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AUGUST 19, 2020
1:00 – 2:00 p.m. (Pacific) with Q & As

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LeadingAge Washington member:
$79.00 per community

Webinar participant:
$119.00 per community

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Healthcare in Assisted Living: Historical Perspective and Future Opportunities

This session will focus on the benefits of blending a core competency of healthcare delivery in the social model of assisted living. A historical perspective of the origins of healthcare in assisted living will be presented to as a method to engage audience interest and to educate listeners about opportunities for improvement in healthcare delivery in their communities. The discussion will propose that healthcare must be actively managed in assisted living rather than passively observed. It will describe a model of standardized, predictable, high quality healthcare that will achieve outcomes beneficial to residents and the communities in which they live.

Details:

Assisted living (AL) was created in the early 1980s as a social model alternative to nursing homes. It targeted fragile, elderly residents who needed assistance in managing the debility caused by their multiple chronic diseases. It promised to deliver an enriched and more desirable life experience that offered greater quality of life and cost less than nursing homes where residents were often subjected to an institutional setting of squalid living conditions, poor quality care, and abuse.

The new AL model catered to more affluent, private pay residents in contrast to the less profitable, lower income, mostly Medicaid residents living in nursing homes. The resultant financial success garnered the attraction of Wall Street whose profit-driven investors flooded the fledgling AL industry with capital that funded explosive growth. By 2007, barely 20 years after the opening of the first AL, there were more than 38,000 ALs that housed nearly 1 million fragile, elderly residents whose healthcare dependency drove them to this setting.

But it was never the intent of the AL industry to provide healthcare to its residents. The diagnosis and treatment of diseases was not in the mindset of the non-medically trained entrepreneurs who favored a more enthusiastic focus on hospitality.

While healthcare in nursing homes was far from ideal in the 1980s, at least patients had dependable access to their physicians who delivered their medical care directly to them, onsite, predictably, and more-or-less regularly. In contrast, the new AL model, unprepared to meet the medical needs of it residents, forced residents to travel offsite for their healthcare, creating a distance that separated residents from their physicians and that made access much more challenging. Furthermore, ALs provided little assistance with helping residents communicate with their physicians, make appointments, arrange for prescriptions and durable medical equipment, etc. And it made timely response to changes in resident condition problematic.

Thus, a paradox emerged:

the AL industry exists only because their residents need assistance with managing failing health, and yet managing healthcare isn't a priority in most ALs. Rather, the industry is dominated by a hospitality model that often has no healthcare professionals in its leadership. The outcomes of this fractured model speak for themselves: resident length of stay is only 22 months and declining, annual resident turnover is 54% and increasing, and the current occupancy rate (less than 86%) is one of the lowest in AL's 40-year history.

But encouraging trends are now appearing. A few AL corporations have integrated healthcare as a core service, breaking away from an industry and its trade organizations that remain stubbornly resistant to this necessary evolution. In addition, a growing number of physician practices are collaborating with nurse practitioners and physician assistants to deliver medical services onsite to AL residents using a House Calls model. The promising outcomes of this approach confirm improved resident health: fewer ER trips, fewer hospitalizations, fewer readmissions, lower overall healthcare costs, and more timely and effective responses to changes in resident condition, all of which translate to increased length of stay.

Session Learning Objectives:

- Contrast how the location of healthcare delivery differs between nursing homes and assisted living.
- Articulate a paradox in assisted living and describe how it negatively impacts resident healthcare outcomes.
- List at least 3 beneficial healthcare outcomes that result from having an integrated care model of assisted living.

Speaker:

Dr. Steven Fuller, President, Illumination Analytics

Dr. Fuller was a triple board certified Pulmonary and Critical Care specialist for more than 20 years. During this time he was also a medical director of skilled nursing facilities, home health and hospice companies, and a long term acute care hospital. For the past 10 years he has focused exclusively on improving healthcare delivery to the assisted living setting. His efforts have included developing a healthcare coordination service, a House Calls company, a healthcare analytics service for assisted living, and a service to reduce assisted living readmissions. He has been the Corporate Medical Director for a large nonprofit senior housing corporation, and he has been the Executive Vice President for one of the largest geriatric medical practices in the US southeast who delivers care exclusively to assisted living residents onsite in the communities in which they live. Dr. Fuller has presented at LeadingAge Washington's Assisted Living Workshop and Annual Conference.

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