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Variable Access to Medical Care

Many assisted living communities provide access to some onsite medical care and services, but the quality of these services varies. Assisted living facilities are primarily staffed by direct care workers who may or may not be licensed as nursing assistants. The larger assisted living facilities may have a registered nurse on staff at least some of the time, but most assisted living communities use a delegated nurse model of care. Assisted living communities' access to social workers, consultant pharmacists, behavioral health specialists, and other consultants is also limited in most states.

As noted by the Society's Assisted Living Subcommittee, there is also a lack of medical direction in most assisted living communities. Some medical practices actually specialize in the provision of medical care to assisted living communities, and some of the best ones that I have encountered use an interdisciplinary team approach, consisting of mostly nurse practitioners and physician assistants for medical care needs with the support and guidance of physicians, a licensed clinical social worker, and a consultant pharmacist who may provide services to several assisted living facilities.

Please share with us some of the things you love about assisted living communities and what you would like to see change.

Dr. Galik is editor in chief of *Caring for the Ages*. The views the editor express are her own and not necessarily those of the Society or any other entity. Dr. Galik is a nurse practitioner in LTC- and community-based settings through a clinical practice with Sheppard Pratt Health System. She is a professor at the University of Maryland School of Nursing, where she teaches in the Adult-Gerontology Primary Care Nurse Practitioner Program and conducts research to improve care practices for older adults with dementia and their caregivers in long-term care. She may be reached at galik@umaryland.edu.

Letter to the Editor: Disclosing Race in Case Reports

Dear Editor,

*Thank you for the instructive case reports of young people in long-term care in the May, 2021 issue (*Caring for the Ages *2021, 22(4): 10-11; https://bit.ly/3hH7kzF). I noticed that the person's race was documented at the beginning of the report. Specifying the race of the patient in the opening sentence of the physical exam was a habit that I picked up in medical school. I have discontinued this habit in answer to the call of the Massachusetts Medical Society leadership to be anti-racist.*

*An article by Johns Hopkins geriatrician Thomas E. Finucane, MD, a frequent contributor to publications of AMDA – The Society for Post-Acute and Long-Term Care, addresses the proper place of race and ethnicity in our case presentations (*AMA J Ethics *2014, 16(6): 423-427; https://bit.ly/3hJDTNz). Dr. Finucane advises that identifying race/ethnicity simply by observation may be more a manifestation of prejudice than observational data. It is best to ask the patient what group they identify with and then to record it in the social history. While perceived race certainly affects life experience, we are learning that race is a social, rather than genetic, construct.*

Eric Reines, MD, FACP
Marblehead, MA

Dear Dr. Reines,

Thank you for raising this important question. The editors of Caring for the Ages asked the Diversity and Inclusion Workgroup of AMDA – The Society for Post-Acute and Long-Term Care Medicine to discuss your query and return an opinion. After much discussion, the consensus was that, while there is not a simple answer to the question you raised, the racial and ethnic identity of a patient in long-term care is an important cultural element essential to understanding a case in its entirety.

In contrast to outpatient clinical settings or inpatient hospital units, long-term care settings serve as a home for their residents, a place where their racial and ethnic identity plays an important role. Knowing race and ethnicity is also vital in providing person-centered care. The Workgroup has concluded that race should be included in reports of cases in long-term care.

Members of the workgroup felt this was an important discussion that went well beyond case reports into all clinical assessments. They proposed having this be a topic for a panel discussion at the Society's 2022 Annual Conference, and perhaps a workshop on cultural competency in clinical assessments in PALTC medicine.

Christopher Laxton, CAE
Executive director of AMDA – The Society for Post-Acute and Long-Term Care Medicine

Challenges

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primary care groups, geriatricians, and other practitioners.

Dr. Howd and her group also will address the value of having a medical director in assisted living communities. "In our experience, during the past year the communities that had active medical directors got through the pandemic better than those that didn't. Having this clinician leader can make a big difference." However, she stressed that the subcommittee isn't looking to increase regulations for assisted living communities. "We aren't looking to make them little nursing homes," she said.

Another issue that needs attention, said Dr. Howd, is infection prevention and control in assisted living. "Education in this area needs to be a focus," she stressed, adding, "Few states have infection prevention written into their regulatory guidance, and this mostly involves teaching universal precautions." When facilities are asking employees to be on the frontline during a deadly pandemic, she stated, it is important that they have resources, skills, and knowledge such as how to don and doff personal protective equipment.

Bringing telemedicine into assisted living is another priority, Dr. Howd said. "When we looked at infection rates and deaths in our region, we found that COVID-positive patients in assisted living were more likely to go the hospital than those in nursing homes. Because assisted living facilities didn't have the same level of staffing, we had a high rate of hospitalizations." Telemedicine, she said, allows clinicians to see patients faster, start a plan of care promptly, and prevent avoidable hospitalizations.

Another challenge that needs to be addressed, said Dr. Howd, is that hospitals often misclassify assisted living residents as being from skilled nursing facilities. The hospital staff assume they will get skilled nursing care after they leave the hospital, so they are discharged too soon and with unrealistic expectations about the level of care they will receive when they go home. "We have to help them understand what the assisted living community can and can't do and what kinds of care and services are available in this setting," Dr. Howd said.

Powerful Paradigm Shift

When assisted living first appeared on the landscape in the 1980s, they were promoted and positioned as strictly social settings. There has been a huge paradigm shift as residents have come to this setting older and sicker, with issues such as chronic illnesses, physical disabilities/limitations, and cognitive impairment. "The increasing incidence and recognition of dementia has created a niche in assisted living, and many have special units for memory care," said Dr. Howd. Although these units generally have more staff, she said, they're not staffed like a nursing home. As in nursing homes and other settings, attracting and keeping frontline caregivers and other workers is a challenge that is not likely to go away soon.

Bringing All Parties to the Table

"We have committee members who've had loved ones in assisted living. We also have wonderful members from national organizations and large communities who can bring the industry perspective. Of course, we have great practitioners with an array of experiences and special interests. I think bringing all these parties to the table is important, and we can do that now," she said. "We have a diverse, engaged committee, and this will make us more productive, our goals more realistic, and our products more impactful."

Like her Society colleagues, Dr. Howd is excited about meeting with her committee in person at PALTC2022 next March. "This will be the first in-person meeting I've had with this group. Zoom has helped a lot and enabled us to interact and socialize more. But it's no substitute for connecting face to face," she said. In addition to a meeting, she said, "We are hoping to have some assisted living–focused presentations at the conference and to carve out our place in AMDA. We are definitely making our imprint."

Senior contributing writer Joanne Kaldy is a freelance writer in Harrisburg, PA, and a communications consultant for the Society and other organizations.

Let's Heal Together

AMDA – The Society for Post-Acute and Long-Term Care (PALTC) Medicine recently launched the Healing Together Campaign to formally acknowledge the pain we have all endured, and continue to endure, as part of the COVID-19 pandemic. You can read AMDA's official statement about the campaign: https://bit.ly/3esPJJB.

The campaign includes an extensive list of resources assembled by AMDA's Behavioral Health Advisory Council (https://www.paltcfoundation.org/node/358). They are meant to be shared with all of your work partners, from food services professionals to medical providers, to administrative staff and environmental services teams, and everyone in between.

The Behavioral Health Advisory Council also has developed a free webinar series to share strategies for coping with the grief and trauma experienced by PALTC health-care professionals as a result of the pandemic. Learn more and register: https://bit.ly/3esBZyE.