To:	EmpowerMe Wellness, LLC (btravers@cedarhurstliving.com)
Subject:	U.S. TRADEMARK APPLICATION NO. 88015111 - GUIDING INDEPENDENCE - N/A
Sent:	10/18/2018 5:27:25 PM
Sent As:	ECOM107@USPTO.GOV
Attachments:	Attachment - 1 Attachment - 2 Attachment - 3 Attachment - 4 Attachment - 5 Attachment - 6 Attachment - 7 Attachment - 8 Attachment - 9 Attachment - 10 Attachment - 11 Attachment - 12 Attachment - 13 Attachment - 14 Attachment - 15 Attachment - 16 Attachment - 17 Attachment - 18 Attachment - 19 Attachment - 20 Attachment - 21 Attachment - 22 Attachment - 23 Attachment - 24 Attachment - 25 Attachment - 26 Attachment - 27 Attachment - 28 Attachment - 29 Attachment - 30 Attachment - 31 Attachment - 32 Attachment - 33 Attachment - 34 Attachment - 35 Attachment - 36 Attachment - 37 Attachment - 38 Attachment - 39 Attachment - 40 Attachment - 41 Attachment - 42 Attachment - 43 Attachment - 44

Attachment - 45

UNITED STATES PATENT AND TRADEMARK OFFICE (USPTO)
OFFICE ACTION (OFFICIAL LETTER) ABOUT APPLICANT'S TRADEMARK APPLICATION

U.S. APPLICATION SERIAL NO. 88015111

MARK: GUIDING INDEPENDENCE

88015111

CORRESPONDENT ADDRESS:
BRETT TRAVERS
120 S CENTRAL AVE STE 1050
CLAYTON, MO 63105

CLICK HERE TO RESPOND TO THIS LETTER:
http://www.uspto.gov/trademarks/teas/response_forms.jsp

VIEW YOUR APPLICATION FILE

APPLICANT: EmpowerMe Wellness, LLC

CORRESPONDENT'S REFERENCE/DOCKET NO:
N/A
CORRESPONDENT E-MAIL ADDRESS:

btravers@cedarhurstliving.com

OFFICE ACTION

STRICT DEADLINE TO RESPOND TO THIS LETTER

TO AVOID ABANDONMENT OF APPLICANT'S TRADEMARK APPLICATION, THE USPTO MUST RECEIVE APPLICANT'S COMPLETE RESPONSE TO THIS LETTER **WITHIN 6 MONTHS** OF THE ISSUE/MAILING DATE BELOW. A RESPONSE TRANSMITTED THROUGH THE TRADEMARK ELECTRONIC APPLICATION SYSTEM (TEAS) MUST BE RECEIVED BEFORE MIDNIGHT **EASTERN TIME** OF THE LAST DAY OF THE RESPONSE PERIOD.

ISSUE/MAILING DATE: 10/18/2018

The referenced application has been reviewed by the assigned trademark examining attorney. Applicant must respond timely and completely to the issue(s) below. 15 U.S.C. §1062(b); 37 C.F.R. §§2.62(a), 2.65(a); TMEP §§711, 718.03.

The examining attorney respectfully advises applicant that this Office Action contains the following refusal(s)/requirement(s) summarized immediately below and further explained within the body of this Office Action.

SUMMARY OF ISSUES that applicant must address:

- LIKELIHOOD OF CONFUSION REFUSAL -- *applicant must respond to the examining attorney's refusal to register the proposed mark because of a likelihood of confusion with the cited registered mark(s).*

SUMMARY OF ADVISORIES:

- DISCLAIMER UNNECESSARY

SECTION 2(d) REFUSAL – LIKELIHOOD OF CONFUSION

Registration of the applied-for mark, **GUIDING INDEPENDENCE** in standard characters, is refused because of a likelihood of confusion with the mark, **GUIDED INDEPENDENCE** in U.S. Registration No. **4140492** in standard characters. Trademark Act Section 2(d), 15 U.S.C. §1052(d); *see* TMEP §§1207.01 *et seq.* See the attached registration.

Legal Standard

In any likelihood of confusion determination, two key considerations are similarity of the marks and similarity or relatedness of the goods and/or services. *Syndicat Des Proprietaires Viticulteurs De Chateauneuf-Du-Pape v. Pasquier DesVignes*, 107 USPQ2d 1930, 1938 (TTAB 2013) (citing *Federated Foods, Inc. v. Fort Howard Paper Co*., 544 F.2d 1098, 1103, 192 USPQ 24, 29 (C.C.P.A. 1976)); *In re Iolo Techs., LLC*, 95 USPQ2d 1498, 1499 (TTAB 2010); *see* TMEP §1207.01. That is, the marks are compared in their entireties for similarities in appearance, sound, connotation, and commercial impression. *In re Viterra Inc.*, 671 F.3d 1358, 1362, 101 USPQ2d 1905, 1908 (Fed. Cir. 2012) (quoting *In re E. I. du Pont de Nemours & Co.*, 476 F.2d 1357, 1361, 177 USPQ 563, 567 (C.C.P.A. 1973)); TMEP §1207.01(b)-(b)(v). Additionally, the goods and/or services are compared to determine whether they are similar or commercially related or travel in the same trade channels. *See Coach Servs., Inc. v. Triumph Learning LLC*, 668 F.3d 1356, 1369-71, 101 USPQ2d 1713, 1722-23 (Fed. Cir. 2012); *Herbko Int'l, Inc. v. Kappa Books, Inc.*, 308 F.3d 1156, 1165, 64 USPQ2d 1375, 1381 (Fed. Cir. 2002); TMEP §1207.01, (a)(vi).

Analysis

Comparison Of The Marks

In the present case, applicant's mark consists of the literal element **GUIDING INDEPENDENCE** in standard characters. The cited registration mark, **GUIDED INDEPENDENCE** in U.S. Registration No. **4140492** in standard characters consists of the same and highly similar elements (**GUIDING GUIDED + INDEPENDENCE**) as appears in the applicant's mark.

Marks must be compared in their entireties and should not be dissected; however, a trademark examining attorney may weigh the individual components of a mark to determine its overall commercial impression. *Stone Lion Capital Partners, LP v. Lion Capital LLP*, 746 F.3d 1317, 1322, 110 USPQ2d 1157, 1161 (Fed. Cir. 2014) ("[Regarding the issue of confusion,] there is nothing improper in stating that . . . more or less weight has been given to a particular feature of a mark, provided the ultimate conclusion rests on consideration of the marks in their entireties." (quoting *In re Nat'l Data Corp.* , 753 F.2d 1056, 1058, 224 USPQ 749, 751 (Fed. Cir. 1985))).

The terms "GUIDING" and "GUIDED" are merely different grammatical forms of the same root word "GUIDE".

Both marks also contain the identical term, "INDEPENDENCE."

Marks are compared in their entireties for similarities in appearance, sound, connotation, and commercial impression. *Stone Lion Capital Partners, LP v. Lion Capital LLP*, 746 F.3d 1317, 1321, 110 USPQ2d 1157, 1160 (Fed. Cir. 2014) (quoting *Palm Bay Imps., Inc. v. Veuve Clicquot Ponsardin Maison Fondee En 1772*, 396 F.3d 1369, 1371, 73 USPQ2d 1689, 1691 (Fed. Cir. 2005)); TMEP §1207.01(b)-(b)(v). "Similarity in any one of these elements may be sufficient to find the marks confusingly similar." *In re Davia*, 110 USPQ2d 1810, 1812 (TTAB 2014) (citing *In re 1st USA Realty Prof'ls, Inc.* , 84 USPQ2d 1581, 1586 (TTAB 2007)); *In re White Swan Ltd.*, 8 USPQ2d 1534, 1535 (TTAB 1988)); TMEP §1207.01(b).

Marks may be confusingly similar in appearance where similar terms or phrases or similar parts of terms or phrases appear in the compared marks and create a similar overall commercial impression. *See Crocker Nat'l Bank v. Canadian Imperial Bank of Commerce* , 228 USPQ 689, 690-91 (TTAB 1986), *aff'd sub nom. Canadian Imperial Bank of Commerce v. Wells Fargo Bank, Nat'l Ass'n* , 811 F.2d 1490, 1495, 1 USPQ2d 1813, 1817 (Fed. Cir. 1987) (finding COMMCASH and COMMUNICASH confusingly similar); *In re Corning Glass Works*, 229 USPQ 65, 66 (TTAB 1985) (finding CONFIRM and CONFIRMCELLS confusingly similar); *In re Pellerin Milnor Corp.*, 221 USPQ 558, 560 (TTAB 1983) (finding MILTRON and MILLTRONICS confusingly similar); TMEP §1207.01(b)(ii)-(iii).

Generally, the greater degree of similarity between the applied-for mark and the registered mark, the lesser the degree of similarity between the goods and/or services of the parties is required to support a finding of likelihood of confusion. *In re C.H. Hanson Co.*, 116 USPQ2d 1351, 1353 (TTAB 2015) (citing *In re Opus One Inc.*, 60 USPQ2d 1812, 1815 (TTAB 2001)); *In re Thor Tech, Inc.*, 90 USPQ2d 1634, 1636 (TTAB 2009).

Comparison Of The Goods And Services

The goods and/or services are compared to determine whether they are similar, commercially related, or travel in the same trade channels. *See Coach Servs., Inc. v. Triumph Learning LLC*, 668 F.3d 1356, 1369-71, 101 USPQ2d 1713, 1722-23 (Fed. Cir. 2012); *Herbko Int'l, Inc. v. Kappa Books, Inc.*, 308 F.3d 1156, 1165, 64 USPQ2d 1375, 1381 (Fed. Cir. 2002); TMEP §§1207.01, 1207.01(a)(vi).

The compared goods and/or services need not be identical or even competitive to find a likelihood of confusion. *See On-line Careline Inc. v. Am. Online Inc.*, 229 F.3d 1080, 1086, 56 USPQ2d 1471, 1475 (Fed. Cir. 2000); *Recot, Inc. v. Becton*, 214 F.3d 1322, 1329, 54 USPQ2d 1894, 1898 (Fed. Cir. 2000); TMEP §1207.01(a)(i). They need only be "related in some manner and/or if the circumstances surrounding their marketing are such that they could give rise to the mistaken belief that [the goods and/or services] emanate from the same source." *Coach Servs., Inc. v. Triumph Learning LLC*, 668 F.3d 1356, 1369, 101 USPQ2d 1713, 1722 (Fed. Cir. 2012) (quoting *7-Eleven Inc. v. Wechsler*, 83 USPQ2d 1715, 1724 (TTAB 2007)); TMEP §1207.01(a)(i).

In the present case, applicant's mark **GUIDING INDEPENDENCE** is for use on or in connection with "*Healthcare*" in Class 43.

The cited registration mark, **GUIDED INDEPENDENCE** in U.S. Registration No. **4140492**, is for use on or in connection with "*Providing independent living residences and living facilities, assisted living facilities; and living facilities for persons with advancing memory decline*" in Class 43.

Applicant's and registrant's services are both for use in or in connection with the healthcare and assisted living facilities industry. Consequently, applicant's and registrant's services would typically be available and marketed to consumers via the same trade channels.

Where the goods and/or services of an applicant and registrant are "similar in kind and/or closely related," the degree of similarity between the marks required to support a finding of likelihood of confusion is not as great as in the case of diverse goods and/or services. *In re J.M. Originals Inc.*, 6 USPQ2d 1393, 1394 (TTAB 1987); *see Shen Mfg. Co. v. Ritz Hotel Ltd.*, 393 F.3d 1238, 1242, 73 USPQ2d 1350, 1354 (Fed. Cir. 2004); TMEP §1207.01(b).

The trademark examining attorney refers to the excerpted materials from the Google search engine in which "healthcare" appeared in reference to "assisted living facilities" in numerous stories. See attachments.

For example, see:

Facility-based long-term care services include: board and care homes, assisted living facilities, nursing homes, and continuing care retirement communities.

Some facilities have only housing and housekeeping, but many also provide personal care and medical services. Many facilities offer special programs for people with Alzheimer's disease and other types of dementia.

https://www.nia.nih.gov/health/residential-facilities-assisted-living-and-nursing-homes

Nursing Homes, Assisted Living, and Home Care: What's the Difference?

https://www.homehero.org/blog/lifestyle/nursing-homes-assisted-living-and-home-care-what-s-the-difference

Aging & Health A to Z

Assisted Living

Basic Facts & Information

There are times when an older adult needs more assistance with personal care than can be provided in the home, but doesn't need the round-the-clock skilled nursing and medical care that a nursing home provides. In that case, an assisted living arrangement might be an option to consider in order to protect the older person's independence and privacy for as long as possible.

http://www.healthinaging.org/aging-and-health-a-to-z/topic:assisted-living/

Improving Health Care for Assisted Living Residents

Robert L. Kane, MD

John R. Mach, Jr., MD

The Gerontologist, Volume 47, Issue suppl_1, 1 December 2007, Pages 100–109, https://doi.org/10.1093/geront/47.Supplement_1.100

Published: 01 December 2007

Article history

Abstract

Purpose: The purpose of this article is to explore how medical care is delivered to older people in assisted living (AL) settings and to suggest ways for improving it. Design and Methods: We present a review of the limited research available on health care for older AL residents and on building testable models of better ways to organize primary health care and other health services for AL residents. Results: AL residents are frequently frail older persons who need good chronic care. The predominant care models today do not respond adequately to this challenge. Medical care for AL residents is currently practiced very much like that for persons living in the community. The potential for using the aggregation of patients has not been effectively tapped. We review some managed care models from other elements of long-term care to look for ways that might be adapted. However, the current funding approach emphasizes living settings rather than inherent client characteristics. Implications: A research agenda might include ways to improve communication between AL and medical providers and to get AL staff more actively involved in daily care. Research support might produce the data necessary to entice the Centers for Medicare & Medicaid Services into changing its current reimbursement policies to create a climate better suited to delivering good chronic disease care in AL facilities.

https://academic.oup.com/gerontologist/article/47/suppl_1/100/614157

Material obtained from the Internet is generally accepted as competent evidence in trademark examination. *See In re Jonathan Drew Inc.*, 97 USPQ2d 1640, 1641-42 (TTAB 2011); *In re Davey Prods. Pty Ltd.*, 92 USPQ2d 1198, 1202-03 (TTAB 2009); *In re Leonhardt*, 109 USPQ2d 2091, 2098 (TTAB 2008); TBMP §1208.03; TMEP §710.01(b).

Any goods or services in the registrant's normal fields of expansion should be considered when determining whether the registrant's goods and/or services are related to the applicant's goods and/or services. TMEP §1207.01(a)(v); see In re 1st USA Realty Prof'ls, Inc., 84 USPQ2d 1581 1584 (TTAB 2007). Evidence that third parties offer the goods and/or services of both the registrant and applicant suggest that it is likely that the registrant would expand their business to include applicant's goods and/or services. In that event, customers are likely to believe the goods and/or services at issue come from or, are in some way connected with, the same source. In re 1st USA Realty Prof'ls, 84 USPQ2d at 1584 n.4; see TMEP §1207.01(a)(v).

A determination of whether there is a likelihood of confusion is made solely on the basis of the goods and/or services identified in the application and registration, without limitations or restrictions that are not reflected therein. In re Dakin's Miniatures, Inc., 59 USPQ2d 1593, 1595 (TTAB 1999); TMEP §1207.01(a)(iii). If the cited registration describes the goods and/or services broadly and there are no limitations as to their nature, type, channels of trade or classes of purchasers, then it is presumed that the registration encompasses all goods and/or services of the type described, that they move in all normal channels of trade, and that they are available to all potential customers. In re Linkvest S.A., 24 USPQ2d 1716, 1716 (TTAB 1992); In re Elbaum, 211 USPQ 639, 640 (TTAB 1981); TMEP §1207.01(a)(iii).

The overriding concern is not only to prevent buyer confusion as to the source of the goods and/or services, but to protect the registrant from adverse commercial impact due to use of a similar mark by a newcomer. *See In re Shell Oil Co.*, 992 F.2d 1204, 1208, 26 USPQ2d 1687, 1690 (Fed. Cir. 1993). Therefore, any doubt regarding a likelihood of confusion determination is resolved in favor of the registrant. TMEP §1207.01(d)(i); *see Hewlett-Packard Co. v. Packard Press, Inc.*, 281 F.3d 1261, 1265, 62 USPQ2d 1001, 1003 (Fed. Cir. 2002); *In re Hyper Shoppes (Ohio), Inc.*, 837 F.2d 463, 464-65, 6 USPQ2d 1025, 1026 (Fed. Cir. 1988).

Conclusion

Accordingly, the applicant's proposed mark, **GUIDING INDEPENDENCE**, is refused for likelihood of confusion under Trademark Act Section 2(d).

Although applicant's mark has been refused registration, applicant may respond to the refusal by submitting evidence and arguments in support of registration.

If applicant responds to the refusal(s), applicant must also respond to the requirement(s) set forth below.

DISCLAIMER IS NOT REQUIRED (ADVISORY)

The application includes a disclaimer of the following matter in the applied-for mark: "GUIDING" or "INDEPENDENCE". An applicant may voluntarily disclaim matter in a mark regardless of whether the matter is registrable. TMEP §1213.01(c); *see* 15 U.S.C. §1056(a). However, a disclaimer of this matter is not required.

Therefore, applicant may request to withdraw this disclaimer from the application. If applicant does not expressly request its withdrawal, the disclaimer will remain in the application and will be printed on the registration certificate.

RESPONSE GUIDELINES

If applicant has questions regarding this Office action, please telephone or e-mail the assigned trademark examining attorney. All relevant e-mail communications will be placed in the official application record; however, an e-mail communication will not be accepted as a response to this Office action and will not extend the deadline for filing a proper response. *See* 37 C.F.R. §§2.62(c), 2.191; TMEP §§304.01-.02, 709.04-.05. Further, although the trademark examining attorney may provide additional explanation pertaining to the refusal(s) and/or requirement(s) in this Office action, the trademark examining attorney may not provide legal advice or statements about applicant's rights. *See* TMEP §§705.02, 709.06.

To expedite prosecution of the application, applicant is encouraged to file its response to this Office action online via the Trademark Electronic Application System (TEAS), which is available at http://www.uspto.gov/trademarks/teas/index.jsp. If applicant has technical questions about the TEAS response to Office action form, applicant can review the electronic filing tips available online at http://www.uspto.gov/trademarks/teas/e_filing_tips.jsp and email technical questions to TEAS@uspto.gov.

TEAS PLUS OR TEAS REDUCED FEE (TEAS RF) APPLICANTS – TO MAINTAIN LOWER FEE, ADDITIONAL REQUIREMENTS MUST BE MET, INCLUDING SUBMITTING DOCUMENTS ONLINE: Applicants who filed their application online using the lower-fee TEAS Plus or TEAS RF application form must (1) file certain documents online using TEAS, including responses to Office actions (see TMEP §§819.02(b), 820.02(b) for a complete list of these documents); (2) maintain a valid e-mail correspondence address; and (3) agree to receive correspondence from the USPTO by e-mail throughout the prosecution of the application. *See* 37 C.F.R. §§2.22(b), 2.23(b); TMEP §§819, 820. TEAS Plus or TEAS RF applicants who do not meet these requirements must submit an additional processing fee of $125 per class of goods and/or services. 37 C.F.R. §§2.6(a)(1)(v), 2.22(c), 2.23(c); TMEP §§819.04, 820.04. However, in certain situations, TEAS Plus or TEAS RF applicants may respond to an Office action by authorizing an examiner's amendment by telephone or e-mail without incurring this additional fee.

/Ronald E. DelGizzi/
Trademark Examining Attorney
Law Office 107
Phone - (571) 272-2754
ronald.delgizzi@uspto.gov

TO RESPOND TO THIS LETTER: Go to http://www.uspto.gov/trademarks/teas/response_forms.jsp. Please wait 48-72 hours from the issue/mailing date before using the Trademark Electronic Application System (TEAS), to allow for necessary system updates of the application. For *technical* assistance with online forms, e-mail TEAS@uspto.gov. For questions about the Office action itself, please contact the assigned trademark examining attorney. **E-mail communications will not be accepted as responses to Office actions; therefore, do not respond to this Office action by e-mail.**

All informal e-mail communications relevant to this application will be placed in the official application record.

WHO MUST SIGN THE RESPONSE: It must be personally signed by an individual applicant or someone with legal authority to bind an applicant (i.e., a corporate officer, a general partner, all joint applicants). If an applicant is represented by an attorney, the attorney must sign the response.

PERIODICALLY CHECK THE STATUS OF THE APPLICATION: To ensure that applicant does not miss crucial deadlines or official notices, check the status of the application every three to four months using the Trademark Status and Document Retrieval (TSDR) system at http://tsdr.uspto.gov/. Please keep a copy of the TSDR status screen. If the status shows no change for more than six months, contact the Trademark Assistance Center by e-mail at TrademarkAssistanceCenter@uspto.gov or call 1-800-786-9199. For more information on checking status, see http://www.uspto.gov/trademarks/process/status/.

TO UPDATE CORRESPONDENCE/E-MAIL ADDRESS: Use the TEAS form at http://www.uspto.gov/trademarks/teas/correspondence.jsp.

DESIGN MARK

Serial Number
85383745

Status
SECTION 8-ACCEPTED

Word Mark
GUIDED INDEPENDENCE

Standard Character Mark
Yes

Registration Number
4140492

Date Registered
2012/05/08

Type of Mark
SERVICE MARK

Register
SUPPLEMENTAL

Mark Drawing Code
(4) STANDARD CHARACTER MARK

Owner
Buron, Inc. CORPORATION WASHINGTON 1201 Third Avenue, Suite 3400 SEATTLE WASHINGTON 98101

Goods/Services
Class Status -- ACTIVE. IC 043. US 100 101. G & S: Providing independent living residences and living facilities, assisted living facilities; and living facilities for persons with advancing memory decline. First Use: 2011/07/11. First Use In Commerce: 2011/07/11.

Filing Date
2011/07/28

Amended Register Date
2012/03/12

Examining Attorney
VANSTON, KATHLEEN M.

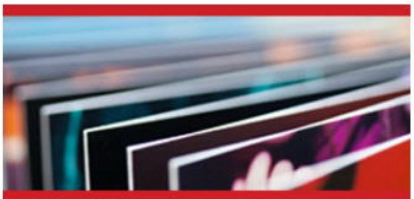
GUIDED INDEPENDENCE

LONG-TERM CARE

Residential Facilities, Assisted Living, and Nursing Homes

At some point, support from family, friends, and local programs may not be enough. People who require help full-time might move to a residential facility that provides many or all of the long-term care services they need.

Facility-based long-term care services include: board and care homes, assisted living facilities, nursing homes, and continuing care retirement communities.



retirement communities.

Some facilities have only housing and housekeeping, but many also provide personal care and medical services. Many facilities offer special programs for people with Alzheimer's disease and other types of dementia.

Board and Care Homes

Board and care homes, also called residential care facilities or group homes, are small private facilities, usually with 20 or fewer residents. Rooms may be private or shared. Residents receive personal care

Stay connected! Join NIA email lists and find us on social media.

ARTICLES

Participating in Activities You Enjoy

Quitting Smoking for Older Adults

ADVANCE CARE PLANNING
Getting Your Affairs in Order

Rooms may be private or shared. Residents receive personal care and meals and have staff available around the clock. Nursing and medical care usually are not provided on site.

Assisted Living

Assisted living is for people who need help with daily care, but not as much help as a nursing home provides. Assisted living facilities range in size from as few as 25 residents to 120 or more. Typically, a few "levels of care" are offered, with residents paying more for higher levels of care.

Assisted living residents usually live in their own apartments or rooms and share common areas. They have access to many services, including up to three meals a day; assistance with personal care; help with medications, housekeeping, and laundry; 24-hour supervision, security, and on-site staff; and social and recreational activities. Exact arrangements vary from state to state.

Nursing Homes

Nursing homes, also called skilled nursing facilities, provide a wide range of health and personal care services. Their services focus on medical care more than most assisted living facilities. These services typically include nursing care, 24-hour supervision, three meals a day, and assistance with everyday activities. Rehabilitation services, such as physical, occupational, and speech therapy, are also available.

Daytime sleepiness linked to elevated brain amyloid

10/11/2018

Some people stay at a nursing home for a short time after being in the hospital. After they recover, they go home. However, most nursing home residents live there permanently because they have ongoing physical or mental conditions that require constant care and supervision.

To look for and compare nursing homes in your area, see Medicare's Nursing Home Compare. Also get tips for choosing a nursing home.

Continuing Care Retirement Communities

Continuing care retirement communities (CCRCs), also called life care communities, offer different levels of service in one location. Many of them offer independent housing (houses or apartments), assisted living, and skilled nursing care all on one campus. Healthcare services and recreation programs are also provided.

In a CCRC, where you live depends on the level of service you need. People who can no longer live independently move to the assisted living facility or sometimes receive home care in their independent living unit. If necessary, they can enter the CCRC's nursing home.

There are many sources of information about facility-based long-term care. A good place to start is the Eldercare Locator at **1-800-677-1116** or https://eldercare.acl.gov. You can also call your local Area Agency on Aging or Aging and Disability Resource Center.

Area Agency on Aging, Aging and Disability Resource Center, department of human services or aging, or a social service agency.

For More Information About Facility-Based Long-Term Care

Centers for Medicare & Medicaid Services
1-800-633-4227 (toll-free)
1-877-486-2048 (TTY/toll-free)
www.medicare.gov

Centers for Medicare & Medicaid Services
1-800-633-4227 (toll-free)
1-877-486-2048 (TTY/toll-free)
www.medicare.gov

Eldercare Locator
1-800-677-1116 (toll-free)
https://eldercare.acl.gov

National Association of Area Agencies on Aging
1-202-872-0888
info@n4a.org
www.n4a.org

Content reviewed: May 01, 2017

RELATED ARTICLES

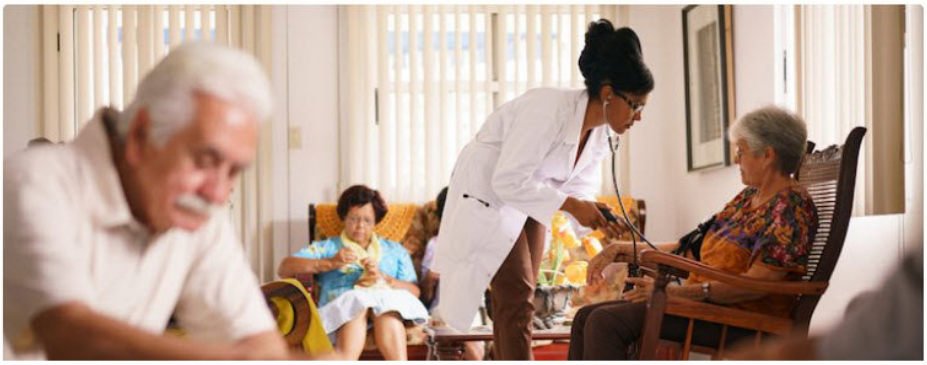
Choosing a Nursing Home

Paying for Care

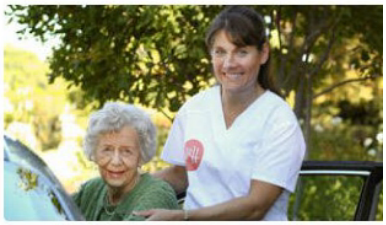
Planning for Long-Term Care

Nursing Homes, Assisted Living, and Home Care: What's the Difference?

By Steven Richmond • Nov 15th, 2016 Blog / Lifestyle



About Us



HomeHero is the fastest and most affordable way for families to find quality in-home senior care. We are the #1 rated health care startup in the country.

FIND A HERO

Categories

Today's guest post comes from Sue Logan, R.N.

If you are looking at care options for yourself or a loved one, it can seem like the more you look, the more confused you get. It used to be that the nursing home was the only choice. But now, the number of options available for senior care services is overwhelming. What's the difference between a skilled nursing facility, assisted living, and home care? How do you make a decision? What do services cost?

Before you look any further, let's stop for a minute and get some direction. Below, you will find basic information about the top three kinds of care available for the elderly: Nursing homes, assisted living facilities, and home care. This information will help you make sense of services for seniors.

Nursing Homes: Skilled Nursing and Intermediate Care Facilities

Entertainment
Health
Lifestyle
News
Opinions
Technology
Updates

Follow Us

Physicians often recommend skilled nursing facilities (SNFs) or rehab care following surgery or a stay in the hospital for a medical condition. The various therapies, such as occupational, speech, or physical therapy help patients regain the strength or skills they need to be able to return home.

Other reasons for admission to an SNF include:

- Intravenous medication administration
- Wound care
- Nutritional management
- Respiratory therapy or treatments

If a person does not require “skilled” care, but is frail and has complex needs, an intermediate care facility (ICF) may be necessary. The care provided in an ICF includes assistance with getting into and out of bed, bathing, grooming, dressing, and eating. Laundry service is also provided.

Unlike assisted living facilities, nursing homes provide a high level of medical services and care. Licensed doctors supervise the care of every patient in a nursing home, whether a skilled or intermediate care facility. Medications are carefully administered by professional staff and are reviewed by physicians and pharmacists.

Nursing Home Costs

While the goal of nursing home care is to meet all of the patient’s physical and emotional needs, the financial burden can be tremendous, ranging from $5000 to $9000 or more per month. This cost includes meals but often does not include the cost of medications.

Medicare or private health insurance may pay for skilled nursing facility care, but only for 100 days of care per year — patients must cover the costs out-of-pocket for anything beyond that during the same year.

Likewise, Medicare does not pay for help with bathing, eating, or dressing, if that is the only assistance needed. You may qualify for Medicaid if your assets and income are limited, but many nursing facilities do not accept this form of payment.

Some people are fortunate enough to have long-term care insurance that sometimes helps cover the cost of a nursing home stay. Veteran's benefits are another possible source of funding to help defray the expense. Unfortunately, out-of-pocket (private pay) is how many families are forced to pay for their loved one's nursing home care.

Assisted Living Facilities

An assisted living facility (ALF) consists of seniors who no longer wish to stay at home, or

An assisted living facility (ALF) consists of seniors who no longer wish to stay at home, or are no longer able to safely live independently, but do not require the extensive level of assistance provided in a skilled or intermediate care facility.

For seniors and their families, an assisted living facility can provide companionship and structure and may ease the transition out of the no-longer safe or practical family home. Most residents enjoy a high level of autonomy combined with privacy — something not possible in a nursing home — with the benefit of supervision or assistance as needed.

Assisted Living Services

Services routinely provided in an ALF include three meals daily in a central dining location, assistance with medications, housekeeping, laundry, and personal care such as dressing, bathing, and grooming. Transportation services and social activities are also offered in most assisted living facilities.

Residents of assisted living facilities most often reside in private, small apartments, sometimes equipped with a limited kitchenette. Staff members are available throughout the day and night for safety. Most ALFs provide nursing services, but this may not include 24-hour per day professional nursing coverage.

Assisted Living: Cost

The vast majority of residents in assisted living facilities pay privately, or out of their own personal resources for their care. Most ALFs do not accept Medicaid and, since the care provided is not skilled, Medicare does not cover the cost. The cost of staying in an assisted living facility ranges from $3000 to $4500 per month.

Assisted Living: Levels of Care

If you are looking for assisted living for yourself or a family member, one important concept to become familiar with is “levels of care.” This is essential because, in many ALFs, the monthly cost is based on how much care the resident requires.

Levels of care are a way for facilities to stratify costs — as levels of care increase, so do monthly costs. Most ALFs that use levels of care in this way assign three to four levels.

This not only simplifies their billing, but it makes the process easier for the consumer too: You know what you will pay up front, and the monthly charge is fairly consistent.

A resident who is independent with all activities of daily living (ADLs) would be assessed no cost-of-care fee in addition to the monthly fee. From there, most facilities calculate points, based on whether simple verbal reminders, stand-by assistance, or complete physical assistance is needed with tasks like taking medications, dressing, toileting, grooming, mobility and bathing.

Extra points are also sometimes assigned if a resident is incontinent, confused, or requires a wheelchair or other assistive devices. Facilities also take into account how many staff members would be needed to assist the resident. For example, if a resident requires help from more than one caregiver to transfer in and out of bed safely, additional points are assigned.

The level of care is then determined, based on the total number of these points. The more points, the higher the level of care, the steeper the monthly cost.

A representative from an assisted living facility will typically visit with you or your family before admission if you are considering a move to their community. An assessment will be completed, and you will be given the opportunity to ask questions about the costs and the care they can provide.

Home Care

Home care covers a wide range of personalized services that are provided in your home. It is just as effective, but more convenient and much less expensive than the care you receive in an assisted living facility.

Home Care: Medical vs. Non-Medical

Many seniors don't require specialized medical attention, but could use additional help to maintain their independence. In these situations, non-medical home care is the perfect answer. Unlike assisted living, care is provided in the client's home, according to their needs and schedule.

Non-medical home care is tailored for seniors who need help with:

- Dressing, bathing, daily hygiene, and toileting needs
- Moving into and out of bed and around the home
- Meal preparation and shopping
- Routine housekeeping
- Transportation and appointments
- Bill paying and correspondence
- Medication reminders

Caregivers also provide one-on-one loving companionship and emotional support to their clients. This can sometimes be hard to find in large group facilities.

Should the senior require the kind of medical attention you'd normally find in a nursing home or assisted living facility, then you may consider *home healthcare*, sometimes

shortened to just "home health". As you might expect, this level of care will require the experience of (or equivalent to) a registered nurse, and will likely cost much, much more than non-medical home care.

Home Care: Cost

The cost of home care is determined by how frequently the services are needed, but policies vary depending on which agency you choose: some may require an upfront deposit equal to so many hours or days worth of care, while others impose shift minimums (i.e., you can't schedule less than X hours at a time).

Non-medical home care costs are generally not covered by Medicare because the services are non-medical in nature. However, there are tax breaks available to individuals who help coordinate home care services for themselves and loved ones. Likewise, eligible veterans and their spouses can take advantage of the VA's Aid & Attendance program, which provides an increased monthly pension to help cover the costs of home care.

Families eligible for Medi-Cal are typically eligible for In-Home Supportive Services (IHSS), a program that helps offset the cost of non-medical home care.

Home Care: Where to Find Caregivers

Unless a family member or friend provides care directly, you generally have two options for hiring in-home caregivers:

Hire a caregiver directly — Many families place ads on local community message boards (like Craigslist or NextDoor) or visit referral sites looking for caregivers. While this may be the cheapest option, hiring a caregiver directly means you may be liable for certain legal obligations as that caregiver's employer, such as employment taxes, health insurance, workman's comp, background checks, and more (depending on your relationship with the caregiver). Also, you will have no support in the event the caregiver cancels or performs their job poorly.

Hire a caregiver through an agency — If the idea of taking on employer responsibilities sounds like too much work, you may want to consider hiring a caregiver through a

licensed home care agency. The costs will likely be higher than hiring a caregiver directly, but you will have peace of mind knowing the caregiver has been thoroughly screened and is backed by a support team that can help coordinate additional care and services.

Interested in scheduling non-medical home care for a loved one? HomeHero is a fully-licensed home care agency that combines human compassion and smart technology to help people live independently at home.

Click here to learn more and receive a free consultation from one of our Care Advisors today!

Share On

Basic Facts & Information

Other Resources

- Caregiving How To's
- Tools & Tips
- Latest Research
- Getting More Help

Related Topics

- Community-Based Care
- Home Care
- Nursing Homes

Aging & Health A to Z

Assisted Living

Basic Facts & Information

There are times when an older adult needs more assistance with personal care than can be provided in the home, but doesn't need the round-the-clock skilled nursing and medical care that a nursing home provides. In that case, an assisted living arrangement might be an option to consider in order to protect the older person's independence and privacy for as long as possible.

Is Assisted Living Right for You?

Assisted living facilities (ALFs) have many names and may also be called adult care or residential care facilities. ALFs are licensed by state governments through the Centers for Medicare and Medicaid Services. (Since ALFs are not licensed by the federal government, the services provided and quality controls vary by state.) More than 500,000 people live in ALFs, and this number is expected to grow as our population ages. Even though ALFs offer a social model of care, not a medical one, they provide residents with a support staff and meals, as well as assistance with activities of daily living such as dressing and bathing.

Older adults have a variety of choices in ALFs, ranging from smaller, simple home-like environments, to larger, fancier accommodations. This wide range in types of ALFs allows people to choose a home that best suits their needs, tastes, and financial situation. Most ALFs offer private rooms or apartments. Special care units that focus on Alzheimer's disease and other forms of dementia are also becoming more common.

ALFs are required to provide a variety of services, including the following:

- 24-Hour staffing to provide oversight to meet the scheduled and unscheduled needs of

- 24-Hour staffing to provide oversight to meet the scheduled and unscheduled needs of residents (*Note*: This does not mean that skilled nursing must be available 24 hours a day.)
- Social services
- Housekeeping and laundry
- Recreation and meals
- Help with activities of daily living (ADLs)
- Health-related services (e.g., help with medication management)
- Transportation

Other services vary considerably from state to state. For example, depending on licensing requirements, giving and managing medications may be handled by unskilled, skilled, or fully licensed nursing staff.

Most older adults must pay for assisted living themselves, although some states now may pay costs through Medicaid. Generally, care in an ALF is less expensive than in a nursing home. Part of this difference in cost is because ALFs provide less service and have less overhead. In addition, ALFs generally have fewer regulations to observe (at least for now) and are therefore able to operate with fewer expenses.

Types of Assisted Living

Group Homes

Group homes are houses or apartments where two or more unrelated people live together. These include domiciliary care, single-room occupancy residences, board-and-care homes, and some group living situations. Group homes vary in the types of residents that live there. For example, many can accommodate people with chronic mental illness or dementia. Most group homes are run as for-profit businesses, and some states require licensing.

Residents share a living room, dining room, and kitchen but usually have their own bedrooms. Advantages of this arrangement include a lower cost of living and ability to socialize with peers. Independence and ability to function are supported through the interdependence and relationships of the residents. Opportunities for socialization are increased, reducing social isolation. Resident-to-staff ratios may also be higher than in other supported-living environments.

Adult Foster Care

Foster care homes generally provide room, board, and some help with activities of daily living. This is provided by the sponsoring family or other paid caregivers, who usually live on the premises. Adult foster care has the advantage of maintaining frail older adults in a more home-like environment. Regulations for foster care vary by state, and some states require licensing. Some states will cover costs of adult foster care through their Medicaid programs. Perhaps the longest experience with adult foster care is in the state

of Oregon, where it is used as an alternative to long-term care and institutional living.

Sheltered Housing
Sheltered housing is often in a home that offers personal-care support, housekeeping services, and meals. Social work services and coordination for activities can be added to these programs. Charges to clients are based on a sliding scale, which may cost up to 30% of income.

Continuing-Care Retirement Communities
Some older adults may choose to live in a continuing-care retirement community (CCRC). These communities usually have a variety of living options, ranging from apartments or condominiums, to assisted living and then to skilled nursing home care. Often, older adults enter the CCRC in the more independent living areas. If they become more disabled, they may progress to the assisted living and skilled care areas.

Health care in CCRCs is generally provided using three financial models:

1. The all-inclusive model. This provides total health care coverage, including long-term care.
2. The fee-for-service model, in which payments match the level of care
3. The modified coverage model, which covers long-term care to a predetermined maximum amount.

Most CCRCs require an entry fee, which may or may not be refundable, plus a variable monthly fee to pay for rent and supportive services. Monthly fees vary, depending on the level of care being provided. Older adults generally pay to live in these communities, though some facilities have beds for skilled care that are funded by Medicare or Medicaid.

Updated: July 2017
Posted: March 2012

Volume 47, Issue suppl_1
December 2007

Article Contents

Improving Health Care for Assisted Living Residents

Robert L. Kane, MD , John R. Mach, Jr.,, MD

The Gerontologist, Volume 47, Issue suppl_1, 1 December 2007, Pages 100–109,
https://doi.org/10.1093/geront/47.Supplement_1.100
Published: 01 December 2007 **Article history**

Abstract

Purpose: The purpose of this article is to explore how medical care is delivered to older people in assisted living (AL) settings and to suggest ways for improving it. ***Design and Methods:*** We present a review of the limited research available on health care for older AL residents and on building testable models of better ways to organize primary health care and other health services for AL residents. ***Results:*** AL residents are frequently frail older persons who need good chronic care. The predominant care models today do not respond adequately to this challenge. Medical care for AL residents is currently practiced very much like that for persons living in the community. The potential for using the aggregation of patients has not been effectively tapped. We review some managed care models from other elements of long-term care to look for ways that might be adapted. However, the current funding approach emphasizes living settings rather than inherent client characteristics

adapted. However, the current funding approach emphasizes living settings rather than inherent client characteristics.

Implications: A research agenda might include ways to improve communication between AL and medical providers and to get AL staff more actively involved in daily care. Research support might produce the data necessary to entice the Centers for Medicare & Medicaid Services into changing its current reimbursement policies to create a climate better suited to delivering good chronic disease care in AL facilities.

Keywords: Chronic care, Managed care, Nurse practitioners, Proactive primary care, *Special needs populations*

Issue Section: SPECIAL TOPICS IN ASSISTED LIVING RESEARCH

Assisted living (AL) lies somewhere between community care and the nursing home. Not surprisingly, medical care for AL residents has some elements of both. In essence, AL offers some potential advantages in congregating residents to make them more geographically accessible, but it leaves the choice of physicians and the responsibility for care largely in the hands of each resident. The medical structures found in nursing homes are not typically available in AL. As described elsewhere in this issue, all AL facilities (ALFs) are not the same; they cover a broad spectrum in terms of their structures and clientele. The role of medical care and the potential for creative new partnerships will depend on where along the spectrum of service a given ALF is located and the nature of the clientele it serves.

Methods

This article examines the patterns of care appropriate for AL residents. We have written it in the form of an essay, drawing on the literature from a variety of sources, especially a systematic literature review done on chronic care (Kane, Priester, & Totten, 2005). The article begins with the premise that most AL residents suffer from multiple chronic diseases and hence would be ideal candidates for more organized and effective chronic disease care. It examines models of successful medical care in nursing homes to see what can be extrapolated and offers a research agenda of possible next steps. In effect, this analysis addresses the art of the possible. If ALFs prefer to serve less ill residents and transfer them elsewhere when their conditions deteriorate, the case for a closer linkage with medical services evaporates. However, for those ALFs that seek to be a part of the care system for persons with substantial disability, there are opportunities for new partnerships and new approaches to care.

The Chronic Disease Model

Although researchers have focused little attention on medical and health outcomes for elderly AL residents, the correlates examined have

tended to be descriptors of the facilities and their staff rather than of the medical and health care provision itself (Zimmerman et al., in press). Some sense of basic functional levels of AL residents is available. Zimmerman and her colleagues identified three classes of residential care/AL: those with fewer than 16 beds, traditional board-and-care facilities with 16 or more beds, and a new model that reflects the purpose-built ALFs. Table 1 shows the characteristics of residents in each of these AL types based on the Zimmerman survey in four states (Florida, Maryland, New Jersey, North Carolina) compared to a national sample of nursing home residents (Zimmerman et al., 2003). The nursing home residents show more functional and cognitive deficiencies but fewer behavioral problems; however, the small board-and-care institutions seem to have the most severe caseloads among the ALFs. Table 2, derived from a large national study of AL, also suggests that ALF residents are less disabled than those in nursing homes (Hawes, Philips, & Rose, 2000). More than three fourths receive help with medications.

People enter AL for many reasons, but a substantial number of residents are frail older persons facing difficulties associated with multiple chronic illnesses (Carpenter, Bernabei, Hirdes, Mor, & Steel, 2000; Sligh & Vicioso, 2001). Thus, organizing medical care for AL residents requires the same diligence that must be directed toward chronic care management in general (Kane et al., 2005). AL residents need the full range of medical services required by any group of frail older persons. These include both primary and specialty care.

Various authors have enunciated the principles of good chronic disease care (Institute of Medicine, 2001; Kane, 2006; Wagner, Austin, & Von Korff, 1996). The main features include the following:

- a recognition that care is best measured in episodes rather than events;
- a commitment to proactive primary care, designed to avoid clinical catastrophes by managing early manifestations of disease exacerbations aggressively;
- a willingness to invest in up-front efforts to prevent subsequent high-cost events;
- a definition of success based on comparing actual expected change;
- a need to involve patients (and their caregivers) actively and meaningfully in their care;
- the centrality of effective information systems that alert clinicians to changes in patients' status and focus the clinicians' attention on salient clinical information; and
- creative use of clinical personnel.

The evidence to demonstrate the benefits of this chronic care model is still sparse. Studies have demonstrated that investing in intensive care at critical junctures can avert hospitalizations (Naylor et al., 1999). Proactive primary care has shown results (Beck et al., 1997). Activating patients has proven effective (Lorig et al., 1999). However, efforts to organize systematic approaches to address chronic disease in the United Kingdom did not show advantages over regular care, although the exposure time for many clients was short (Gravelle et al., 2006).

Challenges to Implementing the Chronic Disease Model in AL

Ideally, health care for AL residents would follow the principles of sound chronic disease management, which involves proactive investing in close observations and early interventions that prevent complications and exacerbations, which in turn can lead to costly hospital care (Kane et al., 2005). It would actively involve the patients in meaningful roles as observers and self-carers. These roles would be supported by AL staff, who could provide additional assistance to those residents who could perform the functions on their own. For some AL residents, staff might need to play a more active role, making the observations and reporting the findings. AL staff would collaborate with primary caregivers to plan treatments and establish expected clinical trajectories, deviation from which would alert the caregivers to act. Information would readily flow in both directions: instructions from caregivers would be used as the basis for AL staff care planning, and observations from AL staff would alert primary caregivers to the need for more intensive evaluations. AL staff could be recruited to provide extra care when a minor illness or exacerbation occurs, allowing the resident to remain in the ALF.

The current situation fails these criteria in many ways. Most of the medical care for AL residents is intermittent, with intervening observations and treatments left to either the resident or the AL staff. Relationships between AL staff and medical providers can thus become very crucial. The lack of concentration of medical oversight in the hands of a small group makes such interactions problematic. One might suppose that having access to many people in the same congregate setting could generate some economies of scale, which would facilitate better care. However, residence in AL does not necessarily involve using the services of a given physician. Most AL residents are free to see whomever they wish. More often than not, care for AL residents resembles that of any other older person living the community. However, the AL resident's underlying frailty may mean many more trips to the emergency room and hospital admissions.

In some ways, AL could be a good site for delivering the new version of chronic care, but so far, AL has not lived up to its promise (Kane & West, 2005). Several factors stand in the way of providing better care to AL residents. Perhaps the greatest impediment has been the reluctance of AL to see itself as a medical venue. AL staff have hesitated to take on responsibility for monitoring residents' medical status (Kane & West, 2005). Many ALFs are not prepared to mount a proactive effort to monitor the health status of their residents. Because they see themselves primarily as in the housing business, few ALFs have pursued developing any form of moderately sophisticated medical record keeping. Nor do most have any arrangements with physicians to develop strong working partnerships. Most physicians have small caseloads in any given ALF and hence are not motivated to establish the sorts of proactive observational systems needed. Moreover, no payer covers the costs of such an approach to care. Perhaps fearing coming under the severe regulatory scrutiny applied to nursing homes, some ALFs have instead distanced themselves as much as possible from medical care responsibilities; but played a more proactive role. Wanting to avoid the consequences of having their residents traumatized by a hospital stay, some ALFs are seeking ways to manage their residents in their facilities, thereby avoiding a trip to the emergency room.

Given the heterogeneity of AL and the availability of staff, the extent of overall coordination required to establish such an operation will vary greatly. Those ALFs that view themselves as largely residential will be much less likely to accept a proactive role in monitoring residents' clinical status

residents' clinical status.

The opportunity for more consolidated care requires that patients agree to change physicians. Many AL residents may be reluctant to give up their doctors when they enter the ALF. Experience from Program of All-inclusive Care for the Elderly (PACE) suggests that the requirement to change doctors is a major impediment to recruiting clients (Kane & Huck, 2000). However, some clinicians may not want to continue to serve AL residents, even if these patients are transported to their offices. The greater their chronic disease burden, the more likely the resident may be viewed as too frail and demanding.

Medical directors in nursing homes are quick to point out that many critical tasks are either poorly reimbursed or not covered at all (Stone & Reublinger, 1995). Physicians are not paid for the time they spend working with staff or talking to families. Although managed care offers more flexibility, it will not be workable unless experts can create some method to create an appropriately risk-adjusted capitation payment. An intermediate solution might be to pay for specific services under a fee-for-service (FFS) arrangement. These could include physician time for working with staff and family members. The FFS could cover specific case management arrangements, which could be tied to savings in hospital and emergency room care.

ALFs worry about increasing their role in care. If they become more active partners in monitoring residents' health status, how will this affect their liability? Are they adequately staffed to assume such responsibilities? Such quandaries reflect the indeterminate role of AL in the long-term-care spectrum.

It is even possible that some AL residents might be worse off if their physicians incorrectly expect that AL staff (a) will attend to changes in the residents' status and notify them of such changes or (b) are committed to carrying out therapeutic regimens. Physicians placing undue confidence in AL staff may actually put their patients at risk by being too complacent, under the assumption that their patients are receiving more oversight than they are.

Current State of AL Care

Medication Management

One symptom of inadequate primary care is poor use of drugs. A study of 193 ALFs found that most residents were taking five or more medications, of whom 16% were receiving inappropriately prescribed medications (Sloane, Zimmerman, Brown, Ives, & Walsh, 2002). At the same time, there was also considerable evidence of undertreatment. Residents were not receiving the most effective drugs for their conditions, and more than half were not receiving any medication treatment for conditions that warranted medical attention (Sloane et al., 2004). Medications are likewise a major concern among nursing home patients, among whom the case mix may be more severe and the numbers and potency of medications even greater. Several studies have uncovered prescribing errors (Briesacher, Limcangco, Simoni-Wastila, Dioshi, & Girwitz, 2005; Lau, Kasper, Potter, & Lyles, 2004; Liu & Christensen, 2002).

Mental Health

Many AL residents display symptoms of dementia and other mental health problems. The study of medical management noted earlier found that more than one third of AL residents exhibited one or more mental symptoms at least once a week, and more than half were taking some type of psychotropic medication (Gruber-Baldini, Boustani, Sloane, & Zimmerman, 2004). A study of the prevalence of dementia in AL found that more than two thirds of the residents examined had diagnosable dementia. Most cases had been recognized by families or caregivers and had been adequately evaluated (Rosenblatt et al., 2004). Although this level is likely high, because of sampling issues, it nonetheless points to the need to more actively address these conditions (Ruckdeschel & Katz, 2004). Some ALFs have specifically targeted dementia. Some have created special dementia units. The evidence on the effectiveness of these units is still scarce, but many others have developed policies to discharge demented persons once their behaviors become troublesome. Researchers have enunciated principles for improving mental health care among this population (G. D. Cohen et al., 2003). Principles include the following:

- staff attention to residents' strengths to personalize care and maximize independence;
- alertness for symptoms of mental illness;
- recognition that mental problems can be treated effectively;
- active surveillance for mental health problems, especially depression and cognitive impairment;
- environmental adaptations that minimize limitations of autonomy, relieve emotional distress, and prevent dysfunctional behavior due to cognitive impairment;
- adequate access to mental health professionals; and
- close coordination between the mental health and primary care clinicians.

End-of-Life Care

It is feasible to view AL as a care location that can last a lifetime. Comparisons of end-of-life care between ALFs and nursing homes suggest that the former provides as supportive a death as the latter (Sloane et al., 2003), but neither may achieve the goals residents might hope for. Much remains to be done to create a more supportive environment, including establishing a more active role for hospice teams (Dixon, Fortner, & Travis, 2002). One promising model for such palliative care is the TLC (tender loving care) model, which tries to introduce this concept earlier on and more effectively in the dying process, essentially merging it with better primary care. In this conception, palliative care does not begin with a terminal prognosis but is incorporated into ongoing chronic care. It involves comprehensive assessment and the active involvement of patients. Such an assessment was able to identify more than 250 recommendations for care improvements in 50 elderly AL residents (Jerant, Azari, Nesbitt, & Meyers, 2004). An important part of palliative care is pain management. Although no direct information about the degree of pain control is available for AL residents, the

palliative care is pain management. Although no direct information about the degree of pain control is available for AL residents, the observations of failures in the nursing home setting (Bernabei et al., 1998) suggest a likely need for more attention in AL as well (American Geriatrics Society, 1998).

Managed Care as a Model for AL Care Delivery

The underlying principle of good chronic care is to detect problems early on and intervene in order to prevent clinical and economic catastrophes. As noted previously, this approach may call for extensive monitoring at a distance with personal visits only when a change in status is noted. There is a serious question about whether FFS payment for medical care, which pays only for selected services provided (usually only in-person), is consistent with these principles. Managed care, which pays a fixed amount regardless of the intensity of the care, seems better suited to redistributing effort to conform to the chronic disease model. At least in theory, managed care is compatible with philosophy of investing in more intensive primary care with the expectation of staving off more expensive hospital care.

Managed care has two primary strategies: prevention and substitution. Prevention is really better management of extant disease. It implies that more aggressive proactive primary care with close attention to subtle changes in patients' status can trigger early intervention that can prevent an exacerbation from becoming a catastrophe requiring an emergency room visit and possibly hospitalization. Substitution implies that when a problem arises it is treated on site rather than after transporting the patient to the hospital. Managing a medical problem on site, the equivalent of home care, requires having sufficient nursing staff to monitor and attend to the patients and a medical support system that visits regularly and responds rapidly to crises. Such a system is feasible in some nursing homes, but it would be harder to establish in less well staffed ALFs.

Several models of effective chronic care are available for adaptation to AL, but there are barriers for each. In the world of nursing home care, one model that has research has shown to reduce hospital use was developed by Evercare, which is a wholly owned subsidiary of the large, diversified health care organization UnitedHealth Group (Kane, Keckhafer, Flood, Bershadsky, & Siadaty, 2003). In essence, Evercare operates as a Medicare managed care organization, voluntarily enrolling long-stay nursing home residents in a *Medicare Advantage* program (the term now used to describe managed care programs under Medicare). It is preferable to concentrate Evercare services in homes with high penetrance and where the care is consolidated among only a few physicians. Evercare can take advantage of a high capitation rate for nursing home residents to provide extensive primary care. It has established an efficient approach to providing medical services by employing nurse practitioners (NPs) who, in effect, augment the primary care team by providing first-hand, hands-on care on a frequent basis (Kane, Flood, Keckhafer, & Rockwood, 2001). These NPs work with nursing home staff to encourage them to make more astute and systematic observations and respond quickly to requests for help. The NPs work under the direction of existing primary care physicians, many of whom devote a substantial proportion of their practice to caring for nursing home residents. Thus, there is an opportunity for the NPs to develop a relationship with the supervising physicians, which often grants them considerable leeway in managing patients.

Because Evercare is offered under a capitated arrangement whereby the organization receives a fixed sum in exchange for providing all of the care Medicare would ordinarily cover, there is a strong incentive to minimize the use of hospitals. Under Evercare, nursing homes make substantial efforts to manage cases whenever feasible in the home, without transferring residents to the hospital. As an added inducement to discourage transferring residents who develop medical problems to the hospital, Evercare pays the nursing homes a fee, called an *intensive service day*, which is intended to recompense them for the costs of additional nursing staff needed to manage the resident in the nursing home. By contrast, an ALF may perceive incentives to call emergency medical technicians at the first sign of trouble and to press them to transport the resident at risk to the emergency room. Such action absolves the ALF of any responsibility and makes few demands on the AL staff. Moreover, the ALF continues to receive payment while the resident is in the hospital.

Evercare clients use much less hospital care and the savings more than cover the added costs of the NPs (Kane, Keckhafer, et al., 2003). The bulk of this reduction in hospital use occurs because of a shift in the location of care rather than prevention of the occurrence of the problem. Residents who would otherwise be transferred to the hospital are treated in the nursing home. However, there is at least some indication that more aggressive primary care prevents some problems from occurring. One study found that the rate of so-called preventable hospital admissions was lower than that for controls. Evercare clients, and especially their families, are very happy with the care because the NPs interact actively with the families (Kane, Flood, Keckhafer, Bershadsky, & Lum, 2002).

Evercare operates as a Medicare Advantage program payment (i.e., a managed care program that receives a fixed payment from Medicare for each beneficiary who elects to join). The Medicare Modernization Act changed Medicare Advantage payment by mandating a new level of care directed at Special Needs Plans, which are specialized Medicare Advantage plans that serve identified population groups such as dually eligibles (for Medicare and Medicaid), people living in institutions or in the community with similar needs, and persons with severe or disabling chronic conditions (Bringewatt, 2006; Bringewatt & Stefanacci, 2005). Although this definition does not specifically recognize ALFs, these facilities could work with managed care plans to target at least some of their heavier care residents.

There are effectively two payment systems: one for community-living Medicare recipients (which includes AL) and one for those in for nursing homes (as Medicare certified). Each payment system is nearly identical. Each derives a score from two parts—demographic data plus a diagnosis-related adjustment (based on the hierarchical condition categories [HCC]) methodology). Because diagnoses account for a smaller part of cost variability in the nursing home model than in the community model, the nursing home model is more heavily weighted on the demographic factors. In fact, under the current system the payment for community-living residents with multiple chronic diagnoses may exceed that for nursing home residents. Such an arrangement makes it feasible to establish partnerships between ALFs and Medicare Advantage plans.

Work is continuing on the HCC adjuster. Many observers feel that it underpays for the highest risk people. Experts have created a "frailty factor" to improve the model, but its implementation is not yet clear.

PACE is another Medicare-certified managed care program, but it targets clients who are dually eligible for both Medicare and Medicaid, who are nursing home certifiable, but who live in the community (Kane, 1999). The capitation rate for PACE is also substantially higher because the enrollees are assumed to be eligible for nursing home care (Branch, Coulam, & Zimmerman, 1995). This higher capitation rate provides a fiscal resource to use as an investment in more active primary care

rate provides a fiscal resource to use as an investment in more active primary care.

Evercare and PACE share another characteristic. They concentrate the primary care in the hands of a few physicians. PACE contracts with, or hires, physicians who work for the organization. These physicians, either by self-selection or adaptation, adopt PACE's fundamental care philosophies. Evercare tries hard to work with nursing homes where the medical care is concentrated in a few physicians who must agree to contract with Evercare.

Other managed care programs serving frail elderly clients that did not concentrate their physician care have not been as successful in changing health care patterns. The Wisconsin Partnership Program is a PACE variant wherein medical care is allowed to continue with the client's own physician, and team management is provided by an interdisciplinary team of NP, nurse, and social worker. The former acts as the liaison with the physician. On average, Wisconsin Partnership Program physicians have only about half a dozen clients in the program, not nearly enough to warrant changing their practice styles. The Wisconsin Partnership Program has not been as effective as PACE in controlling utilization (Kane, Homyak, & Bershadsky, 2006).

The Minnesota Senior Health Options (MSHO) contracts with managed care organizations to manage dually eligible older clients. These plans also allow clients to choose their physicians, and, again, the extent of concentration is weak. MSHO physicians also have only about six clients on average. The effect of MSHO on utilization for community-living clients has been minimal. In contrast, nursing home MSHO residents showed substantially less hospital use than controls, but many of the MSHO nursing home clients were managed by Evercare (Kane, Homyak, Bershadsky, Flood, & Zhang, 2004).

The basic Evercare model is not unique to the program marketed by UnitedHealth Group. Several different variations are available nationally. Each relies on the favorable conditions currently available to induce managed care for nursing home residents. Managed care corporations who serve nursing home residents receive a capitated rate that is substantially higher than the average Medicare rate. This higher rate is based on the observation that nursing home residents on average use substantially more care than do typical Medicare beneficiaries. This higher capitation rate provides the resources to develop the special care programs noted.

In theory, AL could use a similar approach. However, two major barriers intervene. First, medical care of AL residents is usually not consolidated within a few physicians; hence the physicians may not be oriented toward such care or eager to work closely with NPs. Second, many AL staffs do not view themselves as being in the active caring business. They do not want to assume the responsibility for either actively monitoring residents or caring for them when they become ill. Many do not have the nursing staff to assume even modest care responsibilities.

Building on the Evercare Model

The challenge then is how to reproduce the strengths of the Evercare approach in a situation in which the payment system is less rich. The first step should be to consolidate the care. If physicians are to change their practice patterns, it cannot create disruption to do so. At a minimum, the change should affect enough of their practice to make it feasible. A new approach to primary care implies doing things differently. No physician can be expected to practice schizophrenically, with one set of rules for some patients and another for the rest.

differently. No physician can be expected to practice schizophrenically, with one set of rules for some patients and another for the rest. The physicians will need help; ideally they can recruit NPs to share some of the burden, but either they will have to use the NPs judiciously or the volume of the practice will have to be high enough to make this addition affordable.

The ALF staff need to buy into a proactive model of care, whereby they monitor residents closely and notify medical staff about changes in condition. Some ALF residents may be able to do their own monitoring, but others will need assistance and oversight. ALF staff need to see themselves as active members of a care team.

Some additional case management may be needed. If NPs prove too expensive for extensive duty, some of their roles can be filled by nurses with less training, who can serve as the frontline workers to monitor change in status and take first-level steps in response.

In either case, an information system capable of recording client status on a regular basis and prompting alerts to changes in status will be needed. This system will likely come from the medical team overseeing the client's care, but ALF staff must be trained and competent to use it. The medical care team will develop and underwrite the medical information system as part of the costs of doing business in this new way, but the ALF staff should be prepared to play an active role in using the system to communicate with the medical team regularly. The intensity of staff participation can vary from facilitating AL residents' reporting on their own health status to doing the reporting for those unable to communicate effectively.

Some work has gone into developing clinical information systems for nursing home use, but most of these systems have been based on the mandatory Minimum Data Set. Such a design is extremely limited because it relies on information that is infrequently collected. The Minimum Data Set is updated only every 3 months or when a change in condition occurs. A useful clinical system must be sensitive to subtle changes in a patient's status and provide, in effect, an early warning system that allows a clinician to intervene in a timely manner to prevent a more serious exacerbation. One such system is the clinical glidepath, which compares observed and expected clinical courses for defined parameters that correspond to common chronic conditions. The patient or his or her caregiver records basic status observations daily, and the system alerts the clinician when the observed pattern deviates significantly from what has been predicted (Kane, Ouslander, & Abrass, 2003).

The underlying information technology need not be very complex. Devices equivalent to personal digital assistants can be programmed to record salient clinical information and to transmit that information (via modem) to a central computer, which can interpret trends and calculate deviations from preprogrammed bounds. The computer can notify relevant clinicians and the ALF staff when a boundary has been crossed. This notification would trigger a visit by a clinician (often an NP), who would assess the situation to ascertain whether (a) the data were correct, (b) the patient had not followed the prescribed regimen, or (c) a new problem had arisen.

If none of these are present, a full workup is indicated.

Proactive Primary Care

The basic principle of good chronic disease management is proactive primary care. Good primary care does not simply treat problems promptly when they arise; it looks for signs of problems while they are small and treats them early to prevent their becoming

promptly when they arise; it looks for signs of problems while they are small and treats them early to prevent their becoming catastrophes. People living in AL should be able to get at least the same level of care that they would receive if they were living at home with family members. Such care requires no special training.

One of the cardinal principles of chronic disease management is to track the status of disease closely and intervene at early signs of change to prevent the onset of catastrophic exacerbations. Experts have proposed various systems to monitor the status of these chronic diseases. Some involve elaborate technology and telemedicine. Some can be applied quite simply. The common theme to all of them is systematic observation and action when the observed pattern deviates by some predetermined amount.

AL staff should be able to play a central role in making systematic, regular observations about the residents. These observations might include simple physiological measures, like weight, but would primarily be recording symptoms (e.g., shortness of breath, lack of appetite, fatigue, or lethargy). These observations can be captured in simple flow sheets that contain instructions about when to notify the primary care providers about an observed change in pattern.

Such an approach requires two key elements: (a) a willing staff and (b) a supportive primary care system. At present, both elements seem to be missing in many instances. As noted earlier, AL staffs are very reluctant to assume any responsibility that might place extra burdens on them or render them vulnerable to litigation for neglect. At the same time, the lack of organized medical care for AL residents means that these persons have little chance of being cared for by care systems that are prepared to invest the time and effort to install and maintain a proactive observational approach. Indeed, under the current FFS payment arrangements, these care systems have no incentive to do so. They are not paid for such services, and the effective implementation of such a program might even decrease the number of events that are reimbursable. Modern communication technology makes it conceptually easy to keep primary care providers in close touch with AL staff and quickly apprised of any changes in their patients' conditions.

NPs may well become the dominant primary care providers of the future. The shortage of physicians entering primary care and the growing recognition that NPs can handle many primary care tasks well (Mundinger et al., 2000) suggest an active role for NPs in primary care in general and especially in long-term care. However, it may not be any easier to attract nurses into geriatric careers than it has been to attract physicians (Cooper, 1995; Warshaw, Bragg, Shaull, & Lindsell, 2002). Beyond the Evercare model, NPs have made a substantial contribution to improving care in the nursing home setting (Buchanan et al., 1990; Garrard et al., 1990; Kane et al., 1991). They have at least as much potential to play an active role in caring for AL residents.

NPs seem to be the ideal candidates for becoming the case managers for AL residents. They can intervene as well as oversee. However, if the reimbursement for medical care to AL residents is substantially lower than that for nursing home residents, it is unlikely that NPs will be used for this purpose. Instead, the care is more likely to come from registered nurses.

AL shares with the rest of society the problem of a medical care system that is more attuned to responding to acute events than managing the prevalent chronic diseases (Kane et al., 2005). Most of the elements that make up good geriatric care, even those that have been shown to have promise in improving the outcomes of care, do not make good economic sense in the current FFS reimbursement climate. At the same time, managed care has not proven to be a panacea. Many managed care efforts have been reluctant to take on high-cost

clients without appropriate case-mix payment adjustments. Medicare capitation rates are currently based on nursing home residency rather than actual clinical status. If AL could harness the PACE precedent of using equivalency as the rationale for extending capitation rates, managed care might be more attracted to AL. In other words, there is no business case for good medical care for AL residents.

Activities like comprehensive geriatric evaluations, which have benefit (Stuck, Siu, Wieland, Adams, & Rubenstein, 1993) but have been challenged as well (H. J. Cohen et al., 2002), are not well reimbursed on their own; they need to be subsidized by organizations that would benefit by subsequent reductions in heavy care use. Group visits, which could be readily organized in an AL environment, work well in managed care (Scott et al., 2004) but are not reimbursable per se. Monitoring patients' clinical status by telephone is not currently a reimbursable cost.

What Can Be Done Today?

There is a growing sense that good chronic disease care is difficult to achieve under an FFS payment structure. The incentives are misplaced. Chronic care requires investment to avoid expensive catastrophes. FFS requires payment for each activity at the time it is performed. Catastrophes are income generating. Nonetheless, several projects are currently underway to test models of chronic care that might be applied in the FFS setting. These include disease management and better coordination of care.

At a larger level, Medicare or even Medicaid (although the medical care cost burden for ALF residents falls primarily on Medicare) could become de facto managed care organizations, creating payments systems that would reward practitioners for proactive care and offsite monitoring (Wolff & Boult, 2005). This might be done by direct payment (although there would be active concerns about exploitation) or it might be accomplished by some form of risk sharing. Some of the demonstration projects called for under the Deficit Reduction Act point in these directions, paying for care coordination (creating what is now termed a *medical home*). Another approach could use pay-for-performance incentives to make caring for AL residents with heavy medical needs more attractive and rewarding those who provide good care for them.

Research Agenda

Research projects could proceed at several levels. Work is already underway to identify models of care that are commensurate with the lower capitation rates for AL. Various versions of case management might be adapted from community models for application in AL. The Visiting Nursing Service of New York, for example, has a care management model designed for Medicaid recipients living at home that works with a wide variety of physicians and does not require them to make special home visits. Something similar could be developed for AL. NPs might be more widely used as primary caregivers. It is not clear that substituting NPs for physicians will reduce costs per se (this would depend on how the NPs were reimbursed), but NPs might be more effective in working with AL staffs.

Some support to test the role of client status tracking systems and early warning approaches is certainly warranted. Ultimately, because any benefits in lower utilization will accrue to Medicare, that agency must be involved in developing the reimbursement system, but the

any benefits in lower utilization will accrue to Medicare, that agency must be involved in developing the reimbursement system, but the Centers for Medicare & Medicaid Services has shown recent interest in creating various incentive systems that have the potential to save money. Developing more empirical data demonstrating such effects might induce such an investment.

It would be worthwhile to see how much of an impact a medical director might have in creating a new model for ALF medical care. Establishing such a position might include making some efforts to consolidate (at least voluntarily) the care of residents to the point where some services might be delivered economically on site.

Research on improving medical care for AL residents could proceed at two levels. A series of demonstrations could be launched to establish the technical feasibility and benefits of various strategies to approach such care more systematically and proactively. The major challenge is to find a model that is affordable without the augmented capitation rate provided to nursing home residents and those deemed to be nursing home certifiable. A considerable degree of scaling down will be necessary. The big question is how to retain effectiveness under these more austere conditions. The models described here (or variations of them) could be applied to the AL setting.

Presumably, such demonstrations would provide adequate funding to support the tests, but ultimate implementation would depend on creating an economic climate that would support such care and ideally make it financially desirable. At first blush, the most compatible approach would be some form of capitated care. Hence, research should also be directed toward developing methods to create a capitation rate that adequately captures the real risks associated with the factors that underlie many people being in AL. Such a rate might induce managed care corporations to create a product that would consolidate medical care and employ innovative approaches.

Another level of research falls under the general heading of culture change. AL management and staff need to become convinced that their roles extend beyond hospitality. The so-called wellness nurses should be harnessed to become more actively involved in resident care. ALFs must come to view themselves as having a caring role, which includes being involved in care activities to the full level that their skills and training permit. They need to move away from practices based on risk reduction to a mode that rewards problem solving and creativity.

1 University of Minnesota School of Public Health, Minneapolis.

2 Ovations, Minneapolis, MN.

Decision Editor: Susan L. Hughes, DSW

Table 1.

Variation in Functional Conditions Across Different Types of Assisted Living and Nursing Home Residents.

	Assisted Living			
Condition	**<16 Beds**	**Traditional**	**New Model**	**Nursing Homea**

Condition	<16 Beds	Traditional	New Model	Nursing Homea
% Age 85+	46	57	52	49
% Heart condition	38	48	49	48
% ADL impairmentb	37	15	25	83
% Cognitive impairmentc	42	23	35	51
% Behavioral impairmentd	49	37	39	30

Notes: *Source*: Zimmerman et al., 2003, Table 4.

[a]From the 1996 National Nursing Home Survey (Krauss & Altman, 1998).

[b]Impairment in at least one of six activities of daily living (ADLs; transferring, locomotion, dressing, eating, using the toilet, and bathing).

[c]For the residential care/assisted living cohort, cognitive impairment was scored as moderate or severe dementia as reflected in a Mini-Mental State Examination (Folstein et al., 1975) score < 17 or a score > 3 on the Minimum Data Set–Cognition Scale (Hartmaier et al., 1994), or a reported diagnosis of dementia. For the nursing home cohort, dementia was based on Minimum Data Set information.

[d]At least one form of inappropriate or dangerous behavior, based on the Cohen-Mansfield Agitation Inventory (Cohen-Mansfield, 1986).

View Large

Table 2.

Health and Functional Characteristics of a National Sample of Assisted Living Residents (*N* = 192,046).

Characteristic	%
Self-reported health	
Excellent	7
Very good	19
Good	35
Fair	29

Fair	29
Poor	10
Health service use (past 12 months)	
Hospital	32
Emergency room	24
Health events	
Stroke	6
Heart attack	3
Hip fracture	3
Fall	37
Supervision of physical assistance in activities of daily living	
None	79
One or two	13
Three to five	8
Cognitive impairment	
None/mild	73
Moderate	13
Severe	14
Incontinent of urine	32
Received help with medications	77

Source: Hawes et al., 2000.

View Large

References

References

American Geriatrics Society. (1998). *Clinical practice guideline for the management of chronic pain in older persons*. New York: Author.
Google Scholar

Beck, A., Scott, J., Williams, P., Robertson, B., Jackson, D., & Gade, G., et al (1997). A randomized trial of group outpatient visits for chronically ill older HMO members: The cooperative health care clinic. *Journal of the American Geriatrics Society,* 45, 543-549.
Google Scholar

Bernabei, R., Gambassi, G., Lapane, K., Landi, F., Gatsonis, C., & Dunlop, R., et al (1998). Management of pain in elderly patients with cancer: SAGE Study Group. Systematic Assessment of Geriatric Drug Use via Epidemiology. *Journal of the American Medical Association,* 279, 1877-1882.
Google Scholar

Branch, L. G., Coulam, R. F., & Zimmerman, Y. A., (1995). The PACE evaluation: Initial findings. *The Gerontologist,* 35, 349-359.
Google Scholar

Briesacher, B., Limcangco, R., Simoni-Wastila, L., Dioshi, J., & Girwitz, J., (2005). Evaluation of nationally mandated drug use reviews to improve patient safety in nursing homes: A natural experiment. *Journal of the American Geriatrics Society,* 53, 991-996.
Google Scholar

Bringewatt, R., (2006). Special needs plans: Building a successful care system for high-risk beneficiaries. *Medicare Patient Management,* 1, (5), 8-21.
Google Scholar

Bringewatt, R., & Stefanacci, R. G., (2005). The Medicare Modernization Act may help ALFs. *Assisted Living Consult,* 1, (4), 8-19.
Google Scholar

Buchanan, J. L., Bell, R. M., Arnold, S. B., Witsberger, C., Kane, R. L., & Garrard, J., (1990). Assessing cost effects of nursing-home-based geriatric nurse practitioners. *Health Care Financing Review,* 2, (3), 67-78.

effects of nursing-home-based geriatric nurse practitioners. *Health Care Financing Review,* 2, (3), 67-78.
Google Scholar

Carpenter, G. I., Bernabei, R., Hirdes, J. P., Mor, V., & Steel, K., (2000). Building evidence on chronic disease in old age. *British Medical Journal,* 320, 528-529.
Google Scholar

Cohen, G. D., Blank, K., Cohen, C. I., Gaitz, C., Liptzin, B., & Maletta, G., et al (2003). Mental health problems in assisted living residents: The physician's role in treatment and staff education. *Geriatrics,* 58, (2), 44-55.
Google Scholar

Cohen, H. J., Feussner, J. R., Weinberger, M., Carnes, M., Hamdy, R. C., & Hsieh, F., et al (2002). A controlled trial of inpatient and outpatient geriatric evaluation and management. *New England Journal of Medicine,* 346, 905-912.
Google Scholar

Cohen-Mansfield, J., (1986). Agitated behaviors in the elderly. II: Preliminary results in the cognitively deteriorated. *Journal of the American Geriatrics Society,* 34, 722-727.
Google Scholar

Cooper, R. A., (1995). Perspectives on the physician workforce to the year 2020. *Journal of the American Medical Association,* 274, 1534-1543.
Google Scholar

Dixon, S., Fortner, J., & Travis, S. S., (2002). Barriers, challenges, and opportunities related to the provision of hospice care in assisted-living communities. *American Journal of Hospice & Palliative Care,* 19, 187-192.
Google Scholar

Folstein, M. F., Folstein, S., & McHugh, P. R., (1975). "Mini-mental state": A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research,* 12, 189-198.
Google Scholar

Garrard, J., Kane, R. L., Radosevich, D. M., Skay, C. L., Arnold, S., & Kepferle, L., et al (1990). Impact of geriatric nurse practitioners on nursing-home residents' functional status, satisfaction, and discharge

outcomes. *Medical Care,* 28, 271-283.
Google Scholar

Gravelle, H., Dusheiko, M., Sheaff, R., Sargent, P., Boaden, R., & Pickard, S., et al (2007). Impact of case management (Evercare) on frail elderly patients: Controlled before and after analysis of quantitative outcomes data. *British Medical Journal,* 334, 31-34.
Google Scholar

Gruber-Baldini, A. L., Boustani, M., Sloane, P. D., & Zimmerman, S. I., (2004). Behavioral symptoms in residential care/assisted living facilities: Prevalence, risk factors, and medication management. *Journal of the American Geriatrics Society,* 52, 1610-1617.
Google Scholar

Hartmaier, S. L., Sloane, P. D., Guess, H. A., & Koch, G. G., (1994). The MDS Cognition Scale: A valid instrument for identifying and staging nursing home residents with dementia using the Minimum Data Set. *Journal of the American Geriatrics Society,* 42, 1173-1179.
Google Scholar

Hawes, C., Philips, C. D., & Rose, M. S., (2000). *High service and high privacy assisted living facilities, their residents and staff: Results from a national survey*. College Station: Texas A&M University System Health Science Center.
Google Scholar

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.
Google Scholar

Jerant, A. F., Azari, R. S., Nesbitt, T. S., & Meyers, F. J., (2004). The TLC model of palliative care in the elderly: Preliminary application in the assisted living setting. *Annals of Family Medicine,* 2, (1), 54-60.
Google Scholar

Kane, R. L., (1999). Setting the PACE in chronic care. *Contemporary Gerontology,* 6, (2), 47-50.
Google Scholar

Kane, R. L., (2006). Aligning healthcare with chronic disease. *Aging Health,* 2, (2), 221-227.

Kane, R. L., (2006). Aligning healthcare with chronic disease. *Aging Health,* 2, (2), 221-227.
Google Scholar

Kane, R. L., Flood, S., Keckhafer, G., Bershadsky, B., & Lum, Y.-S., (2002). Nursing home residents covered by Medicare risk contracts: Early findings from the EverCare evaluation project. *Journal of the American Geriatrics Society,* 50, 719-727.
Google Scholar

Kane, R. L., Flood, S., Keckhafer, G., & Rockwood, T., (2001). How Evercare nurse practitioners spend their time. *Journal of the American Geriatrics Society,* 49, 1530-1534.
Google Scholar

Kane, R. L., Garrard, J., Buchanan, J. L., Rosenfeld, A., Skay, C., & McDermott, S., (1991). Improving primary care in nursing homes. *Journal of the American Geriatrics Society,* 39, 359-367.
Google Scholar

Kane, R. L., Homyak, P., & Bershadsky, B., (2006). Variations on a theme called PACE. *Journal of Gerontology: Medical Sciences,* 61A, 689-693.
Google Scholar

Kane, R. L., Homyak, P., Bershadsky, B., Flood, S., & Zhang, H., (2004). Patterns of utilization for the Minnesota Senior Options Program. *Journal of the American Geriatrics Society,* 52, 2039-2044.
Google Scholar

Kane, R. L., & Huck, S., (2000). The implementation of the EverCare demonstration project. *Journal of the American Geriatrics Society,* 44, 218-228.
Google Scholar

Kane, R. L., Keckhafer, G., Flood, S., Bershadsky, B., & Siadaty, M. S., (2003). The effect of Evercare on hospital use. *Journal of the American Geriatrics Society,* 51, 1427-1434.
Google Scholar

Kane, R. L., Ouslander, J. P., & Abrass, I. B., (2003). *Essentials of clinical geriatrics* (5th ed.). New York: McGraw-Hill.
Google Scholar

Kane, R. L., Priester, R., & Totten, A. M., (2005). *Meeting the challenge of chronic illness*. Baltimore: Johns Hopkins University Press.
Google Scholar

Kane, R. L., & West, J. C., (2005). *It shouldn't be this way: The failure of long-term care*. Nashville, TN: Vanderbilt University Press.
Google Scholar

Krauss, N. A., & Altman, B. M., (1998). *Characteristics of nursing home residents, 1996. MEPS Research Findings No. 5*. Rockville, MD: Agency for Health Care Policy and Research, U.S. Department of Health and Human Services.
Google Scholar

Lau, D. T., Kasper, J. D., Potter, D. E., & Lyles, A., (2004). Potentially inappropriate medication prescriptions among elderly nursing home residents: Their scope and associated resident and facility characteristics. *Health Services Research,* 39, 1257-1276.
Google Scholar

Liu, G. G., & Christensen, D. B., (2002). The continuing challenge of inappropriate prescribing in the elderly: An update of the evidence. *Journal of the American Pharmaceutical Association,* 42, 847-857.
Google Scholar

Lorig, K. R., Sobel, D. S., Stewart, A. L., Brown, J. B.W., Bandura, A., & Ritter, P., et al (1999). Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization: A randomized trial. *Medical Care,* 37, 5-14.
Google Scholar

Mundinger, M., Kane, R., Lenz, E., Totten, A., Tsai, W.-Y., & Cleary, P., et al (2000). Primary care outcomes in patients treated by nurse practitioners or physicians: A randomized trial. *Journal of the American Medical Association,* 283, 59-68.
Google Scholar

Naylor, M. D., Brooten, D., Campbell, R., Jacobsen, B. S., Mezey, M. D., & Pauly, M. V., et al (1999). Comprehensive discharge planning and home follow-up of hospitalized elders: A randomized clinical trial.

Comprehensive discharge planning and home follow-up of hospitalized elders: A randomized clinical trial. *Journal of the American Medical Association,* 281, 613-620.
Google Scholar

Rosenblatt, A., Samus, Q. M., Steele, C. D., Baker, A. S., Harper, M. G., & Brandt, J., et al (2004). The Maryland Assisted Living Study: Prevalence, recognition, and treatment of dementia and other psychiatric disorders in the assisted living population of central Maryland. *Journal of the American Geriatrics Society,* 52, 1618-1625.
Google Scholar

Ruckdeschel, K., & Katz, I. R., (2004). Care of dementia and other mental disorders in assisted living facilities: New research and borrowed knowledge. *Journal of the American Geriatrics Society,* 52, 1771-1773.
Google Scholar

Scott, J. C., Conner, D. A., Venohr, I., Gade, G., McKenzie, M., & Kramer, A. M., et al (2004). Effectiveness of a group outpatient visit model for chronically ill older health maintenance organization members: A 2-year randomized trial of the cooperative health care clinic. *Journal of the American Geriatrics Society,* 52, 1463-1470.
Google Scholar

Sligh, T., & Vicioso, B., (2001). Medical problems and care needs of older adults in assisted living facilities. In K. H. Namazi & P. K. Chafetz (Eds.), *Assisted living: Current issues in facility management and resident care* (pp. 29–47). Westport, CT: Auburn House.
Google Scholar

Sloane, P. D., Gruber-Baldini, A. L., Zimmerman, S., Roth, M., Watson, L., & Boustani, M., et al (2004). Medication undertreatment in assisted living settings. *Archives of Internal Medicine,* 164, 2031-2037.
Google Scholar

Sloane, P. D., Zimmerman, S., Brown, L. C., Ives, T. J., & Walsh, J. F., (2002). Inappropriate medication prescribing in residential care/assisted living facilities. *Journal of the American Geriatrics Society,* 50, 1001-1011.
Google Scholar

Sloane, P. D., Zimmerman, S., Hanson, L., Mitchell, C. M., Riedel-Leo, C., & Custis-Buie, V., (2003). End-of-life care in assisted living and related residential care settings: Comparison with nursing homes. *Journal of*

life care in assisted living and related residential care settings: Comparison with nursing homes. *Journal of the American Geriatrics Society,* 51, 1587-1594.
Google Scholar

Stone, D., & Reublinger, V., (1995). Long-term care reimbursement issues. *Clinics in Geriatric Medicine,* 11, 517-529.
Google Scholar

Stuck, A. E., Siu, A. L., Wieland, G. D., Adams, J., & Rubenstein, L. Z., (1993). Comprehensive geriatric assessment: A meta-analysis of controlled trials. *Lancet,* 342, 1032-1036.
Google Scholar

Wagner, E. H., Austin, B. T., & Von Korff, M., (1996). Organizing care for patients with chronic illness. *Milbank Quarterly,* 74, 511-543.
Google Scholar

Warshaw, G. A., Bragg, E. J., Shaull, R. W., & Lindsell, C. J., (2002). Academic geriatric programs in US allopathic and osteopathic medical schools. *Journal of the American Medical Association,* 288, 2313-2319
Google Scholar

Wolff, J. L., & Boult, C., (2005). Moving beyond round pegs and square holes: Restructuring Medicare to improve chronic care. *Annals of Internal Medicine,* 143, 439-445.
Google Scholar

Zimmerman, S., Sloane, P. D., Eckert, J. K., Gruber-Baldini, A. L., Morgan, L. A., & Hebel, J. R., et al in press. How good is assisted living? Findings and implications from an outcomes study. *Journal of Gerontology: Social Sciences*..
Google Scholar

Zimmerman, S. I., Gruber-Baldini, A. L., Sloane, P. D., Eckert, J. K., Hebel, J. R., & Morgan, L. A., et al (2003). Assisted living and nursing homes: Apples and oranges? *The Gerontologist,* 43, (Special Issue II), 107-117
Google Scholar

About The Gerontologist
Editorial Board
Author Guidelines
Contact Us
Facebook
Advertising and Corporate Services
Journals Career Network

Twitter
YouTube
LinkedIn
Purchase
Recommend to your Library

The GERONTOLOGIST®

Online ISSN 1758-5341 Print ISSN 0016-9013

About Us
Contact Us
Careers
Help
Access & Purchase
Rights & Permissions
Open Access

Connect
Join Our Mailing List
OUPblog
Twitter
Facebook
YouTube
Tumblr

Resources
Authors
Librarians
Societies
Sponsors & Advertisers
Press & Media
Agents

Explore
Shop OUP Academic
Oxford Dictionaries
Oxford Index
Epigeum
OUP Worldwide
University of Oxford

To:	EmpowerMe Wellness, LLC (btravers@cedarhurstliving.com)
Subject:	U.S. TRADEMARK APPLICATION NO. 88015111 - GUIDING INDEPENDENCE - N/A
Sent:	10/18/2018 5:27:27 PM
Sent As:	ECOM107@USPTO.GOV
Attachments:	

UNITED STATES PATENT AND TRADEMARK OFFICE (USPTO)

IMPORTANT NOTICE REGARDING YOUR U.S. TRADEMARK APPLICATION

USPTO OFFICE ACTION (OFFICIAL LETTER) HAS ISSUED
ON **10/18/2018** FOR U.S. APPLICATION SERIAL NO. 88015111

Please follow the instructions below:

(1) TO READ THE LETTER: Click on this link or go to http://tsdr.uspto.gov, enter the U.S. application serial number, and click on "Documents."

The Office action may not be immediately viewable, to allow for necessary system updates of the application, but will be available within 24 hours of this e-mail notification.

(2) TIMELY RESPONSE IS REQUIRED: Please carefully review the Office action to determine (1) how to respond, and (2) the applicable response time period. Your response deadline will be calculated from **10/18/2018** (*or sooner if specified in the Office action*). A response transmitted through the Trademark Electronic Application System (TEAS) must be received before midnight **Eastern Time** of the last day of the response period. For information regarding response time periods, see http://www.uspto.gov/trademarks/process/status/responsetime.jsp.

Do NOT hit "Reply" to this e-mail notification, or otherwise e-mail your response because the USPTO does NOT accept e-mails as responses to Office actions. Instead, the USPTO recommends that you respond online using the TEAS response form located at http://www.uspto.gov/trademarks/teas/response_forms.jsp.

(3) QUESTIONS: For questions about the contents of the Office action itself, please contact the assigned trademark examining attorney. For *technical* assistance in accessing or viewing the Office action in the Trademark Status and Document Retrieval (TSDR) system, please e-mail TSDR@uspto.gov.

WARNING

Failure to file the required response by the applicable response deadline will result in the ABANDONMENT of your application. For more information regarding abandonment, see http://www.uspto.gov/trademarks/basics/abandon.jsp**.**

PRIVATE COMPANY SOLICITATIONS REGARDING YOUR APPLICATION: Private companies **not** associated with the USPTO are using information provided in trademark applications to mail or e-mail trademark-related solicitations. These companies often use names that closely resemble the USPTO and their solicitations may look like an official government document. Many solicitations require that you pay "fees."

Please carefully review all correspondence you receive regarding this application to make sure that you are responding to an official document from the USPTO rather than a private company solicitation. All official USPTO correspondence will be mailed only from the "United States Patent and Trademark Office" in Alexandria, VA; or sent by e-mail from the domain "@uspto.gov." For more information on how to handle private company solicitations, see http://www.uspto.gov/trademarks/solicitation_warnings.jsp.