Quality Measurement in Assisted Living: Emerging Practices

By Joanne Kaldy

Quality measurement in assisted living (AL) isn’t a one-size-fits-all proposition, and it is especially challenging because this care setting is state regulated, with wide variations across the country. Yet AMDA – The Society for Post-Acute and Long-Term Care Medicine and its members working in AL have promoted the need to identify metrics for quality care in this setting. “The Role of Quality Measurement in Assisted Living: Current Advances and Controversies,” a session at the Society’s virtual Annual Conference, addressed these efforts in depth.

Sheryl Zimmerman, PhD, coordinator-chief of JAMDA, noted that this isn’t a new issue. She quoted an article with Philip Sloane and Susan Fletcher, “The Measurement and Importance of Quality” from The Assisted Living Resident (Johns Hopkins University Press, 2008): “Judgments about the quality of assisted living may be the single most important factor influencing the health of the people who reside there.”

She then addressed the “big picture” of quality measurement and its domains:

- Regulatory (admission and reten- tion policies; licensure and training requirements; reimbursement policies)
- Community (neighborhood per capita income, nursing home beds and population, and involvement of community agencies)
- Assisted living (structure and process of care)
- Resident (age, gender, and race; health status and social support; ad- vance directives)
- Resident outcomes and staff out- comes

There are controversies about what should be measured in AL, Dr. Zimmerman said. However, she noted, there is agreement that “when measuring outcomes, this should reflect the tenets of AL and be important to residents, families, and care providers.” Additionally, it should involve care that is person-centered and evidence-based to achieve desired outcomes. “Measurement is necessary for quality improvement, and there is a need for quality measurement and improvement in assisted living,” she said.

Ball Is Rolling on Assisted Living Quality Measurement

Dr. Zimmerman pointed to some examples of promising efforts to measure AL quality. Specifically, she mentioned the Wisconsin Coalition for Collaborative Excellence in Assisted Living; a coalition of providers, regulators, and researchers convened to improve outcomes. The group measures performance in areas such as falls, infections, and hospital readmissions, and provides resources to improve care. Data are shared to allow benchmarking.

Other state efforts include:

- Advanced Standing for Assisted Living Facilities, a voluntary quality initiative sponsored by the New Jersey Department of Health
- Oregon Residential Care Quality Measurement Program, a legislatively mandated program that requires re- porting of uniform quality metrics
- The Measurement and Importance of Quality from The Assisted Living Resident (Johns Hopkins University Press, 2008)
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On the national level, the American Health Care Association/National Center for Assisted Living (AHCA/NCAL) Quality Initiative for Assisted Living focuses on quality related to staff stability, customer satisfaction, hospital readmissions, and antipsychotic use. Elsewhere, the Center for Excellence in Assisted Living (CEAL) has developed 96 tools for quality improvement in person-centered care, medication management, care coordination/transitions, resident/patient outcomes, and workforce that have been used in AL and other settings.

Several years ago, the Agency for Healthcare Research and Quality (AHRQ) established a disclosure collabor- ative. The goal of this effort was increasing the value of health care by developing tools that help consumers make better choices based on improved information on AL costs and services. The project didn’t move into implementa- tion, Dr. Zimmerman noted, but it provided some useful information.

Although all these efforts are useful and have contributed to quality mea- surement, Dr. Zimmerman noted that there are ongoing challenges and controversies:

- If measurement is to improve care, which of many outcomes should we measure?
- What components of care should we measure?
- What should we recommend?
- What strategies should we use?

The Path to Person-Centeredness

“There are so many different ways to conceive what is important to each individual and how they define person-centeredness,” Dr. Zimmerman said. “We want to recognize that AL is a step along the continuum, so measures of quality should be relevant and transfer- rable across settings.” She further said, “When we talk about measuring care and person-centeredness, it is important to realize that this issue is complex.”

Ultimately, she said, “We should use measures that are reliable, valid, sensitive, feasible, and meet other criteria.” Measurement selection, she said, must be informed; if measurement is undertaken, change must be possible.

Increasingly, consumers want infor- mation about quality in AL and other care settings. Dr. Zimmerman said, “Consumers want to compare providers to guide decision-making. Therefore, information about services and supports should be made available. And beyond consumer education, publicly available information could inform providers of what others offer ... and could be useful to policymakers, regulators, researchers, and others.” She suggested that unbiased organizations must be responsible for “disseminating information and enabling consumers to compare apples to apples.”

Federal Regulation of Assisted Living: Yes or No?

“Regulations have been with us for many years, and they have been effective in protecting the public,” Paul Katz, MD, CMD, said. He observed that these regulations have also been costly and burdensome, but while asking the indus- try to police itself sounds good, it may not be practical: “History is replete with failures of self-regulation.” He added, “Even when we agree about what standards of care should be and they’re based on good scientific evidence, there remains great variability in acceptance of those standards and their applications.” Nonetheless, Dr. Katz said, regulations are important for AL to address gaps in quality, state-to-state variabilities, and lack of transparency.

The idea that AL and nursing homes are completely different is no longer true, said Dr. Katz, and there are overlapping needs in the two settings. They both have residents who require dementia/ memory care and assistance with activi- ties of daily living such as bathing and toileting. Despite these similarities, it is difficult to assess quality and outcomes in AL. Dr. Katz cited a Government Accounting Office report in which 26 state Medicaid agencies could not report the number of critical incidents that occurred in AL facilities because they lacked the ability to collect or track inci- dents. Further, while states identified physical, emotional, or sexual abuse as a critical incident, many did not identify other incidents with potential for harm such as medication errors and unexplained deaths.

Dr. Katz said, “We have evidence that four areas make a difference” and could benefit from some regulation:

- Resident assessment
- Medication management
- Staffing requirements
- Staff education and training

“We need regulations,” he said. “Should we look to nursing homes for a roadmap? I know many of you are shaking in your boots at the thought. But the populations are so similar, why shouldn’t we provide similar regula- tions?” The answer, he suggested, is somewhat of a compromise, with regu- lations that acknowledge that AL is more of a social model. “What is required is a thoughtful review of both nursing home and state-specific AL regulations/ standards that have proven effective and cost-efficient,” he said. Additionally, he suggested, “We need to ensure flexibility on the state level in the implementation of a set of broad federal requirements to reflect needs of the local populations.”

COVID and Assisted Living

As in other care settings, the COVID-19 pandemic has required AL communi- ties to step up their infection control efforts and protect their residents and staff alike. John P. Hirdes, PhD, from the University of Waterloo in Canada, shared a multinational risk profile based on COVID-19 mortality risk factors. He said, “COVID has varying impact on the health of people affected, and symptoms are often undetected. It’s important for us to think about risk factors, and we need to identify people at highest risk.” By understanding the risk factors, he said, it will be possible to inform person- level clinical management, facility-level...
Type 2 Diabetes Update: Semaglutide and Linagliptin as Basal Insulin Alternatives

By Christine Kilgore

Cardiovascular comorbidities and risk reduction play a major new role in pharmacologic therapy for type 2 diabetes, with sodium-glucose transporter 2 (SGLT2) inhibitors and glucagon-like peptide 1 (GLP-1) receptor agonists now recommended as part of the glucose-lowering regimen for patients who have established atherosclerotic cardiovascular disease (ASCVD). Such indicators of high-risk, chronic kidney disease (CKD) or heart failure (HF).

“We should always assess patients now in that light, asking whether they have a stent, a [history of] stroke, a transient ischemic attack, or any vascular procedure, for instance, because now we have the option — especially if they have heart failure or a cardiovascular complication — to use an SGLT2 inhibitor or a GLP-1 receptor agonist,” said Naushira Pandya, MD, FACP, CMD, professor and chair of the Department of Geriatrics at the Kiran Patel College of Osteopathic Medicine at NOVA Southeastern University in Fort Lauderdale, FL, at the Annual Conference of AMDA – The Society for Post-Acute and Long-Term Care Medicine.

Dr. Pandya commented on the 2020 Standards of Medical Care of the American Diabetes Association (ADA) during a broad discussion of type 2 diabetes management (Diabetes Care 2020;43:S98–S110). The two groups of agents can be safely used in older adults if carefully selected. They have been shown to improve cardiovascular outcomes, “so they’ll take a more central place in our selection of drugs and management of diabetes,” Dr. Pandya said.

SGLT2 inhibitors are oral agents, and they are recommended by the ADA when HF or CKD predominates. The established GLP-1 receptor agonists (e.g., lixisenatide, liraglutide) are injectables, and they are advised when ASCVD predominates. The Food and Drug Administration’s approval last year of semaglutide, an oral GLP-1, is a “revolutionary change,” and it is an option worth considering for long-term care residents, depending on cost and the needs of the patient, Dr. Pandya said during a question-and-answer period, “I personally don’t have experience with it [yet], but I have patients who refuse injections and have poor control and have maxed out on three oral agents, so in that kind of person, yes, I’d consider using it,” she said.

“There is some evidence for improved cardiovascular outcomes.”

In fact, GLP-1 receptor agonists are now the recommended next step instead of basal insulin in patients with type 2 diabetes who need greater glucose lowering than can be obtained with two or three oral agents, Dr. Pandya said in her presentation. This new recommendation in the ADA’s 2020 Standards represents a major change in direction in the last year or so for diabetes treatment, and I think that it can apply to our settings,” she said. “In the past we would have reached for basal insulin. Now, this is the way to advance your therapy.”

Metformin remains the preferred initial treatment, and “it should be kept on board even as you’re adding other things,” Dr. Pandya said. People with ASCVD, CKD, or HF, a SGLT2 inhibitor or GLP-1 receptor agonist should be considered as an add-on independently of A1C goals. If not, other oral agents should be added on if the A1C is above individualized targets, with choices guided by clinical and functional status, personal preference, and sometimes cost.

Medication regimens should be reevaluated every three to six months, the ADA advises, with a focus on safety and simplification as well as intensification of treatment for patients who are not meeting treatment goals. “Remember, you’re going to look at glucose trends rather than adjusting treatment regimens in response to isolated abnormal values, said Dr. Pandya.

Some oral agents have comparable glycemic control to basal insulin, she said, sharing her own tips for managing medications with a focus on safety and simplification. In an “elegant” long-term care/skilled nursing facility study published in 2018 in JAMA (2018;19:399–404), Dr. Pandya reported that the mortality rates increase with major cardiovascular events, with pneumonia having higher mortality rates than those without pneumonia. The mortality rates increase with major comorbidity count for individuals both with and without pneumonia, but the mortality effect is magnified within the pneumonia groups.

In addressing COVID-19, Dr. Hirdes suggested that each setting has unique challenges, but most settings were not equipped to manage the challenges posed by the pandemic.

In a panel discussion on COVID-19 in AL during this session, Kevin O’Neil, MD, CMD, chief medical officer at Affinity Living Group, said, “We had infection control measures which we implemented, and we quickly established a COVID policy.” He added, “Staff is knowledgeable about isolation procedures, and we have prioritized PPE [personal protective equipment] for those providing care to infected residents. We have implemented social distancing for everyone, including staff; and we’ve terminated group activities.”

Affinity has been very careful about new admissions, and they aren’t sending residents with symptoms to the hospital until they have distressed breathing. At the time of the Annual Conference, the community had one resident who had tested positive; that person was in isolation and doing well. Nonetheless, Dr. O’Neil said, “We are advising our teams not to get complacent. We are reinforcing the importance of aggressive measures every day. At the same time, we are urging staff to practice self-care, eat well, and get adequate sleep. It’s critical to pay attention to our teams.” He also stressed, “I’m communicating with practitioners and asking them to let me know if they have challenges or concerns. Communicating with people who have clinical expertise is essential.”

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Simplifying Insulin Management

Decreasing the burden of multiple insulin injections and blood glucose checks — and reducing the risk of hypoglycemia — has long been a goal in LTC, and it is addressed in the 2020 ADA guidelines with an algorithm on simplifying complex insulin regimens for older patients with type 2 diabetes. The algorithm proposes titrating the dose of basal insulin to a fasting blood glucose goal of 90–150 mg/dL (5.5–8.3 mmol/L) and adjusting mealtime insulin regimens, Dr. Pandya said.

If the mealtime dose is <10 U/dose, one can discontinue mealtime insulin and add a noninsulin agent. “Try to stop mealtime insulin if you’re using just 4, 6, or 8 units,” she said. If the mealtime dose is >10 U/dose, one could change mealtime insulin by first reducing the dose by 50% and adding a noninsulin agent, then continuing to titrate the dose of mealtime insulin down as the noninsulin agent is increased.

“The other thing we can do [to simplify insulin management] is consider the use of a second-generation basal insulin such as degludec 200 U/mL or glargine 300 U/mL in those requiring high doses of basal insulin or who have wide fluctuations in glucose levels or hypoglycemia,” she said. “There seems to be less nocturnal and overall hypoglycemia [with such a change].”

The ADA’s algorithm for insulin regimen simplification incorporates the findings of a study described in 2016 in JAMA Internal Medicine (176;1023–1025), in which older adults receiving two or more insulin injections a day transitioned to once-a-day basal insulin glargine with or without noninsulin agents. Hypoglycemia decreased without compromising glycemic control.

To transition away from sliding-scale insulin (SSI) — another goal in PALTC (Diabetes Care 2019;42:1300–1305) — start by replacing it with basal insulin at about 50% to 75% of the total daily dose.”

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