

Medical Direction in the Assisted Living: How a Pandemic Defined a Role

Sarah Howd, MD, CMD

Assistant Professor of Medicine/Geriatrics
University of Rochester Medical Center

Dallas Nelson, MD, CMD, FACP

Associate Professor of Medicine/Geriatrics
University of Rochester Medical Center

**UR Medicine
Geriatrics Group**

MEDICINE *of*
THE HIGHEST ORDER



UR
MEDICINE

HIGHLAND
HOSPITAL

Disclosures

- No financial disclosures for either speaker.

Objectives

- Describe the complexity of providing care to residents within assisted living communities.
- Explain how the COVID 19 pandemic highlighted safety issues that exist in ALFs, particularly related to infection prevention.
- Integrate a model of medical direction in local assisted living facilities.
- Identify medical director functions that will benefit the assisted living as well as its residents.

History of Assisted Living in the US

- Born as a social model
 - Started in the early 1980's as the perception of nursing homes worsened (<https://www.seniorcare.com/assisted-living/resources/history-of-assisted-living/>)
 - Consumer driven model with amenities
 - Residents mostly independent with ADLs
 - Need IADL help with meal prep, medication management, transportation
 - Private pay

Evolution of Assisted Living

- People staying home longer with services
- By time they move to AL, they are more frail
 - Need more hands on care
 - More medical comorbidities and complexity
- Higher expectations
 - High cost of AL increases expectations of families to provide more care in AL
- More recently has been the growth of the option in-house physician

Poll question

- Do you provide medical care for assisted living residents on site?
- Yes
- No

Poll question

- Do you serve as medical director/advisor of an assisted living?
- Yes
- No

Current Landscape of Assisted Living

- Nationally:
 - 28,900 Communities
 - 996,100 total beds, over 810,000 occupied
 - Average # beds/facility is 33 (range 4-150+)



Harris-Kojetin L, Sengupta M, Lendon JP, Rome V, Valverde R, Caffrey C. Long-term care providers and services users in the United States, 2015–2016. National Center for Health Statistics. Vital Health Stat 3(43). 2019.

Current Landscape of Assisted Living

Assisted Living as an Industry

- 453,000 total employees
- 81% are for-profit, 56% are part of a chain
- \$32 Billion annually
- Large source of tax revenue locally and federally



Heather Heights of Pittsford
Pittsford, NY

Harris-Kojetin L, Sengupta M, Lendon JP, Rome V, Valverde R, Caffrey C. Long-term care providers and services users in the United States, 2015–2016. National Center for Health Statistics. Vital Health Stat 3(43). 2019.

Current Landscape of Assisted Living

- Typical AL Resident
 - **71%** are women
 - **81%** are non-Hispanic White
 - **52%** are over 85 years old
 - **22 Month** average length of stay



Most Common Diagnoses of ALF Residents

1. Hypertension
2. Dementia
3. Heart Disease
4. Depression
5. Arthritis
6. Osteoporosis
7. Diabetes
8. COPD
9. Cancer
10. Stroke

Multiple Comorbidities

# of Chronic Conditions	% ALF Residents
0	6
1	18
2-3	50
4-10	26

In one year:

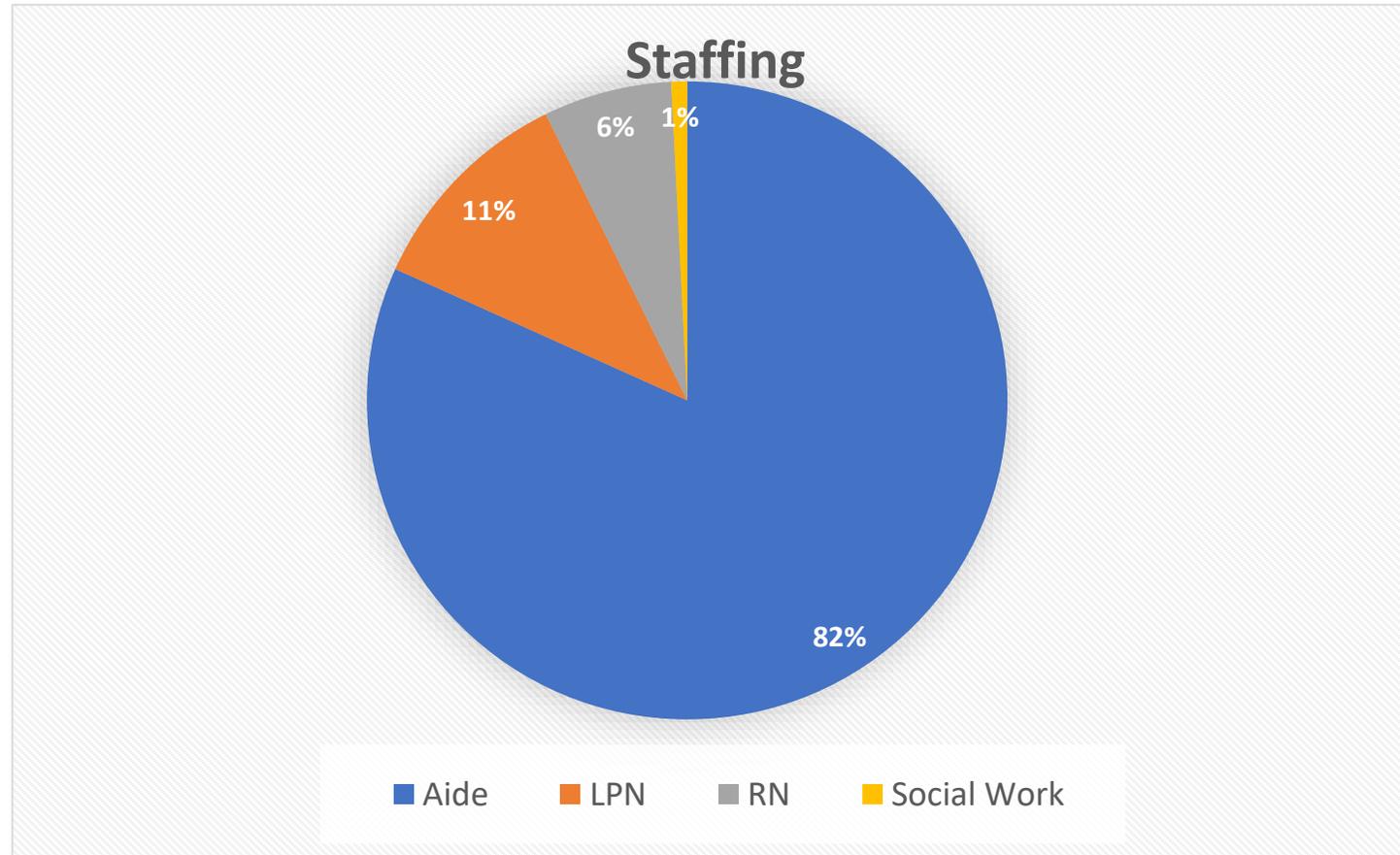
- 33% of all ALF residents with an ER visit
- 24% of all ALF residents hospitalized

Source: CDC/NCHS, 2010 NSRCF

Poll question

- How important do you think a medical director in ALF is in improving patient safety?
- Strongly Agree
- Agree
- Undecided
- Disagree
- Strongly Disagree

Current Landscape of Assisted Living



Harris-Kojetin L, Sengupta M, Park-Lee E, et al. Long-term care providers and services users in the United States: Data from the National Study of Long-Term Care Providers, 2013–2014. National Center for Health Statistics. Vital Health Stat 3(38). 2016.

Contrast of ALF and SNF

- In contrast to nursing homes, ALFs have:
 - Limited structured medical expertise
 - Minimal infection prevention
 - Large variation of services available between facilities
 - Regulations are much less comprehensive
 - Minimal support tools as an industry
 - Presence of medical provider in building is optional

ALF ≠ SNF

NYS Assisted Living Program

- NYS Medicaid funded assisted living beds
- Initially had a medical director mandate
- 3 Assisted Living Program buildings
- 2013 medical director mandate ended
- 2 facilities continued the contract

ALF Medical Direction Contract

UR Medicine Geriatrics Group Medical Direction Services

- Medical Oversight
- Policies and Procedures
- QA Review
- Emergency Treatment
- Transfers of Care
- QAPI Meeting Attendance
- Review for Safe Medical Treatment
- Medical Representation in the Community
- Staff In-service
- Drug Irregularities Review
- Lab Director Coverage

Pre-Pandemic Medical Direction in ALF

- Behavior management
- Family concerns
- PCP consultation
- Transitions of care liaison
- State regulation interpretation
- Lab director review of BG/insulin protocols

Legionella Outbreak

- Notified of Legionella outbreak at ALF (no medical director)
- PA discovered symptomatic patient receiving tap water nebulizers
- Discussed management plan with infectious disease doctor
- Treated our patients
- Gave instructions for the facility to share with other PCPs for the rest of the residents
- Yet facility felt abandoned in a time of need

Scabies Outbreak

- Diagnosed in several residents
- Wrote for Permethrin treatment
- Suggested facility-wide treatment
- Recurrence of symptoms
- Facility refused to notify and treat other residents. “Too much work”

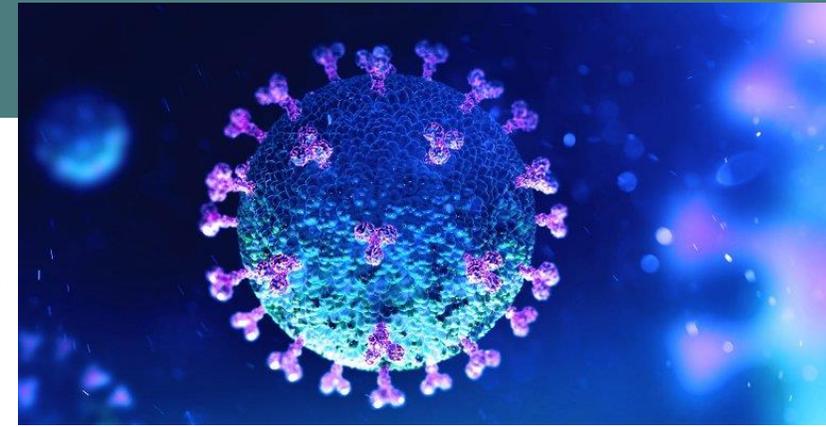


March 2020: Rochester, NY

- March 11 – first person diagnosed with COVID 19
- March 12 – visitor and staff screening in AL, limit unnecessary trips off campus
- March 13 – NYS DOH guidance to suspend visitation, implement health screening for staff, and wear mask if within 6 ft of resident, wash hands between every resident interaction
- March 16 – URMGG starts conversion to telemedicine visits
- April 4 – notified of first case of **COVID** in ALF

ALF COVID 19 Outbreak

- ALF with 93 residents, no medical director
- 27 COVID + residents, 15 from URMGG
- 9 Staff, 7 out on isolation
- Both ALF and memory care effected
- ❌ No physician to coordinate isolation
- ❌ No physician to order tests on staff
- ❌ No coordination of resident testing and limited access to testing on site





Department of Public Health

Monroe County, New York

Adam J. Bello
County Executive

Michael D. Mendoza, MD, MPH, MS
Commissioner of Public Health

**DESIGNATION BY MONROE COUNTY COMMISSIONER OF PUBLIC HEALTH OF
QUALIFIED REPRESENTATIVE PURSUANT TO 10 N.Y.C.R.R. § 2.6**

WHEREAS, it is my duty and responsibility as Commissioner of Public Health to take measures to limit the further spread of COVID-19 in Monroe County, including to order and to conduct testing for COVID-19;

NOW THEREFORE, I, Michael D. Mendoza, MD, MPH, MS, Commissioner of the Monroe County Department of Public Health, pursuant to the authority vested in me under Article 21 of the New York Public Health Law and Title 10, Section 2.6 of the New York Code, Rules and Regulations, hereby designate the physicians of the UR Medicine Geriatrics Group, under the direction of Dallas Nelson, MD, Medical Director, as qualified representatives of the Commissioner of the Monroe County Department of Public Health to order and conduct testing of staff members and residents of the [REDACTED] [REDACTED] County of Monroe, State of New York, for COVID-19.

April 30, 2020

Michael D. Mendoza, MD, MPH, MS
Commissioner of Public Health



COVID 19 Unit in ALF

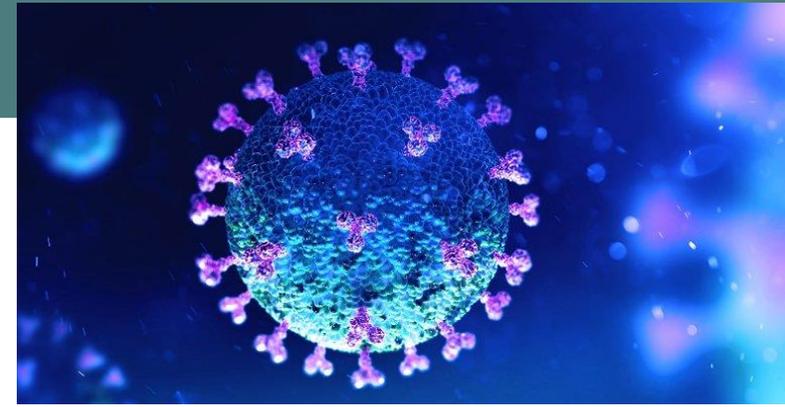


NYS DOH Regulatory Response to COVID in ALF

- April 2020 – Nursing homes and ALFs cannot accept COVID + patients (readmissions or new admissions)
- May 2020 – all NH and ALF staff must be PCR tested twice weekly and quarantined for 14 days if positive
- August 2020 – NYS sends rapid antigen testing kits to all ALFs with a Lab Director/Limited Lab Service Waiver

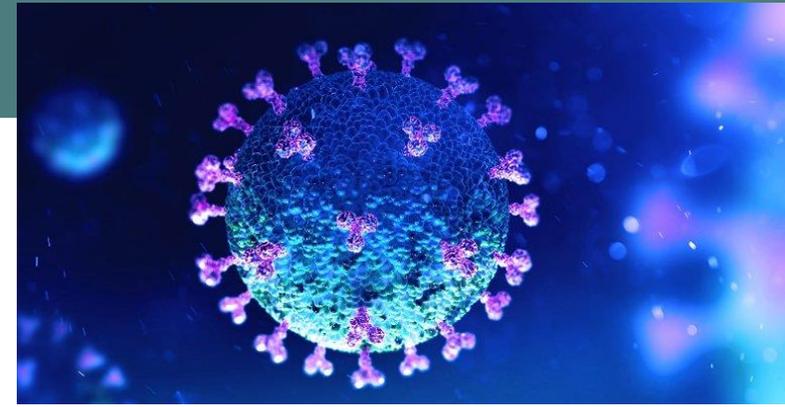


COVID in ALF with Medical Director



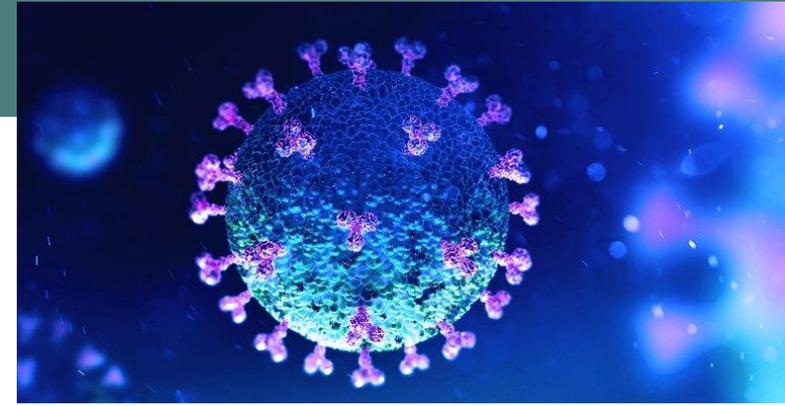
- Staff screening with 11 **COVID +** in one day
- **NO** known resident cases
- NP provides in person training on performing NP swab
- Medical director tests all 42 residents (AL and memory care)
 - Coordinates with Director of University lab to expedite results
- Lab reruns the 11 staff tests – all were false positives, BUT
- **3 COVID + residents** discovered in memory care
- Medical director advises immediate lock down of the building, use of full PPE, and dedicated staff on memory care

COVID in ALF with Medical Director



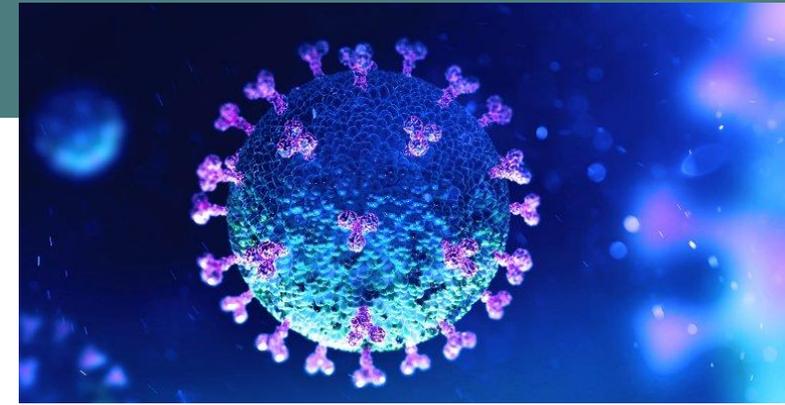
- Over the next four weeks:
 - 6 more residents on memory care **COVID +**
 - Several staff members test positive
- All staff in full PPE with N95s and gowns while on memory unit
- Staff utilizes rapid antigen testing for screening/symptoms
- **7 residents on memory care remained COVID-free**
- **NO spread of COVID on AL (26 residents)**

ALF without a Medical Director



- First resident **COVID+** in the ED
- ALF has to call PCPs of all residents to get an order for testing
- ALF with no direct way to receive results
- PCR turnaround time 36 hours
- First round of resident testing negative

ALF without a Medical Director



- Two days later, another resident with symptoms sent to ED = COVID +
- 2 more residents COVID + on next round of testing
- One COVID + resident cannot quarantine - ? evacuation
- 2 nurses now COVID +
- ❌ No physician to coordinate isolation
- ❌ No coordination of resident testing and limited access to testing on site
- ❌ No physician to communicate with hospital
- ❌ No access to rapid antigen testing to cohort

Questions to Ponder

- What are the **benefits** of medical direction in assisted living?
- What are the **barriers** of medical director implementation in assisted living?
- What would be outside of the **scope** of a medical director in assisted living vs nursing home?

Products of Assisted Living Medical Direction

- Community-wide standards on quarantine
- Checklist for ALFs with COVID+ residents
- Primary Care COVID + Order Set
- EMS Pre-Hospital Intervention

Community ALF Quarantine Standards

- **14 day quarantine for the following residents:**
 - New admissions from the community
 - New admissions or readmissions from the hospital (inpatient or observation stay)
 - New admissions or readmissions from SNF rehab or another ALF **IF** there have been positive residents or staff in the past 14 days
 - Residents who go out on social family outings
- **14 day quarantine NOT required for the following residents:**
 - Residents attending off-site medical appointments
 - Residents who have visited urgent care or the emergency department
 - Residents admitted from SNF rehabs or another ALF that have had no COVID positive residents or staff members in the past 14 days
 - Residents who are on hemodialysis

ALF Facility checklist

1. Call County DOH and Medical Director (if applicable) to notify of positive COVID cases in the community
2. Notify PCP's of positive and exposed residents
3. Obtain orders from PCP/Medical Director to swab residents
4. PCP and Community will communicate COVID results once received
5. ALF Community notifies the resident and their family of positive COVID results
6. Determine Quarantine plan for positive residents
 1. Meals brought to room
 2. Designated staff for COVID positive residents
 3. Vital signs taken every shift
 1. At least O2 and temperature
 4. Ensure capability for telemedicine visits
7. Determine plan to remove residents off quarantine once symptom free and/or 10 days have passed since the initial onset of symptoms
 1. **Retesting for a negative swab is not a recommended practice**

Primary Care COVID + Order Set

PRIMARY CARE INSTRUCTIONS FOR COVID-19 POSITIVE PATIENTS:

- COVID-19 positive patients should be quarantined to their room for 14 days
- All staff members should abide by CDC/DOH guidelines for PPE when caring for these patients
- Facility to check VS daily including BP, pulse, respiratory rate, and temperature
 - Notify PCP immediately if SBP <100 or >170, pulse <55 or >100, RR <10 or >24, O2 sat <90%, temperature < 95° F or >100.4 ° F

Notify PCP if the patient is having any acute changes in condition such as, but not limited to the following:

- Respiratory distress (increased work of breathing/shortness of breath, increased use of accessory muscles, nasal flaring, inability to complete a sentence due to air hunger, excessive wheezing, bluish lips or skin, gurgling sounds during breathing)
- Increased confusion from baseline mental status
- Patient stops eating food or drinking fluids for 24 hours
- Diarrhea for > 48 hours
- Chest pain, heart palpitations
- Excessive sweating
- Lethargy

*We recommend having primary care office nursing touch base with the facility on a regular basis during the 14 days to get regular updates.

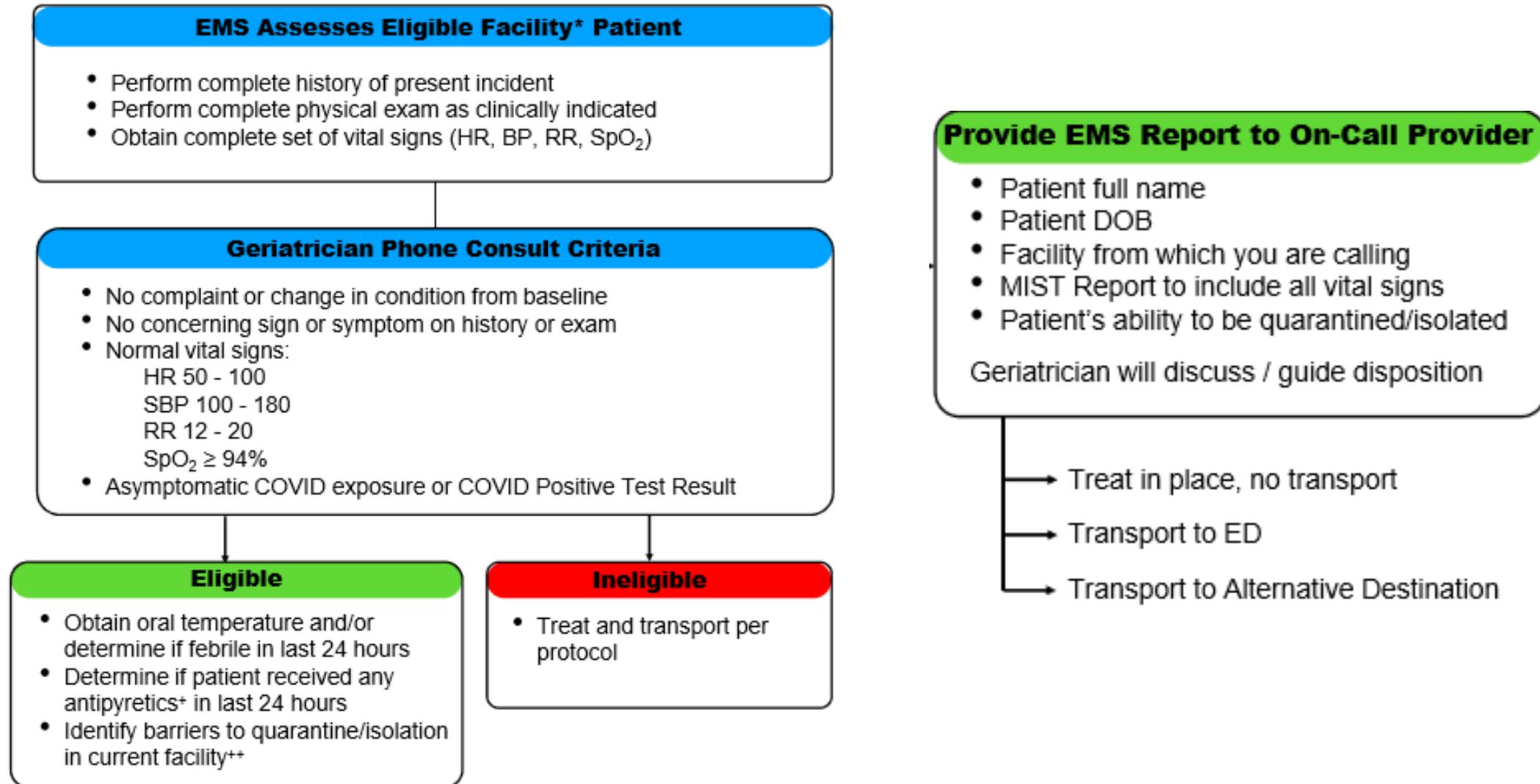
*NYS DOH continues to recommend the non-test based strategy of removing a resident from isolation.

Non-test-based strategy:

- At least 3 days (72 hours) have passed since recovery, defined as resolution of fever (greater than or equal to 100.0) without the use of fever-reducing medications;
AND
- Improvement in respiratory symptoms (e.g., cough, shortness of breath);
AND
- At least **14 days** have passed since symptoms attributed to COVID-19 first appeared.

*For patients who were asymptomatic at the time of their first positive test and remain asymptomatic, at least 14 days have passed since the first positive test.

EMS Pre-Hospital Intervention



Questions to Ponder

- What are the **benefits** of medical direction in assisted living?
- What are the **barriers** of medical director implementation in assisted living?
- What would be outside of the **scope** of a medical director in assisted living vs nursing home?

Why does an ALF want a medical director?

- Provided insight and expertise that improved care
- Family involvement/interventions
- Extended the length of stay
- Reviewed incident reports & policies/procedures
- Residents/families respond better to information coming from a medical expert
- Reviewed resident appropriateness for AL and consideration of higher level of care
- Awareness of how other local ALs operate

Why does an ALF want a medical director?

- Pandemic specific benefits from medical direction
 - Infection control policy creation and review
 - Family reassurance that difficult changes were needed for safety
 - Ordering and review of mandatory staff testing
 - Guidance on quarantine procedures
 - Ordering and guidance on resident testing

Poll question

- How important do you think a medical director in ALF is in improving patient safety?
- Strongly Agree
- Agree
- Undecided
- Disagree
- Strongly Disagree

Where to draw the line

- Different model than SNF
- Far more advising and coaching than directing
- But need ability to write orders in an emergency
- In-house doctors should avoid advising administrators on facility-wide issues

Take Home Points

- AL residents consist of the “oldest old” and are clinically complex
- AL Communities lack infection prevention education and protocols, making them more susceptible to spread of disease
- A formal arrangement with a medical expert will benefit not only the community but also the residents

