major driver of older adult AL/RC admissions (Lieto & Schmidt, 2005). Healthcare professionals prescribe medications to AL/RC residents and may be informed by resident and family preferences and staff requests (Kerns et al., 2018; Look & Stone, 2018; Wolff & Spillman, 2014). Potentially harmful drug classes for older adults include analgesics, anticoagulants, antidepressants, antihypertensives, and antipsychotics due to increased risks of drug interactions, anticholinergic effects, falls, and early mortality (Fick et al., 2019; Ruscin & Linnebur, 2018). With limited clinical staff, physicians may serve as a resource for AL/RC residents and staff for medication-related questions and concerns.

Medication management in AL/RC settings involves direct care staff, nurses, pharmacists, and prescribers (Stefanacci & Haimowitz, 2012; Young et al., 2013). Residents capable of self-administration, as assessed by a physician, may do so in most settings (Carder & O'Keeffe, 2016). Many states permit trained, unlicensed staff to administer medications (Carder & O'Keeffe, 2016; Reinhard et al., 2006; Sikma et al., 2014). AL/RC credentialed and paraprofessional staff implement physicians' orders for prescribed medications and treatments. The implications of this arrangement on resident care quality have not yet been studied.

Nonpharmacologic practices (e.g., psychosocial and environmental interventions) are considered the first line of therapy to manage behavioral expressions in AL/RC residents, though medication may be considered if they prove ineffective (Brodsky & Arasaratnam, 2012; Scales et al., 2018). When changing a resident's medications, physicians should consider potential drug-induced delirium, untreated pain, unrecognized sleep disorders, risk/benefit analysis, and commit to ongoing medication review (Gill et al., 2019; Kales et al., 2014; Moore et al., 2018). Medication interactions can induce changes to

residents' affect, behavioral expressions, or physical conditions, raising the importance of communication and review of medication changes with AL/RC staff (Gurwitz et al., 2018; Mitty, 2009).

Over two-thirds (68%) of AL/RC settings report having a physician or pharmacist review residents' medications for appropriateness (Dwyer et al., 2014). Physicians might collaborate with pharmacists or RNs to evaluate the risks and benefits of stopping, starting, or continuing medications during medication reviews of residents in their care (Hohmeier et al., 2019; Martin, 2007). Further, connecting with the AL/RC setting's consultant pharmacist or nurses may be beneficial, as they are often responsible for regular (e.g., quarterly) medication review (Coulson & Blaszczyk, 2016; Rhoads & Thai, 2003). Managing medications, especially those following transitions in care, can be challenging as medication orders might change and multiple prescribers can be involved (Chhabra et al., 2012; Fitzgibbon et al., 2013). Staff who work with AL/RC residents daily may provide physicians with additional information regarding additional orders from specialists or concerns regarding regulatory compliance given current orders, another reason for clear communication, follow-up, and ongoing medication review.

### *End-of-Life (EoL) Care*

Over half of AL/RC residents (57%) reside in the setting at end-of-life (EoL) (Thomas, Zhang, et al., 2020). EoL care for AL/RC populations is accompanied by unique challenges due to the presence of other residents, who have cognitive impairment as well as staff with varying training and experience with EoL care (Zimmerman et al., 2015). Palliative AL/RC services orient toward management of chronic conditions as most AL/RC resident deaths are attributed to gradual decline (Ball et al., 2014). Physicians may be involved in their patients' EoL services, including managing changing medical care needs and coordinating with AL/RC staff and third-party agencies.

AL/RC settings in most states allow residents to receive third-party care including home health or hospice services while residing in the AL/RC setting. In a nationally representative sample, AL/RC residents' average days spent on hospice in the last month of life ranged from two to fourteen days, depending on the state (Thomas, Zhang et al., 2020). In comparison to older adults living at home, hospice users in AL/RC settings are more likely to have dementia, enroll in hospice services closer to death, and less likely to receive opioids or die in an acute-care setting (Dougherty et al., 2015). Relationships between third-party service providers and AL/RC operators may or may not exist, complicating resident care coordination (Carder & Hernandez, 2004; Hernandez, 2005; Zimmerman & Sloane, 2007). AL/RC administrators value hospice teams that understand and respect the AL/RC staff by

coordinating with AL/RC settings (Dobbs et al., 2006). Additionally, preliminary evidence suggests that when AL/RC staff are educated on EoL services, hospice utilization increases (Dobbs et al., 2018). When compared to SNF, AL/RC provided less pain management at EoL, possibly because these settings typically lack a licensed nurse to coordinate prescriptions with physicians (Dobbs et al., 2006).

Families of AL/RC residents' have expressed concerns about communication between care providers and physicians, inadequate monitoring, and lack of staff knowledge regarding symptom management at EoL (Biola et al., 2007). Introducing the topic of advance care planning may encourage AL/RC residents and their families to discuss advance directives and preferences for their EoL experience. Residents' physicians are expected to oversee medical care, even after residents begin hospice (Weckmann, 2008). Though challenging, physicians can initiate conversations with residents and families in collaboration with AL/RC staff regarding advance care planning, including physicians orders for life-sustaining treatment (POLST), resident preferences, and advance directives (Beck et al., 2015; Dixon et al., 2002; Greenstein et al., 2019; Hickman et al., 2010).

### **Conclusion**

This narrative review describes roles physicians may play in the AL/RC context. Physicians' involvement in care processes for AL/RC residents is crucial but often unclear. While not comprehensive, this review aims to amplify a topic that remains fragmented, yet intimately tied to AL/RC resident care and well-being. Since every state has different AL/RC regulations and specifications of physician responsibilities, future research is necessary to describe the differences across states and implications for physician practices and resident care. AL/RC settings provide varying levels of care services to residents, ranging from assistance with chores to clinical care and hospice aimed to support resident autonomy (Kane & Mach Jr., 2007; Zimmerman & Sloane, 2007). Compared to licensed healthcare settings, AL/RC staff have less clinical training, rendering the role of physicians particularly important.

Caring for AL/RC residents involves balancing clinically desirable goals with residents' preferences and values (McConnell & Meyer, 2019). All care team members must understand how to support informed choices for those in their care to ensure resident well-being and cooperation (Calkins & Brush, 2016). The relationship between residents and their physicians is influenced by care staff, nurses, specialists, and families (Kemp et al., 2019; Schumacher, 2006). While few states require a medical director, most require physician assessment at move-in and after change in condition or at regular intervals thereafter (National Center for Assisted Living [NCAL], 2019). Models of conferencing and monitoring care transitions between acute and post-acute

settings suggest improved communication, increased access to comprehensive information, and fewer medication errors (Farris et al., 2016) providing a potential avenue for physician engagement in AL/RC. By participating on an interprofessional team for residents' care coordination, physicians and AL/RC operators can work together to ensure person-centered care coordination and role definition (Nyrop et al, 2011; Young & Siegel, 2016). Communication, follow-up, and interprofessional care coordination are critical to AL/RC residents' health and healthcare and physician roles must be further clarified through research, policy, and innovative practice.

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