

THRIVING IN PLACE:

A CHRONIC DISEASE MANAGEMENT GUIDE FOR ASSISTED LIVING AND INDEPENDENT LIVING



A Functional Pathways White Paper

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Introduction

Chronic disease is one of the most significant factors influencing health, independence, and quality of life for older adults. Among individuals aged 65 to 74, nearly 80 percent live with at least one chronic condition, and 68 percent manage two or more. In assisted living communities, the figures are even higher, with 94 percent of residents living with at least one chronic disease. As these conditions multiply, so do the functional, cognitive, emotional, and financial challenges they create.

Senior living communities play a critical role in addressing these challenges. Therapists in assisted living (AL) and independent living (IL) environments sit at the intersection of healthcare, wellness, community, and support services, positioning them uniquely to help residents not only manage chronic disease but continue to thrive in place.

This white paper outlines a comprehensive approach to chronic disease management across AL and IL settings. Through structured interventions, proactive care coordination, functional and cognitive assessments, lifestyle strategies, health literacy, caregiver support, technology integration, and targeted rehabilitation services, communities can build a chronic disease management model that enhances wellbeing, reduces hospitalizations, and supports aging in place.

Background: Understanding the Chronic Disease Landscape in AL/IL

Chronic disease becomes increasingly common with age, and its impact extends far beyond medical diagnoses. The top conditions affecting older adults include hypertension, high cholesterol, heart disease, arthritis, diabetes, COPD, cancer, depression, obesity, asthma, chronic pain, sleep disorders, and polypharmacy-related complications.

These conditions significantly increase healthcare utilization. Nearly 90 percent of healthcare dollars are spent on chronic and mental health conditions, and chronic disease can raise annual healthcare spending by four percent or more. In some studies, residents in AL manage an average of up to 12 chronic diagnoses at once.

Chronic disease also intersects with functional impairments, mobility loss, frailty, cognitive decline, social isolation, and elevated fall risks, all of which raise the likelihood of long-term care placement. The challenge for AL and IL providers is not simply to address medical needs, but to create a coordinated, interdisciplinary approach that stabilizes health, enhances engagement, and maintains independence.

The Challenge of Complexity

Residents rarely experience chronic disease in isolation. Instead, multiple conditions interact with functional limitations, medication regimens, mental health needs, sleep issues, nutrition, social determinants of health, and environmental factors. As conditions multiply, so do risks:

- Higher likelihood of hospitalization
- Increased dependency with ADLs and IADLs
- Cognitive strain and emotional distress
- Medication mismanagement
- Fall risk and mobility decline
- Increased care costs
- Accelerated progression toward higher levels of care

The complexity of chronic disease requires deliberate coordination across medical providers, wellness teams, rehabilitation therapists, families, and the residents themselves. Communities that build cohesive systems of support help residents maintain autonomy, reduce preventable hospitalizations, and improve long-term quality of life.

Nearly 80% of adults 65 to 74 have at least one chronic condition



Structured Interventions for Chronic Disease Management

Chronic disease management is most effective when rooted in structured interventions that address prevention, early identification, and ongoing support. These interventions should be customized, resident-centered, and flexible enough to meet the differing needs of AL and IL residents.

Key Components

01

Prioritizing Resident Needs and Preferences

Personalized care or life plans support the resident's goals while addressing the functional, cognitive, and emotional impacts of chronic conditions.

02

Integrating Social Determinants of Health (SDOH)

Access to care, transportation, food security, economic stability, and social support are major predictors of health outcomes. SDOH-driven interventions improve adherence, stability, and engagement.

03

Prevention, Intervention, and Ongoing Management

Successful programs combine education, proactive monitoring, targeted therapy services, and wellness participation to maintain function and reduce decline.

04

Aging in Place Support

Tasks such as assistance with daily activities, medication organization, health monitoring, and regular screenings allow residents to remain independent longer.

Routine Medical Care and Health Monitoring

Access to routine medical care is foundational for chronic disease management. Communities should support:

- Annual wellness visits, dental and eye exams
- Transportation coordination for physician appointments
- Onsite or affiliated chronic disease specialists
- Routine screenings for functional decline, mental health, and chronic disease progression
- Advanced care planning and palliative/hospice coordination

Health Monitoring plays a central role in stabilizing chronic conditions. Monitoring may include:

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| <ul style="list-style-type: none">• Vital signs and daily blood sugars• Changes in strength, flexibility, or mobility• Walking speed and gait stability ("the sixth vital sign")• Weight monitoring and nutrition status | <ul style="list-style-type: none">• Emergency response systems• Use of smart health trackers, wearables, and remote monitoring |
|---|---|

These tools empower residents and provide early warning signs that allow for timely intervention.

Communication and Care Coordination

Chronic disease management requires consistent communication among healthcare providers, residents, families, and community teams.

Examples of effective communication strategies include:

- Educational health talks and workshops
- Written materials in large-print or low-vision formats
- Lists of questions for physician visits
- Printed summaries of services offered on campus
- Provider-to-provider communication to share goals and updates
- Referral pipelines to therapy, wellness, or mental health programs

Communities that provide accessible education and encourage proactive self-advocacy help residents navigate complex conditions with greater confidence.

Medication Management and Safety

Medication mismanagement is one of the leading drivers of hospitalization among older adults. Up to 42 percent of seniors experience medication errors, and 50 percent of treatment failures stem from lapses in adherence.

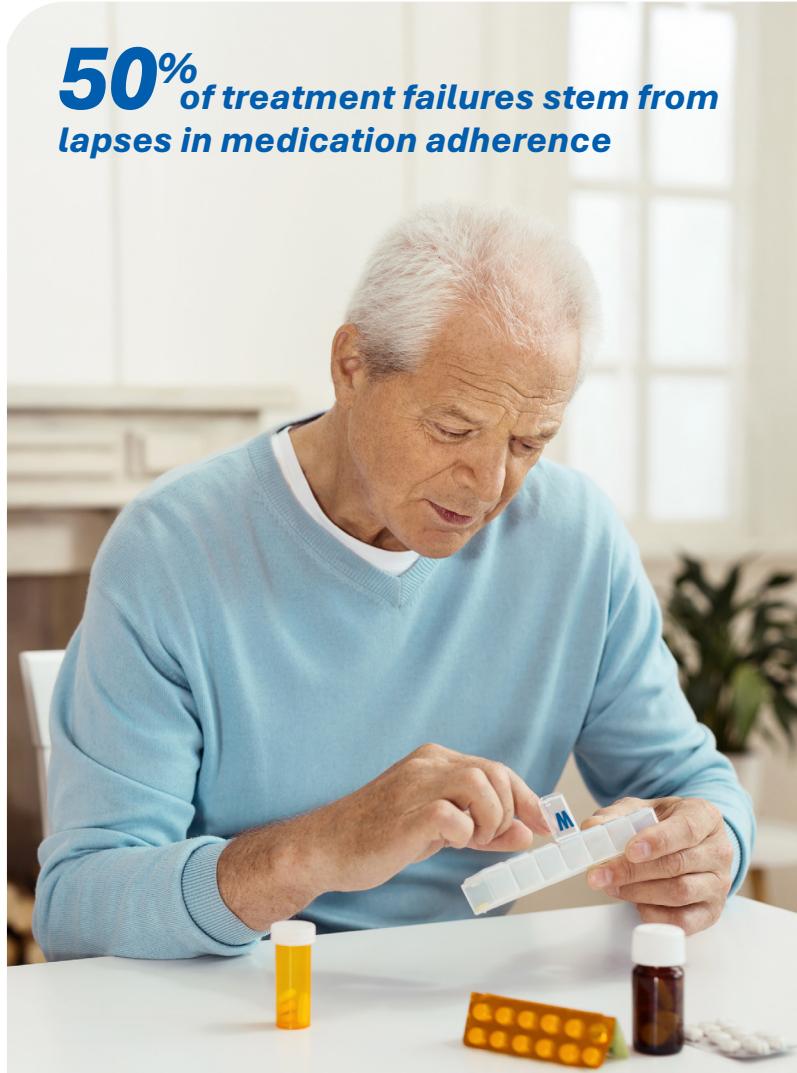
Common risks include:

- Missed doses
- Incorrect doses
- Drug interactions
- Lack of understanding during transitions of care
- Difficulty opening bottles or managing multiple medications

Strategies for medication success include:

- Pill organizers and blister packs
- Reminder systems and automatic refills
- Medication delivery
- Pharmacy education and collaboration
- Therapy-driven cognitive supports for memory
- Fine motor and dexterity interventions
- Swallowing evaluations and adaptive bottles

50% *of treatment failures stem from lapses in medication adherence*





Functional, Cognitive, and Frailty Assessments

Assessment is a cornerstone of proactive chronic disease management. Functional Pathways' Functional Fitness Scorecard, cognitive testing, frailty assessments, and balance screens help identify early signs of decline and guide personalized recommendations.

Frailty is a major predictor of poor outcomes. It is not a normal part of aging, but a state of increased vulnerability.

Key risk factors include:

- Chronic disease burden
- Weight loss and malnutrition
- Polypharmacy
- Cognitive impairment
- Social isolation
- Sedentary lifestyle

Early recognition through tools like the Edmonton Frail Scale allows communities to intervene before declines become irreversible.

Lifestyle Strategies and the 7 Dimensions of Wellness

Lifestyle modification is essential but challenging. Only 6.3 percent of adults meet all recommendations for physical activity, nutrition, sleep, alcohol moderation, health literacy, and smoking avoidance.

Senior living facilities can support residents by providing integrated programming across the 7 Dimensions of Wellness:

- Physical
- Emotional
- Social
- Spiritual
- Intellectual
- Environmental
- Occupational

Examples include yoga, tai chi, mindfulness, walking clubs, functional fitness testing, lecture series, gardening, support groups, resident-led classes, and movement-to-music programs. Programs that engage multiple dimensions promote sustained participation and improved health.



Health Literacy and Self-Management Programs

Health literacy directly impacts chronic disease management. Residents who understand their conditions are more likely to follow treatment plans, maintain appointments, and avoid complications.

Communities can support health literacy by offering:

- Simplified educational materials
- “Traffic light” tools for symptom awareness
- Q&A guides for physician visits
- Technology assistance
- Family and caregiver involvement

Evidence-based Self-Management Programs (e.g., Stanford’s Chronic Disease Self-Management Program, Walk With Ease, Hypertension Coaching) empower residents with practical skills that foster independence and prevent escalation.



Nutrition, Mental Health, and Social Connection

Chronic conditions are strongly influenced by nutrition and emotional wellbeing. Senior living providers can support residents with:

- Balanced dietary offerings aligned with chronic disease needs
- Adequate protein, hydration, vitamins, and fiber
- Specialized nutritional supports (e.g., glycemic control or heart-healthy options)
- Depression and anxiety screenings
- Access to mental health professionals
- Social engagement opportunities
- Support groups



Social isolation is a major risk factor for functional decline and frailty.

Communities that provide structured social programming help residents maintain resilience, cognitive function, and mood stability.

Caregiver and Family Support

Caregivers play a vital role in managing chronic disease but often experience emotional and physical strain.

Communities can strengthen caregiver wellbeing through:

- Education about chronic conditions
- Guidance on care techniques
- Respite opportunities
- Support groups for dementia, heart disease, diabetes, and caregiving
- Advanced care planning resources

Caregivers are “hidden patients.” Supporting them improves resident outcomes.

Leveraging Technology

Technology enhances chronic disease management in meaningful ways:

Monitoring:

- Smart watches
- Wearable health trackers
- Fall detection systems
- Remote vital sign monitoring
- Predictive analytics for early detection

Telemedicine:

- Remote consultations
- Digital follow-up care
- Virtual health coaching

Engagement:

- Communication platforms
- Virtual reality
- Memory care engagement systems

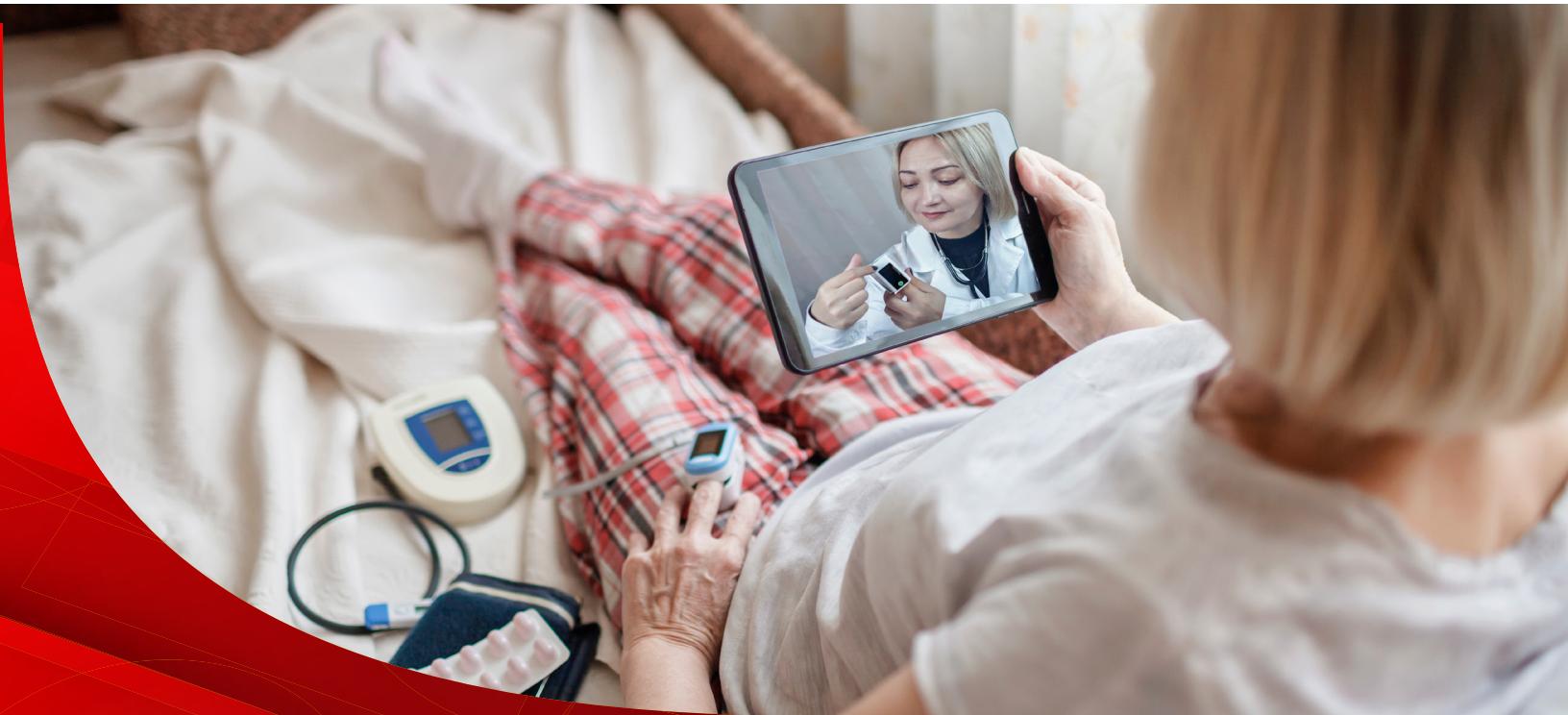
Technology extends care accessibility and allows IL and AL residents to remain independent longer.

Rehabilitation Services and Interdisciplinary Programming

Rehab professionals play a pivotal role in stabilizing and improving chronic conditions. Therapy teams support:

- Pain management
- Functional strengthening
- Disease-specific education
- Fall prevention
- Cognitive training
- Swallowing and oral-motor safety
- Environmental safety
- Post-therapy wellness pathways

Combining therapy, wellness, and chronic disease education ensures continuity across the care continuum.



Evaluating Your Current Offerings

Communities should routinely assess:

- Program completeness
- Functional fitness and frailty testing frequency
- Wellness program diversity
- Medication management support
- Access to health literacy tools
- Technology infrastructure
- Self-management offerings
- Disease-specific programming
- Social connection opportunities
- Caregiver support
- Interdisciplinary coordination

A thriving chronic disease management model is proactive, comprehensive, and rooted in resident engagement.

Conclusion

Chronic disease management in assisted living and independent living is both a challenge and an opportunity. Communities that adopt a structured, interdisciplinary approach can reduce hospitalizations, support independence, and significantly improve residents' quality of life.

By integrating health monitoring, functional assessments, lifestyle programming, medication strategies, technology, rehabilitation, mental health support, and therapist engagement, communities can help residents thrive regardless of diagnosis.





Functional Pathways

30 Years of Excellence

Celebrating 30 years of service, Functional Pathways is a therapist-founded, -owned, and -led company continually reinventing the therapy market. Spanning the full continuum of care, the company provides its hospital rehab and contract therapy clients with enhanced operational efficiencies, improved patient outcomes, and optimized revenue streams that position them as a leader in their market. Through its 4,000 therapists caring for 12,000+ patients a day, Functional Pathways continues to make a difference in every life they touch.



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