August + asha American Seniors Housing ASSOCIATION

The Daily Realities of Clinical Care in Senior Living

2025 State of Senior Living Clinical Leadership

INTRODUCTION

August

We are honored to collaborate with ASHA to shine light on the priorities and perspectives of clinical leaders in senior living. This year's survey results highlight the many ways clinical leaders are actively adapting care models in response to rising resident acuity. In this dynamic environment, it's imperative that we listen to nursing leaders and equip them for success.

In 2025, operators are strengthening partnerships with primary care, therapy groups, and hospice while entering into value-based care arrangements that increasingly include financial risk. The staffing model is being reinforced with more caregivers and an expanded role for med techs. From a systems and technology perspective, investments are being made to identify rising-risk residents sooner, enhance care documentation, and track clinical outcomes.

Notably, two-thirds of clinical leaders identify improving workplace culture and staff retention as their top priority for enhancing resident care. Hiring and retention remain persistent challenges, and training staff to manage higher-acuity residents is paramount.

The path forward requires investment in clinical leadership and the tools that empower them to do their best work. As one nursing leader commented in the survey, "We are the operational leaders, strategic advisors, risk managers, and ethical stewards that the industry needs to empower and recognize for communities to thrive."

Justin Schram, MD
Co-founder & Co-CEO
August Health

INTRODUCTION

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The experiences of clinical leaders deserve to be front and center.

In our second year conducting this survey in partnership with August Health, we chose to explore what clinical leaders see as their most pressing priorities. Across the approximately 530 senior living organizations that ASHA represents, leaders face an urgent tension between rising acuity and staffing needs, leading them to reimagine their care models.

This survey allowed us to identify industry-wide patterns while elevating the human voices within clinical leadership. Its insights reveal where leaders are focusing their attention and how they're adapting to meet the evolving needs of their communities.

I'm energized to see the resiliency and creativity reflected in these findings. Clinical leaders are building infrastructure for higher-acuity care, investing in their teams, and exploring innovative solutions. It's our hope that this and future surveys will help ASHA continue to effectively advocate on Capitol Hill about the important role senior living plays for America's older adults, their families, and for our nation's health care system.

David Schless
President & CEO
ASHA

Survey task force

Our clinical task force includes ten clinical executives across some of the most reputable leaders and operators of senior living in the United States. The task force provided consultation and feedback on survey development and supported the interpretation of analysis of the results.

Josh Allen, RN
Principal
Allen Flores Consulting Group

Sarah Jelinek
VP of Clinical Operations
Jaybird Senior Living

Lynn Chalk
VP of Clinical Services
MBK Senior Living

Liz Jensen, PhD, MSN, RN-BC
Clinical Director
Direct Supply

Jennifer Hellbusch
VP of Health Services
Heritage Communities

Sue Lingo
VP of Quality and Resident Care
American House Senior Living

Gloria Hughes
Senior VP of Operations
Innovation Senior Living

Sara Padilla
VP of Health Services
Senior Resource Group

Amy Kenley
National Director of Operations
Avanti Senior Living

Danielle Parker, RN
Chief Operations Officer
GenCare Lifestyle

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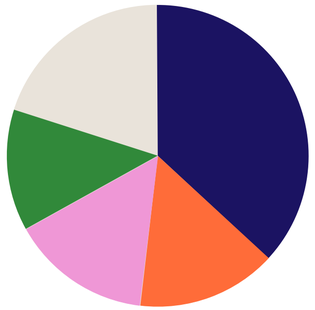
Methodology

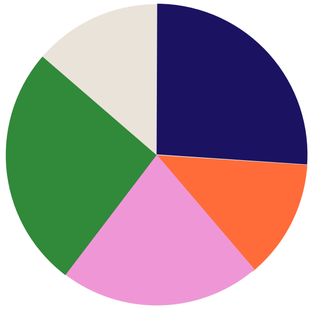
Clinical leaders at senior living operators across the United States were invited to participate in this survey via email outreach and LinkedIn messages. Sixty-eight clinical leaders elected to complete the survey. Data was captured via anonymized online survey between September 16, 2025 and October 21, 2025.

What title best describes your current role?



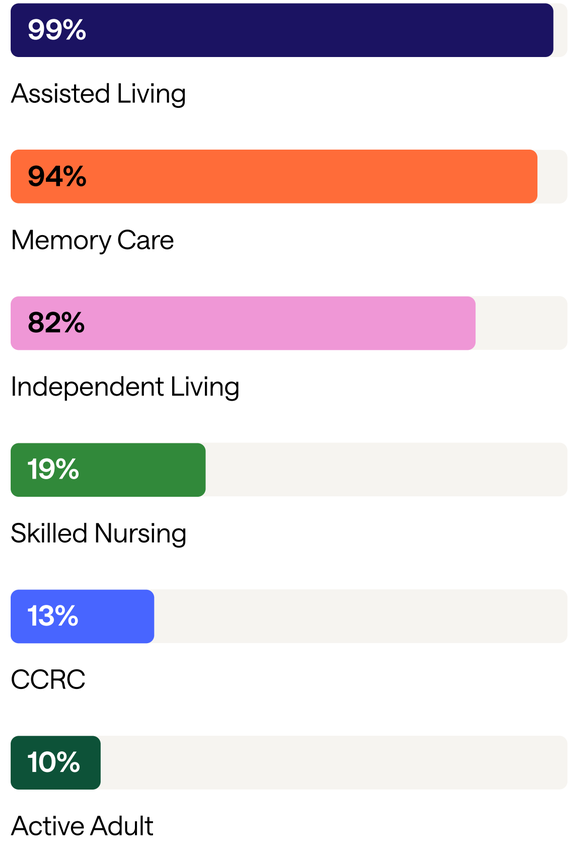
- **40%** Senior Vice President or Vice President of Clinical *(or equivalent)*
- **15%** Regional Vice President or Regional Director of Clinical *(or equivalent)*
- **15%** Senior Director or Director of Clinical *(or equivalent)*
- **13%** Chief Clinical Officer *(or equivalent)*
- **18%** Other *(e.g., Wellness Director, VP of Quality, Wellness Specialist for a Region)*

How many residents are being cared for across all of your operator's communities, excluding Independent Living?



- **26%** 1–500 residents
- **13%** 501–1000 residents
- **22%** 1001–2500 residents
- **26%** 2501–5000 residents
- **12%** 5001+ residents

Which care levels are represented in your communities? (Select all that apply)



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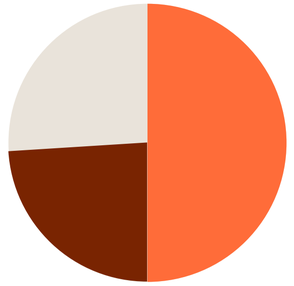
INSIGHT 1

Resident acuity is climbing, yet most communities don’t have a clear view of it.

As residents live at home longer, their care needs upon entering senior living communities have grown. But, clinical leaders aren't getting the data they need to manage this acuity creep.

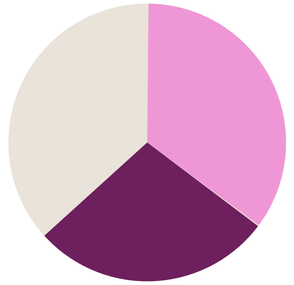
Infrequent assessments and intentionally under-scored assessments are creating a discrepancy between documented and actual acuity in a majority of communities, which has ripple effects on staffing and revenue.

Resident acuity has increased in nearly three-quarters of communities in the last five years.



- **50%** Increased somewhat
- **24%** Increased significantly
- **26%** Stayed the same, decreased somewhat, decreased significantly or not sure

At the same time, nearly two-thirds of respondents believe that **resident acuity is underreported in their communities.**



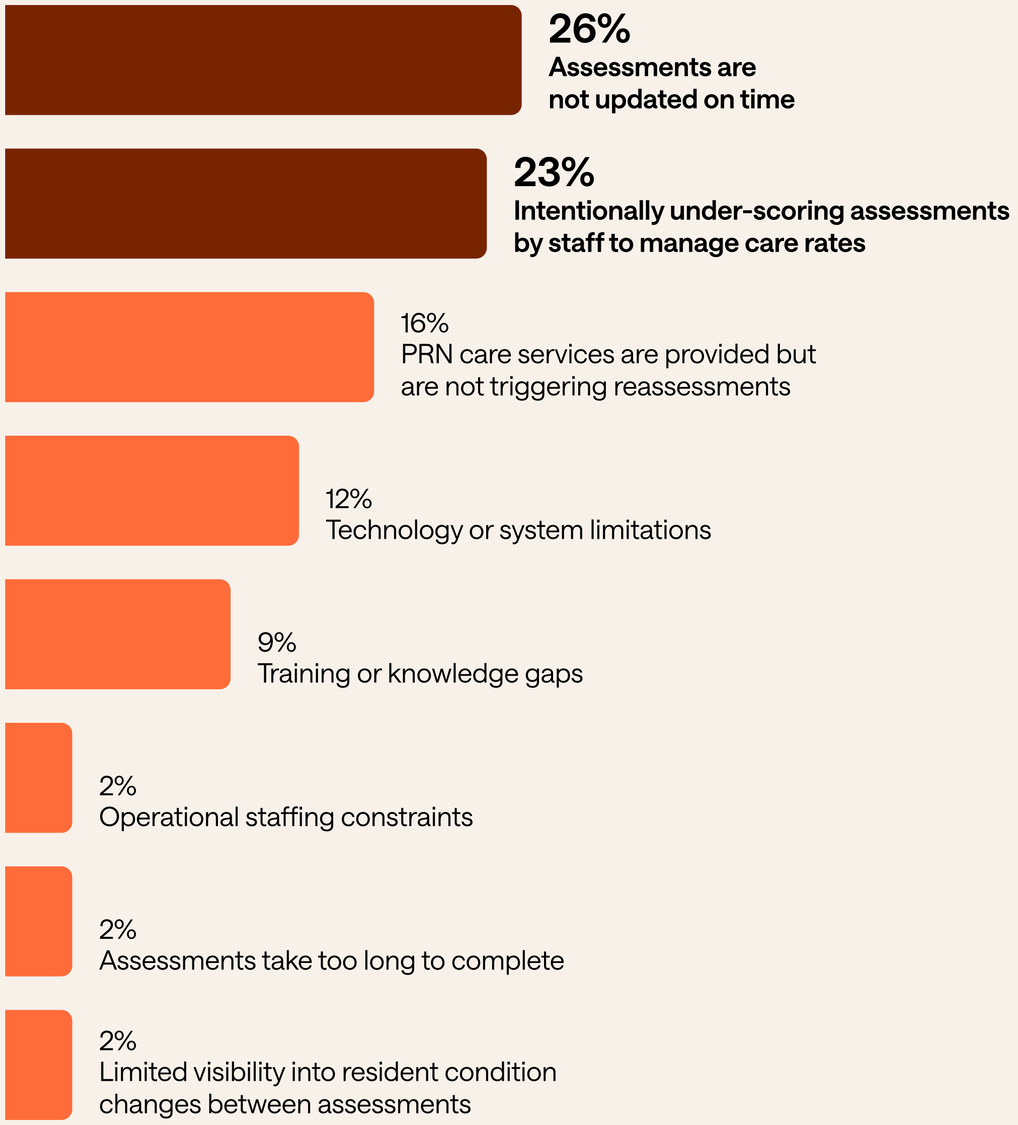
- **35%** Occasionally
- **28%** Frequently
- **36%** Rarely, never, or not sure

“

We’re seeing that acuity continues to increase and shows no signs of slowing down. The question is, **are we assessing for that acuity correctly** — I think for clinical leaders and CEOs, that’s a big, top of mind issue.

Josh Allen
Principal, Allen Flores Consulting Group

In communities where acuity is underreported, it's largely due to **overdue assessments and intentional under-scoring.**



** For complete survey results, please see Appendix, Question 13*

> Needing to have conversations with families about care rates is likely one reason for intentional underscoring. Most nurses **aren't equipped or comfortable** with this type of financial conversation and this shouldn't be part of a nursing responsibility.

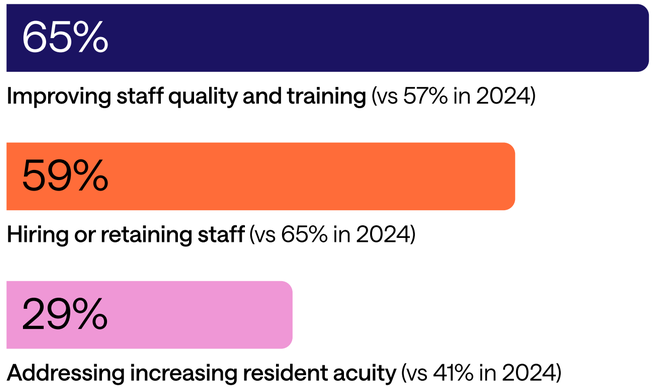
Lynn Chalk
VP of Clinical Services, MBK Senior Living

INSIGHT 2

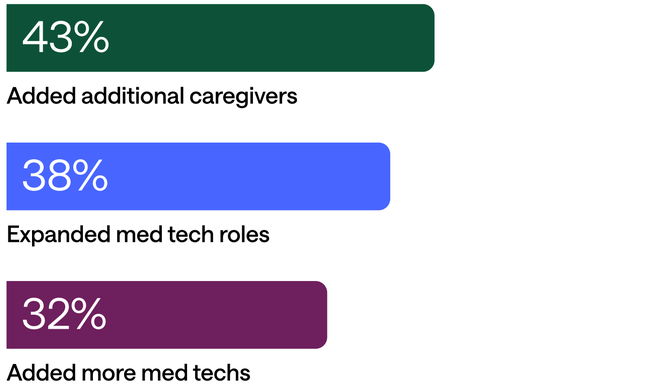
Staffing models are evolving to support rising acuity.

As resident acuity has increased, staffing needs are also evolving. Many communities are adding med techs and expanding their roles while also hiring additional caregivers and nurses. While respondents believe that solving the staffing issue will improve resident care, others hypothesize that poorly designed workflows and systems, which are needlessly time-consuming, create the illusion of understaffed communities.

Hiring staff and improving staff quality remain among the top 3 challenges year over year.*



Higher acuity is driving communities to **add and expand expand caregiver roles***

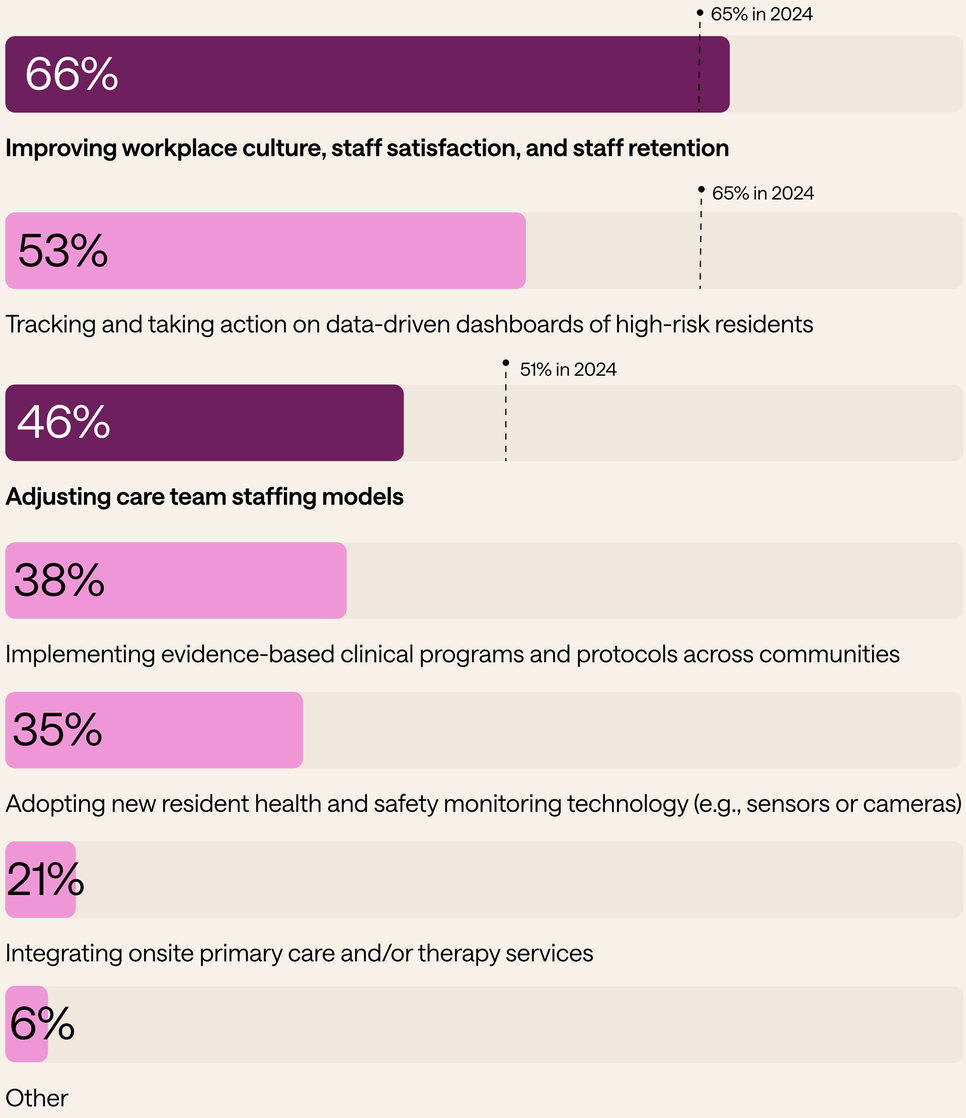


** For complete survey results, please see Appendix, Question 6 + 8*

> Adapting care models to include more med-techs in senior living is a growing trend. Narrowing into specific tasks with specific roles can augment a stretched workforce and elevates the need to ensure the technology and systems supporting their work **are designed for the right knowledge, skillset and ability to do their job well**, and provide safe, effective care.

Liz Jensen, PhD, MSN, RN-BC
Clinical Director, Direct Supply

When asked what they wish they could do more of to improve resident care, a majority of respondents cited workplace improvements, indicating **a direct relationship between staffing and quality of resident care.**



** For complete survey results, please see Appendix, Question 7*

> We're all battling for the same people and it's great to see **there's a huge focus on workplace culture**. The churn and burn is real, so I'm not surprised by the results we're seeing in terms of staff retention being a key challenge. It's an accurate depiction of what's happening.

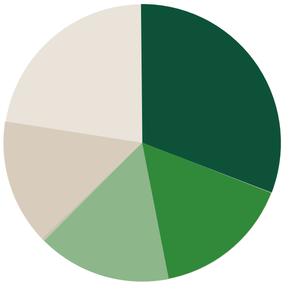
Sara Padilla
VP of Health Services, Senior Resource Group

INSIGHT 3

One-third of respondents are operating in value-based care systems that involve financial risk.

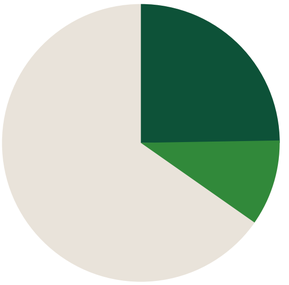
Value-based care continues to be a model that most communities are working toward, yet there's little consensus about what "true" value-based care looks like, specifically regarding financial risk. At the same time, a majority of communities recognize that improved tools and data capture are a key step toward value-based care readiness.

Two-thirds of respondents are **exploring or engaging in value-based care systems.**



- **31%** Actively operating
- **16%** In the process of joining
- **16%** Evaluating opportunities
- **15%** Have plans to evaluate
- **22%** No plans for VBC

Among communities that are actively operating within value-based care systems, **one-third are taking on financial risk.**



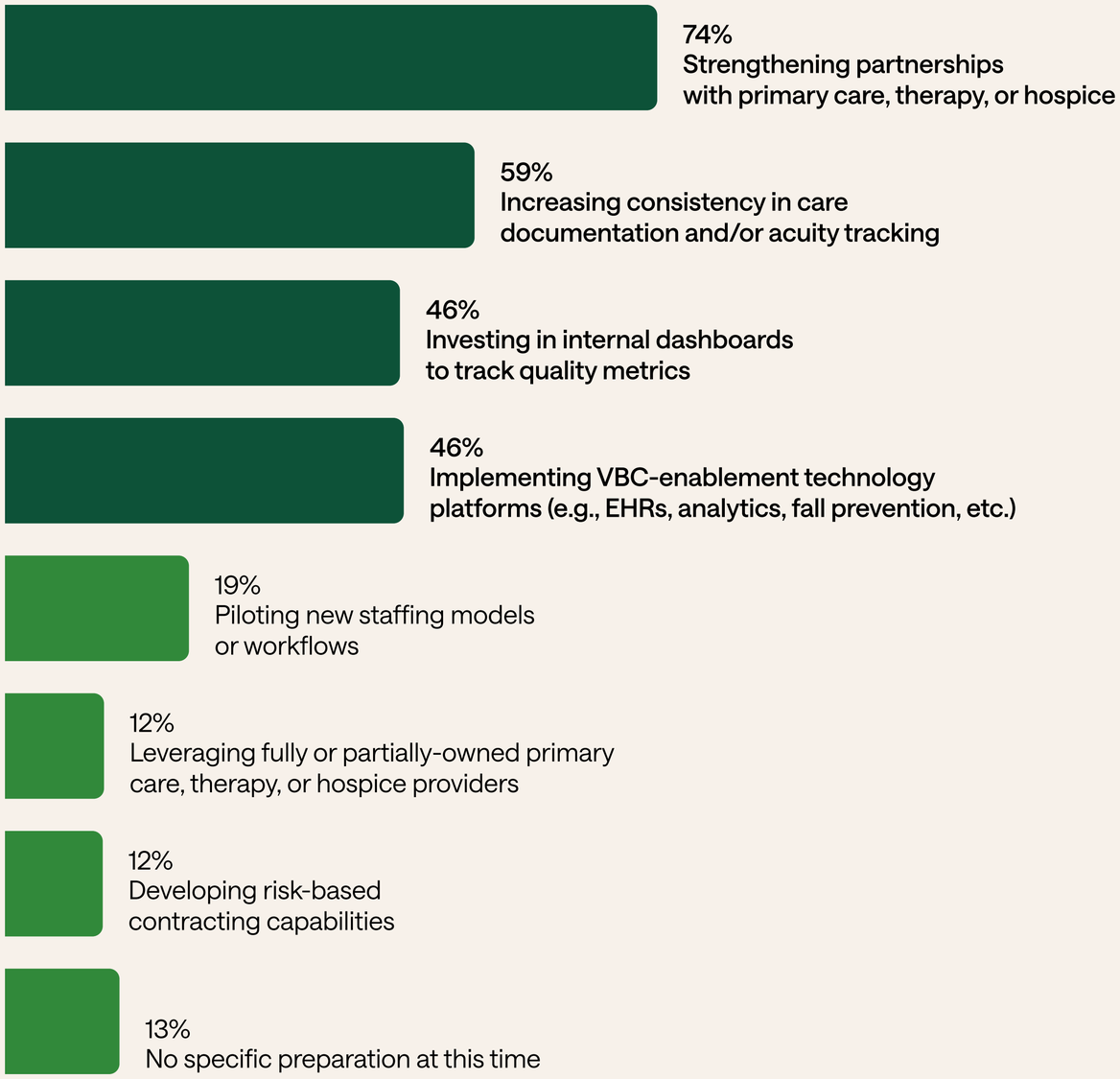
- **25%** Contractual relationship for services and financial risk-sharing
- **10%** Co-owner of a VBC plan with shared financial risk
- **65%** Contractual relationship for services only with no financial risk, or other

> Communities that are more strategic are probably taking on some of these options because this can be an interesting way to bring clinical support to your organization or community.

Jennifer Hellbusch
VP of Health Services, Heritage Communities

Strengthening external partnerships, in addition to closer tracking of resident acuity and clinical quality metrics, are among the primary ways operators are equipping themselves for success in value-based care.

Investing in value-based care technology infrastructure from a data and systems standpoint is also seen as an important strategy for optimizing care quality outcomes while containing costs.



** For complete survey results, please see Appendix, Question 20*

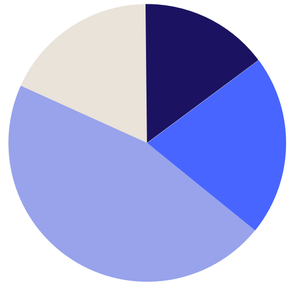
INSIGHT 4

The benefits of predictive analytics and AI are clear, but **adoption remains slow.**

Clinical leaders are fully onboard with moving toward proactive care. However, they consistently report challenges that prevent them from gaining momentum toward this critical shift.

The implementation of AI and predictive analytics is going slowly. And, without these technologies, clinical leaders lack visibility into the very data required to adopt a more proactive posture to care preventatively, anticipate crises, and reduce risk.

About one-third of respondents are currently exploring or using predictive analytics in clinical workflows.

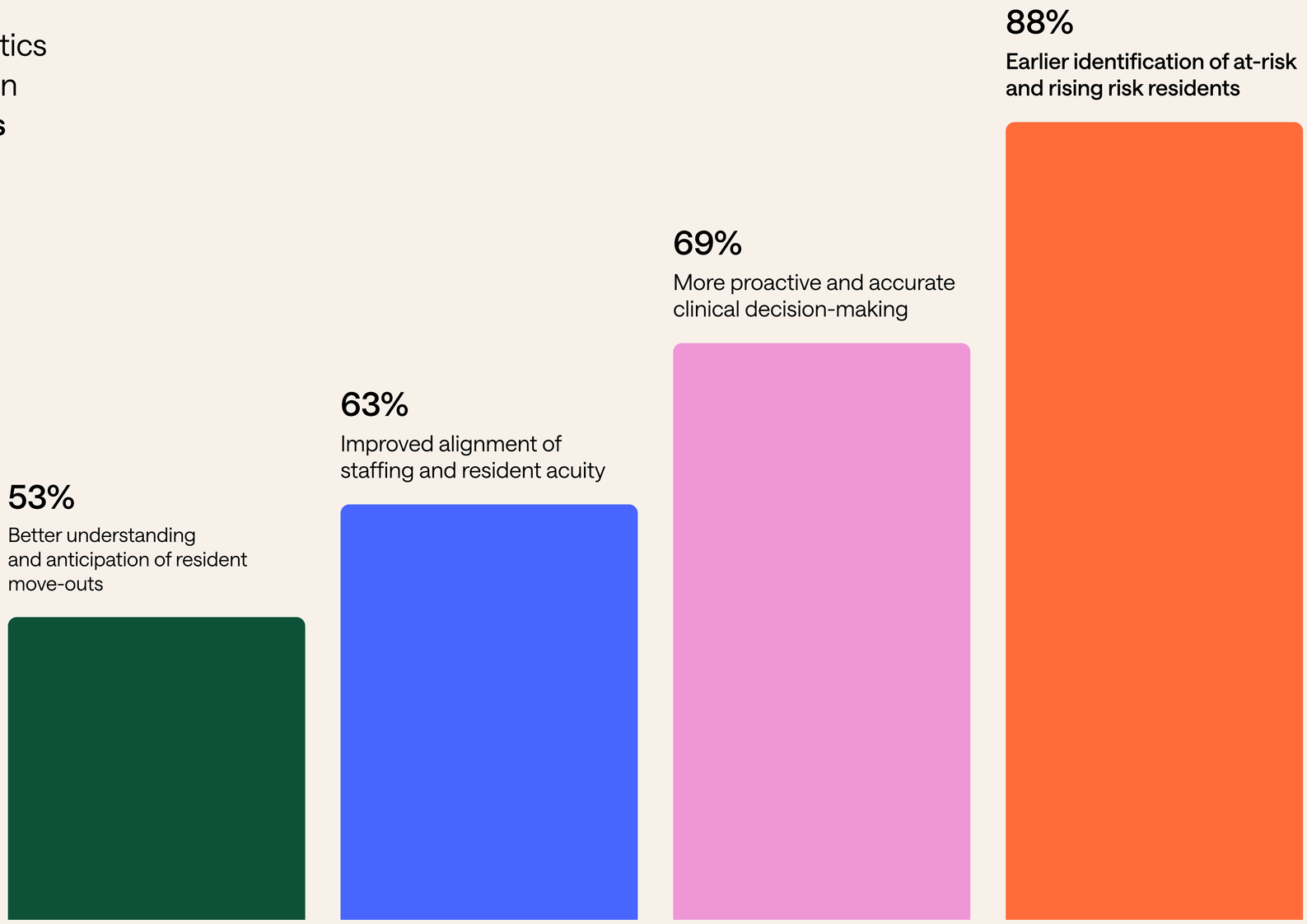


- **15%** Yes, fully implemented
- **21%** Yes, in pilot
- **46%** Not yet, but interested
- **19%** No, have not considered or chose not to, or other

"Operational data has historically been readily accessible while clinical data has been harder to capture. In many companies, nurses are still hand counting monthly data around clinical indicators."

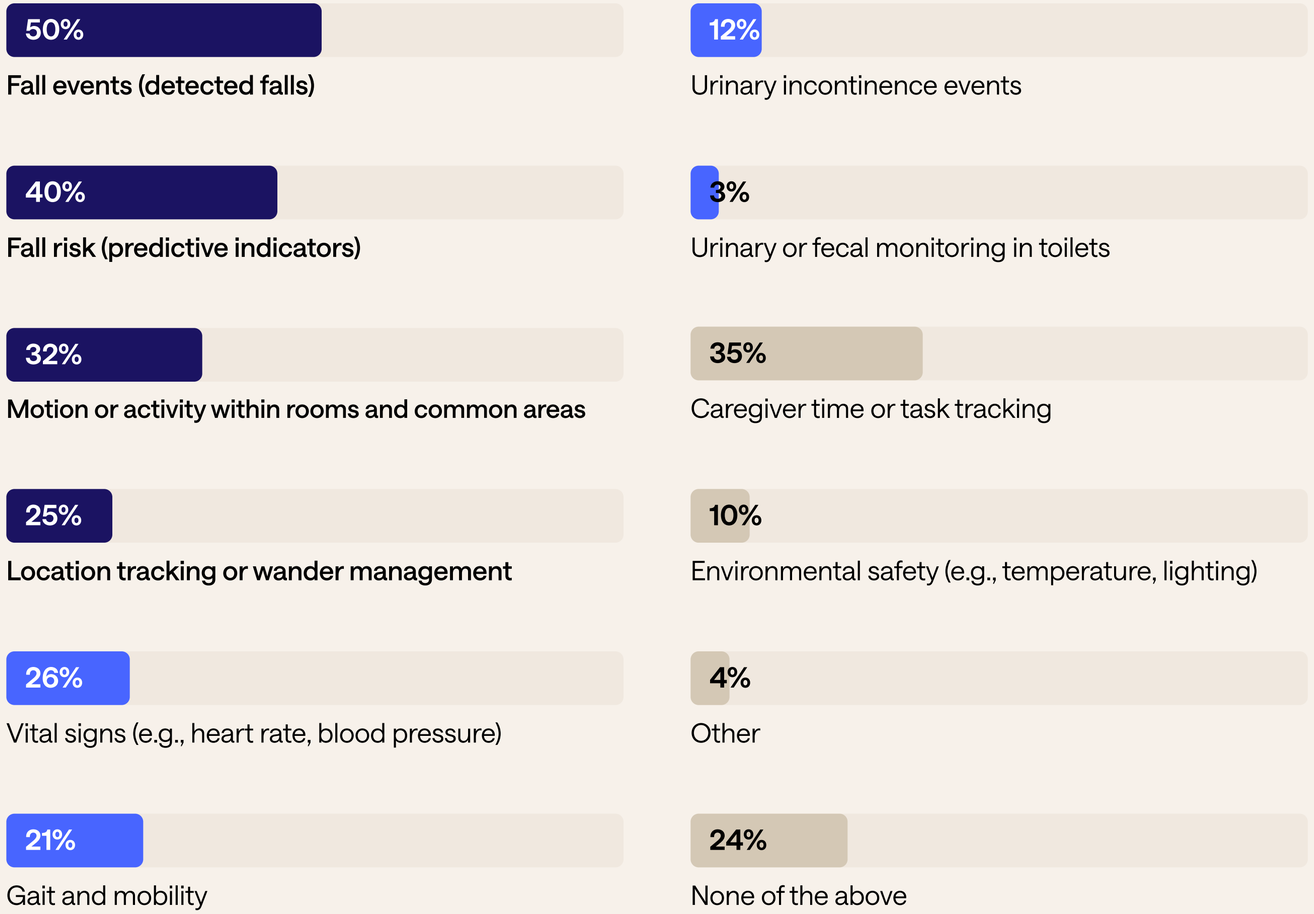
Lynn Chalk
VP of Clinical Services, MBK Senior Living

When asked about the benefits of predictive analytics and AI, respondents largely recognize that both can allow them to **more easily identify at-risk residents and unlock proactive care.**



Communities are primarily **using passive sensors to monitor falls and resident movements**, with slower adoption for bodily functions and vital signs.

**Respondents asked to select all that apply*



> I’ve been in this field for 20 years and in my experience, assisted living tends to be behind on adopting new technologies. With fall detection and fall prevention technology, more people are starting to move forward with it but it took a long time for companies to see the benefit of the investment.

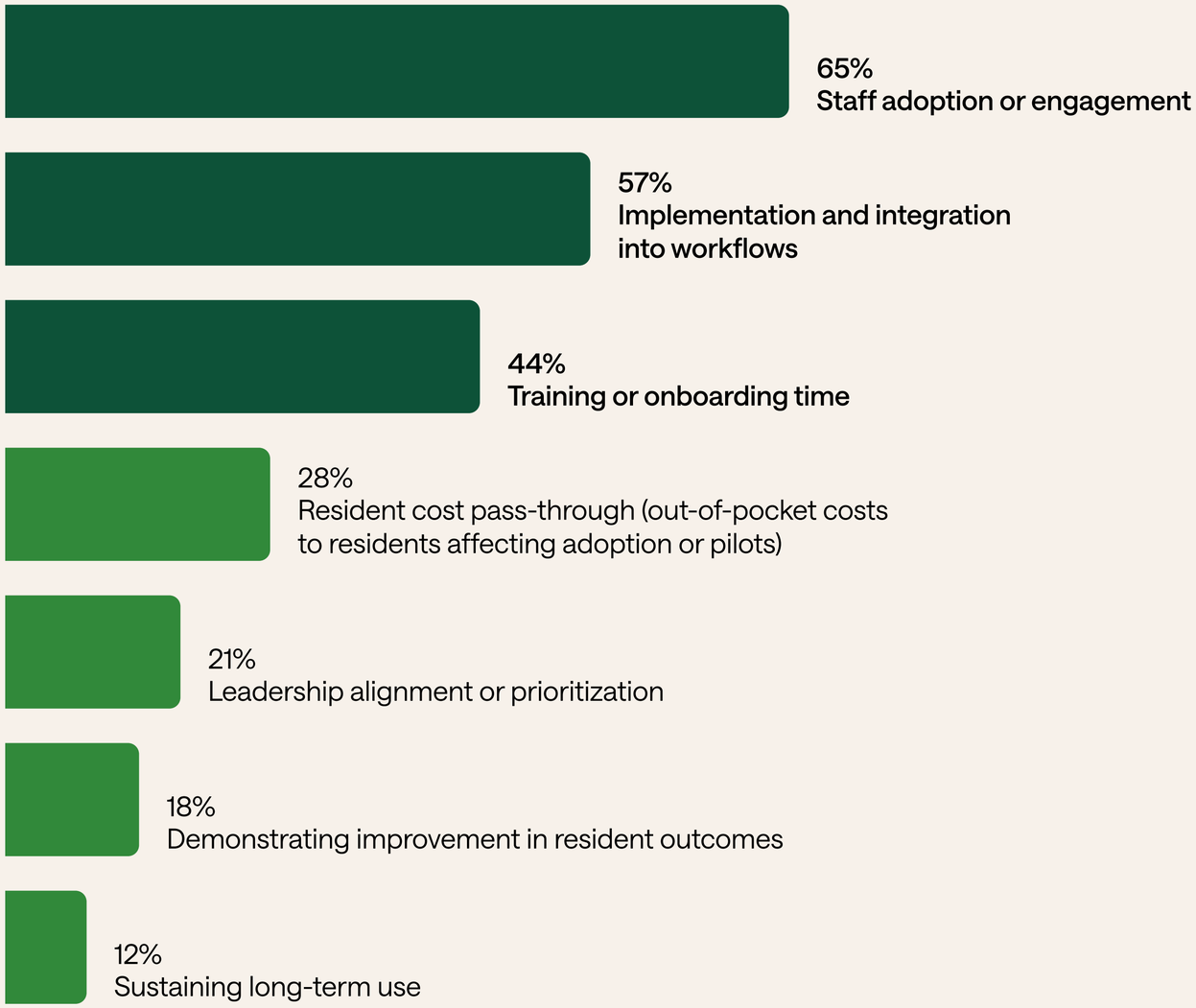
Lynn Chalk
VP of Clinical Services, MBK Senior Living

INSIGHT 5

Effective change management remains a major barrier to improving clinical workflows and care.

While there's a clear desire to move to better tools and systems, many clinical leaders face difficulties in implementing those changes. Challenges around staff engagement and training are among the most common challenges, while other respondents cited difficulty quantifying ROI in clinical care, particularly to the C-suite or a board.

Time-consuming trainings and a lack of stickiness are among the top 3 barriers to adopting new technologies.

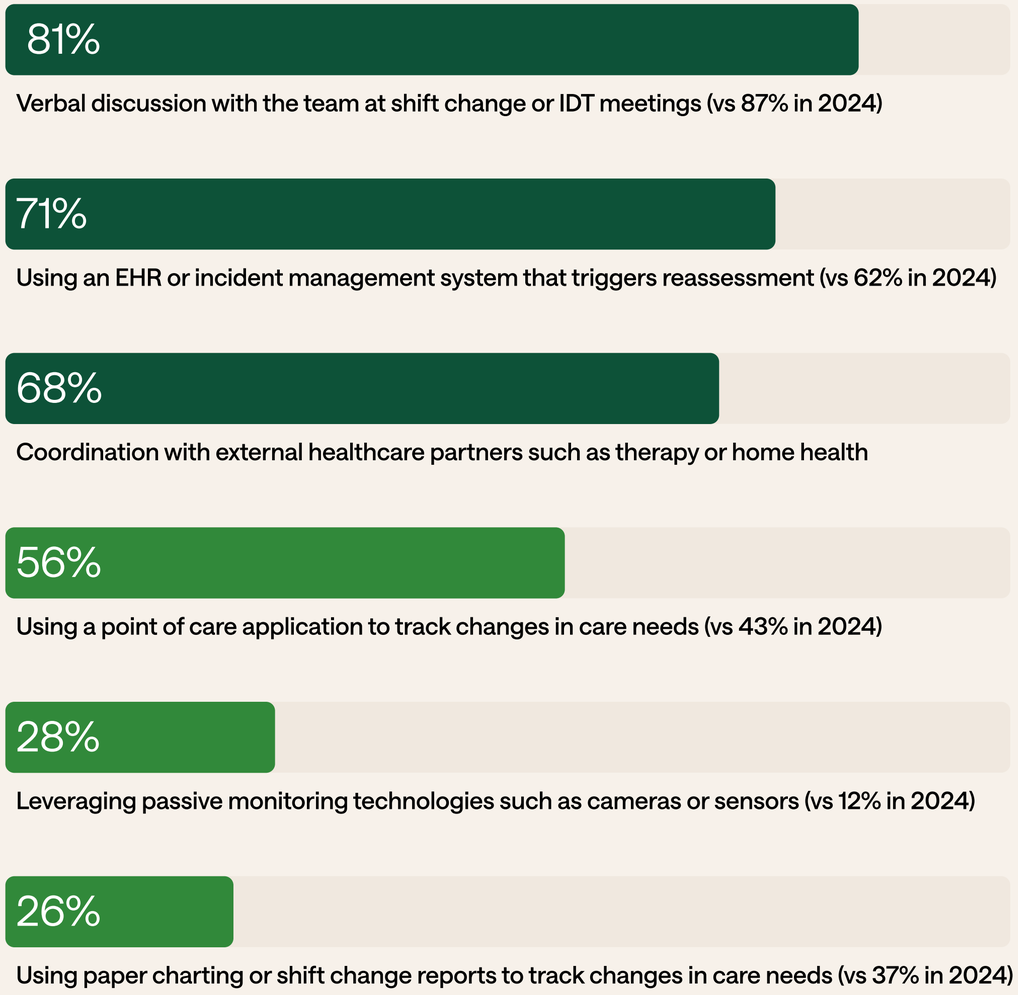


> Explaining the “why” behind a decision matters, but you also need to ensure that **there’s some methodology for project management**. There’s so much nurturing that needs to happen on the backend.

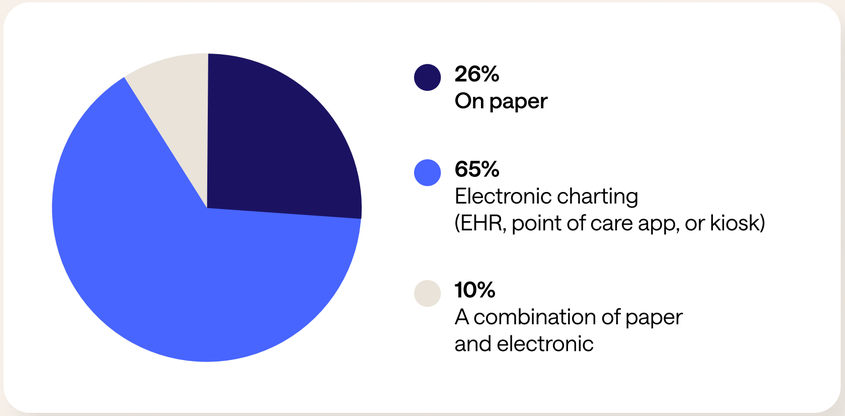
Jennifer Hellbusch
VP of Health Services, Heritage Communities

More communities are monitoring change in condition via **passive monitoring and point of care apps**, while fewer are relying on paper charting (compared to 2024).

**Respondents asked to select all that apply*



At the same time, **one-quarter of communities still rely on paper charting.**



“

Paper documentation doesn’t allow you to capture everything that happens during a shift. Things like extra showers become routine, so when caregivers are asked about changes, they don’t think of that as a change [...] They just think of it as being part of their standard care for that resident.

Gloria Hughes
Chief Operations Officer, GenCare Lifestyle

IN CONCLUSION

Clinical leaders are pushing toward proactive care, but fragmented data holds them back.

Clinical leaders are navigating unprecedented complexity with rising acuity, evolving care models, and mounting operational pressures. **But most are doing so without the data infrastructure necessary to drive meaningful change.**

While the industry recognizes that better tools and analytics are essential for value-based care readiness and proactive decision-making, adoption isn't sticking, hampered by integration challenges and resource constraints.

The path forward requires more than incremental improvements. It demands a fundamental shift in how we capture, analyze, and act on clinical data. Only then can clinical leaders move from reactive problem-solving to the strategic, data-informed leadership that senior living's next chapter demands.

"I want to see the industry shift toward a focus on data and analytics, but buy-in isn't always there and teams are slow to leave behind paper processes."

"Our role requires emotional intelligence, leadership, and systems thinking, not just clinical expertise. When recognized as whole-community leaders rather than just clinical task managers, we are able to drive better clinical outcomes and stronger business performance."

"My role directly influences quality of care, staffing models, and operational outcomes. Integrated data would allow for better forecasting and collaboration between Clinical and Finance."

"Our biggest challenge is overlapping priorities around clinical excellence, hospitality, and wellness in care settings that have traditionally adhered to a medical model."

"We need better resident risk data to drive early interventions and prevent hospitalizations."

"Nurses are not a cost center, they're a core value driver and the reason residents choose our communities"

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Appendix

2025

The State of Senior Living
Clinical Leadership Survey

1

What title best describes your current role?

ANSWERS	RESPONSES	
Chief Clinical Officer (or equivalent)	13.24%	9
Senior Vice President or Vice President of Clinical (or equivalent)	39.71%	27
Regional Vice President or Regional Director of Clinical (or equivalent)	14.71%	10
Senior Director or Director of Clinical (or equivalent)	14.71%	10
Other (please specify)	17.65%	12

OTHER

Managing Director of Wellness Integration	Internal Audit
Wellness Director (x5)	Resident Care Director
Adon	Director of Clinical Operations
Medical Records	Chief Operating Officer
Wellness Specialist for a Region	

2

How many residents are being cared for across all of your operator's communities, excluding Independent Living?

ANSWERS	RESPONSES	
1–500 residents	26.47%	18
501–1000 residents	13.24%	9
1001–2500 residents	22.06%	15
2501–5000 residents	26.47%	18
5001+ residents	11.76%	8

3

Which care levels are represented in your communities? (Select all that apply)

ANSWERS	RESPONSES	
Assisted Living	98.53%	67
Memory Care	94.12%	64
Independent Living	82.35%	56
Active Adult	10.29%	7
Skilled Nursing	19.12%	13
CCRC	13.24%	9

4

As an organization, how would you describe the overall acuity profile of your residents?

ANSWERS	RESPONSES	
Low acuity	4.41%	3
Moderate acuity	55.88%	38
High acuity	5.88%	4
Variable by community	33.82%	23

5

Is there anything you wish the industry better understood about the role of clinical leaders in senior living?

The following is a selection of write-in responses that offer the most robust detail and context. Responses have been lightly edited for clarity.

ANSWERS

Many nurses in senior living are promoted into leadership roles without ever receiving true leadership training. They're expected to be experts in everything from falls and infection control to team culture and financial performance. The reality is that most are highly capable but underdeveloped as leaders. Clinical leadership in senior living demands more than technical skill; it requires the ability to influence, educate, and drive outcomes across every part of the organization. The industry must invest in developing these leaders if it wants sustainable, high-quality care.

I want to highlight changes in the industry with shifts in data, analytics, value-based care, etc., but buy-in from department heads and line staff isn't always there and teams are slow to leave behind paper processes and embrace change.

I think the overlapping priorities of clinical excellence, hospitality, and wellness in care settings that have traditionally practiced in a medical model is challenging.

Clinical services have changed over the past 5–10 years. We can no longer run them as we have in the past. Residents are more acute, families are more demanding and educated, we have fewer licensed nurses, regulations have increased, census pressure is greater than ever, and managing risk is more demanding.

Clinical care extends far beyond medication management. It requires critical thinking, communication, and regulatory expertise. Nurses are not a cost center, they are a core value driver and the reason residents choose our communities.

Understand that a nurse is not necessarily a clinical leader. Clinical leadership requires integrity, resilience, strategic and operational skills, team building, and the ability to interpret data and drive change.

[I wish more people recognized] the breadth and depth of the responsibilities and knowledge required to be successful. The ongoing changes in the industry related to technology require us to adapt quickly.

5 CONTINUED

Is there anything you wish the industry better understood about the role of clinical leaders in senior living?

The following is a selection of write-in responses that offer the most robust detail and context. Responses have been lightly edited for clarity.

ANSWERS, CONTINUED

I believe it's important for our industry to recognize how the rising costs of supplies, utilities, and overall cost of living directly affect staff morale and retention. Many employees are now forced to work multiple jobs simply to meet basic needs, which impacts their well-being and capacity to serve. Healthcare—particularly memory care—demands exceptional skill, compassion, and critical thinking to ensure residents receive the quality of life they deserve. Yet wage growth for nursing and caregiving staff has not kept pace with increases in the minimum wage, cost of living, or level of expertise required in this field. Addressing this disparity is essential for sustaining a committed, skilled workforce.

Clinical leaders are strategic not just operational. They manage care tasks and respond to emergencies. Staffing and retention are clinical issues. We are often expected to solve care delivery problems without influence over staffing models or schedules, which leads to poor clinical outcomes due to understaffing. The emotional and ethical load is real. We carry the burden of supporting residents through decline and death, counseling families through difficult decisions, and mediating between corporate expectations and frontline realities. We are the operational leaders, strategic advisors, risk managers, and ethical stewards that the industry needs to empower and recognize for communities to thrive.

[I wish more people understood] that clinical leaders are the linchpin between Wellness, Ops, and Culture. Not only do we need to completely understand the regulatory compliance piece, but we also need to be strategic partners in bridging the gap between programming and healthcare. Our role requires emotional intelligence, leadership, and systems thinking, not just clinical expertise. When recognized as whole-community leaders rather than just clinical task managers, we are able to drive better clinical outcomes and stronger business performance.

6

What are the most significant challenges you are currently working to address? (Select up to 3 answers)

ANSWERS	RESPONSES	
Improving staff quality through training and upskilling	64.71%	44
Hiring or retaining staff	58.82%	40
Addressing increasing resident acuity	29.41%	14
Adopting or improving clinical analytics and implementing into care operations	27.94%	19
Adopting or updating technology to improve resident wellness	23.53%	16
Maintaining regulatory compliance	22.06%	15
Managing resident family expectations and communication	22.06%	15
Accurately tracking resident care needs and associated costs of care	19.12%	13
Expanding partnerships with healthcare providers	10.29%	7
Other (please specify)	7.35%	5
Expanding number of licensed staff in the community	4.41%	3

6

What are the most significant challenges you are currently working to address? (Select up to 3 answers)

A selection of written responses

OTHER

Managing new acquisitions without the support team to be successful

For addressing staff acuity. The common problem I see is moving in higher acuity but operational leadership fearful to assess/charge families.

Census

Restructuring orientation and staff training or continued education.

Cleaning our EHR platform to more closely match our ERP - disjointed as of now.

7

What do you wish you could do more of to improve resident care? (Select up to 3 answers)

ANSWERS	RESPONSES	
Improving workplace culture, staff satisfaction, and staff retention	66.18%	45
Tracking and taking action on data-driven dashboards of high-risk residents	52.94%	36
Implementing evidence-based clinical programs and protocols across communities	38.24%	26
Adjusting care team staffing model	45.59%	31
Adopting new resident health and safety monitoring technology (e.g., sensors or cameras)	35.29%	24
Integrating onsite primary care and/or therapy services	20.59%	14
Other (please specify)	5.88%	4

OTHER

In-community geri-psych care (huge need in MC settings)
Realize that we also have to look at people not just numbers
More staff technology, technology use for caregiver ADL charting vs. paper used at this current time
Staff retention, stopping "its not my job/resident"

8

How have staffing models in your communities changed in recent years? (Select all that apply)

ANSWERS	RESPONSES	
Added more caregivers	42.65%	29
Expanded role of med techs	38.24%	26
Added more med techs	32.35%	22
Other (please specify)	29.41%	20
Added more licensed nurses on staff	27.94%	19
Added more administrative staff (e.g., assistants, clerical)	19.12%	13
Added more ancillary staff (e.g., housekeeping, maintenance)	11.76%	8

8

How have staffing models in your communities changed in recent years? (Select all that apply)

A selection of written responses

OTHER

Decreased use of LVNs in the communities and at a regional level
Staff reduction every year in budget
Currently census challenged, which make staffing models difficult
Staffing needs are greater than ever. Hiring nurses and caregivers that have skills
Restructuring orientation and staff education/training, increasing use of technology within the community - lack of technology available (laptops/computers/tablets/etc.) to drive the increased tech driven models.
There hasn't been much advancement in more care staff.
Elimination of "floor" nurses that previously supported nurses in leadership

9

What is the most impactful change your organization has made to improve clinical care?

The following is a selection of write-in responses that offer the most robust detail and context. Responses have been lightly edited for clarity.

ANSWERS

Implementation of clinical dashboard to track essential operational and clinical systems. The expectation is that regional support is able to work directly with community teams to discover barriers and apply the appropriate interventions or systems.

We standardized documentation and decreased the amount of time it takes to complete documentation.

We implemented a comprehensive electronic health and billing record across our portfolio, replacing three other systems with one

Integrating pharmacy with our EHR software and adopting a VBC model.

We eliminated our staffing agency, increased base wages, and added healthcare partnerships.

The most impactful change I see is our organization striving to improve clinical care through regular clinical leadership training and integrating technology within communities to streamline processes, reduce waste, and provide a clearer picture with data-driven analytics.

The most impactful change we've made is reframing clinical care through a proactive wellness lens. Instead of seeing clinical only as compliance and illness management, we integrated our wellness model into nursing leadership, aligning care plans with nutrition, movement, cognitive health, and social engagement. This has improved early identification of resident risks, reduced hospital transfers, and increased resident vitality. By embedding our nurses as partners in Sales, Operations, and Wellness, we've shifted clinical care from a siloed function to a driver of outcomes, trust, and occupancy.

9

What is the most impactful change your organization has made to improve clinical care?

The following is a selection of write-in responses that offer the most robust detail and context. Responses have been lightly edited for clarity.

ANSWERS, CONTINUED

We implemented AI tools and are focused on obtaining data to inform decisions as an organization. We're focused on onboarding and orientation roadmaps with a new learning management system to more actively engage associates. We're also working with partner vendors to support improved clinical outcomes.

We added clinical indicators to monthly reporting.

Our staffing is more consistent and we're changing our EHR to improve workflows and reduce time previously spent using paper and generating reports manually.

10

In the last 5 years, how has the resident acuity level that your organization is willing to accept changed?

ANSWERS	RESPONSES	
Increased significantly	23.53%	16
Increased somewhat	50.00%	34
Stayed the same	17.65%	12
Decreased somewhat	5.88%	4
Decreased significantly	0.00%	0
Not sure	2.94%	22

11

How do your communities capture resident change of condition in a timely way? (Select all that apply)

ANSWERS	RESPONSES	
Verbal discussion with the team at shift change or IDT meetings	80.88%	55
Using an EHR alert charting or incident management system that triggers reassessment	70.59%	48
Coordination with external healthcare partners such as therapy or home health	67.65%	46
Using a point of care application to track changes in care needs	55.88%	38
Leveraging passive monitoring technologies such as cameras or sensors	27.94%	19
Using paper charting or shift change reports to track changes in care needs	26.47%	18
Other (please specify)	5.88%	4

11

How do your communities capture resident change of condition in a timely way? (Select all that apply)

A selection of written responses

ANSWERS

A proactive care model and integrating healthcare into communities

Varies by Region - paper trails are retained in our ERP system by resident. Our EHR is meant to be the sole tracker, eventually.

Staff reporting up to DON and/or ED

I feel there is still a lot of need in this area! COC evals don't get updated as needed.

12

Do you believe that resident acuity according to assessment data in your communities is lower than the actual resident acuity?

ANSWERS	RESPONSES	
Yes, frequently	27.94%	19
Yes, occasionally	35.29%	24
Rarely	26.47%	18
Never	1.47%	1
I'm not sure	8.82%	6

13

If yes, what do you believe is the primary reason that documented acuity is lower than actual acuity?

ANSWERS	RESPONSES	
Assessments are not updated on time	23.64%	13
Intentionally under-scoring of assessments by staff to manage care rates	18.18%	10
Other (please specify)	14.55%	8
PRN care services are provided but are not triggering reassessments	12.73%	7
Technology or system limitations	10.91%	6
Training or knowledge gaps among staff	9.09%	5
Operational staffing constraints	7.27%	4
Assessments take too long to complete	1.82%	1
Limited visibility into resident condition changes between assessments	1.82%	1

13

If yes, what do you believe is the primary reason that documented acuity is lower than actual acuity?

A selection of written responses

ANSWERS

CBA Audit tool provides faster insights into actual care delivery that is higher than the assessment, and it takes more time to update the assessment to officially capture the care

Because we have such long term residents as well as many long term team members, I believe they do not fully recognize the changes in residents have actually increased their acuity.

This is rare I believe when assessment done appropriately

The human factor comes it where the clinical manager may be concern of reflecting the increased acuity may increase the resident's costs.

Limited visibility entry assessment and family budgets

Assessments are not written in a way that all nurses would agree how to score. Different nurses understand the assessment differently.
We need assessments that are objective and don't have so much subjectivity. It is from a different era to leave so much to nursing judgement.

14

To what extent do you use assessment point totals or care levels to inform your staffing model?

ANSWERS	RESPONSES	
It is a major factor in informing our staffing model	50.00%	34
It is a minor factor in informing our staffing model	22.06%	15
It is not a factor in informing our staffing model	19.12%	13
Other (please specify)	8.82%	6

OTHER

It is increasing

Points are leveraged in our budgeting process and less impactful on how we determine staffing.

I determined this budget season that finance and operations speak that level of care will assist with staffing however when showing them the needs, they continue to push back related to staffing models. At this point, it does not appear that care levels are supported unless they support reducing staff.

It is designed to inform our staffing model but is often ignored in favor of budget

We review our acuity based on care points and compare that to our staffing prd

It is not a factor for corporate, but it does factor into my decisions

15

Describe your practices around ADL and care task charting

ANSWERS	RESPONSES	
Our caregivers generally sign off on every care task and ADL	64.71%	44
Our caregivers sign off on some care tasks and ADLs (e.g., showers only)	11.76%	8
Our caregivers only chart-by-exception (e.g., resident refused care)	11.76%	8
Our caregivers do not chart, they verbally report exceptions to a supervisor	8.82%	6
Other (please specify)	2.94%	2

OTHER

This varies state to state. We do active documentation where required and chart by exception where it is not.

Paper task sheets completed daily

16

How is caregiver charting of ADLs or care tasks typically completed in your community? (Select all that apply)

ANSWERS	RESPONSES	
Electronic charting (EHR, point of care app, or kiosk)	64.71%	44
On paper	26.47%	18
A combination of paper and electronic	10.29%	7
Other (please specify)	5.88%	4

OTHER

We are moving to care-giver charting
Verbal
The system is still being developed.
Caregivers do not chart ADLs

17

Who is permitted to add narrative or descriptive notes into your EHR? (Select one)

ANSWERS	RESPONSES	
Med techs and above	44.12%	30
All caregivers are permitted	27.94%	19
Other (please specify)	14.71%	10
Directors and above	13.24%	9

17

Who is permitted to add narrative or descriptive notes into your EHR? (Select one)

A selection of written responses

ANSWERS

Licensed nurses

All caregivers are permitted. Med techs and above can enter nurse's notes, which are part of the legal medical record. Caregivers can enter narrative clinical alerts, which are not part of the legal medical record.

nursing

All licensed staff

Nurses and SOME med techs

Directors and med techs

Nursing and above

Licensed nurses only. Med techs not used in this community at this time.

Licensed Nursing and Directors

Unsure

18

Does your clinical team perform medication reviews for residents with polypharmacy and call the pharmacists or prescribers to provide input?

ANSWERS	RESPONSES	
We don't do enough med reviews for polypharmacy. We should do more.	38.24%	26
We do an adequate job.	25.00%	17
Medication review for polypharmacy is not our job. It should be done by the doctors and pharmacists.	22.06%	15
Other (please specify)	14.71%	10
We spend too much time on med reviews for polypharmacy.	0.00%	0

18

Does your clinical team perform medication reviews for residents with polypharmacy and call the pharmacists or prescribers to provide input?

A selection of written responses

ANSWERS

We work with our pharmacy partners in reviewing polypharmacy.

Our pharmacies do quarterly reviews that provide recommendations and we send to provider as recommendations.

rely on pharmacy & doctors too much, lack of staff knowlege

Pharmacy monitors for polypharmacy and recommends reductions.

in collaboration with primary care

Our pharmacy provides quarterly reviews

Our pharmacy completes these reviews quarterly

In a transitioning phase; varies by region

The Wellness Director and the Lead Med Tech

We will encourage a review from the pharmacy or prescriber if we feel it is needed.

19

Which of the following healthcare programs have you integrated into your clinical care or clinical partnership model? (Select all that apply)

ANSWERS	RESPONSES	
Preferred external partnerships (e.g., PT/OT, hospice, home health)	70.59%	48
Preferred Primary Care Provider (PCP) partnership (no ownership)	69.12%	47
The GUIDE Model (CMS dementia care program)	25.00%	17
Medicare Advantage Plan Partnership (MA Plan)	20.59%	14
Accountable Care Organization (ACO)	19.12%	13
Remote Patient Monitoring (RPM)	16.18%	11
None of the above	14.71%	10
Chronic Care Management (CCM)	8.82%	6
Medicare Shared Savings Program (MSSP)	5.88%	4
Owned or partially owned Primary Care Group	5.88%	4
Special Needs Plan (IE-SNP, I-SNP, D-SNP, C-SNP)	4.41%	3
Other (please specify)	4.41%	3
Remote Therapy Monitoring (RTM)	1.47%	1

19

Which of the following healthcare programs have you integrated into your clinical care or clinical partnership model?

A selection of written responses

ANSWERS

Principal Care Management (PCM)

Dental and Podiatry

Use of onsite primary care for around 50% of in-house residents

20

What action(s) is your organization currently taking to prepare for value-based care models? (Select all that apply)

ANSWERS	RESPONSES	
Strengthening partnerships with primary care, therapy, or hospice	73.53%	50
Increasing consistency in care documentation and/or acuity tracking	58.82%	40
Investing in internal dashboards to track quality metrics	45.59%	31
Implementing VBC-enablement technology platforms (e.g., EHRs, analytics, fall prevention, etc.)	45.59%	31
Piloting new staffing models or workflows	19.12%	13
No specific preparation at this time	13.24%	9
Leveraging fully or partially-owned primary care, therapy, or hospice providers	11.76%	8
Developing risk-based contracting capabilities	11.76%	8
Other (please specify)	4.41%	3

20

What action(s) is your organization currently taking to prepare for value-based care models? (Select all that apply)

ANSWERS

Research

EHR Platform

Currently using VBC in select communities with the intent to roll out company wide

21

Which of the following best describes your organization's value-based care readiness, specifically with regards to contracting with a preferred health plan and establishing financial incentives around quality or cost of care?

ANSWERS	RESPONSES	
We are actively operating within a value-based care system	30.88%	21
We are in the process of joining a value-based care system	16.18%	11
We are evaluating opportunities to join a value-based care system	16.18%	11
We are not yet evaluating opportunities to join a value-based care system but plan to do so in the future	14.71%	10
We have no plans to operate within a value-based care system	22.06%	15

22

If you are actively involved in a value-based care partnership, which of the following best describes the nature of the arrangement?

ANSWERS	RESPONSES	
Contractual relationship for services only with no financial risk	52.63%	20
Contractual relationship for services and financial risk-sharing	18.42%	7
Co-owner of a VBC plan with shared financial risk	5.26%	2
Full ownership of a VBC plan with full financial responsibility	0.00%	0
Other (please specify)	23.68%	9

OTHER

Shared savings plan, but there is no financial risk to us.

Wellness care given and help with pcp and HH and hospice help for all residents

Not involved in VBCP at this time

Not applicable.

23

Which of the following metrics are readily accessible to you? (Select all that apply)

ANSWERS	RESPONSES	
Occupancy	88.24%	60
Reason for move-out	76.47%	52
Incident rates	76.47%	52
Length of stay	72.06%	49
ER or hospitalization rates	61.76%	42
Community-wide resident acuity	57.35%	39
High-risk or rising risk resident report	48.53%	33
Exception reasons	47.06%	32
Frequent PRN services	47.06%	32
Polypharmacy	39.71%	27
None of the above	1.47%	1

24

What types of clinical decisions are you making that would benefit from data or more data?

The following is a selection of write-in responses that offer the most robust detail and context. Responses have been lightly edited for clarity.

ANSWERS

Decisions around staffing, fall prevention, and care plan effectiveness would benefit most from stronger data. Having real-time insights into trends like time of day, location, and contributing factors helps transform reactive responses into proactive interventions. Data drives better coaching, resource allocation, and safer outcomes for residents.

Prediction of changes in condition and move-outs based on key factors such as diagnoses, medication changes, falls, hospitalization history, etc.

Fall management, behavior management, weight and diet management, and care levels.

More confidence that data is accurate, incident rates, diagnosis specifics for enhanced focus, and ER/hospitalization rates.

My role involves decisions that directly influence quality of care, staffing models, and operational outcomes. Enhanced access to integrated data would allow for proactive trend analysis, better forecasting, and stronger collaboration between clinical and financial leadership teams.

We need better resident risk data to drive early intervention and prevent hospitalizations.

Using AI agents to synthesize all of our data to predict decline in condition and/or hospitalization and move outs.

24 CONTINUED

What types of clinical decisions are you making that would benefit from data or more data?

The following is a selection of write-in responses that offer the most robust detail and context. Responses have been lightly edited for clarity.

ANSWERS, CONTINUED

Would love EHRs for senior living to push forward and assign a risk score for residents based on clinical KPIs.

Identifying risk metrics and tying them back to documentation and reassessments.

Our clinical leaders would benefit from richer real-time data on resident health trends and engagement. Decisions around fall prevention, medication management, hydration, weight changes, and early identification of decline are often made using fragmented information. More integrated data would allow us to proactively tailor care plans, intervene before hospitalizations, and connect clinical outcomes to wellness and lifestyle programming. We also need better data to evaluate staffing patterns, acuity shifts, and the impact of interventions on resident outcomes and business performance.

25

Are you using predictive analytics or AI-driven alerts in your clinical workflows to identify rising risk or high-risk residents?

ANSWERS	RESPONSES	
Yes, fully implemented	14.71%	10
Yes, in pilot	20.59%	14
Not yet, but interested	45.59%	31
No, have not considered	11.76%	8
No, considered but chose not to	1.47%	1
Other (please specify)	5.88%	4

OTHER

We will be once we implement a new EHR

In our EHR there is a section in the insights that show if a resident is at risk.

Not sure

Use of AI tools only in MS, looking to expand to all residents.

26

What do you see as the most valuable outcome of using predictive analytics or AI-driven alerts? (Select all that apply)

ANSWERS	RESPONSES	
Earlier identification of at-risk and rising risk residents	88.24%	60
More proactive and accurate clinical decision-making	69.12%	47
Improved alignment of staffing and resident acuity	63.24%	43
Better understanding and anticipation of resident move-outs	52.94%	36
Other (please specify)	7.35%	5

OTHER

Earlier and more directed conversations with family

Financial/operational alignment. Using predictive analytics to connect clinical outcomes with occupancy, length of stay, and ROI

Have not looked into AI

Actionable next steps for team members vs data they cannot impact in their role

27

Are you leveraging passive sensors to determine any of the following? (Select all that apply)

ANSWERS	RESPONSES	
Fall events (detected falls)	50.00%	34
Fall risk (predictive indicators)	48.53%	33
Caregiver time or task tracking	35.29%	24
Motion or activity within rooms and common areas	32.35%	22
Vital signs (e.g., heart rate, blood pressure)	26.47%	18
Location tracking or wander management	25.00%	17
None of the above	23.53%	16
Gait and mobility	20.59%	14
Urinary incontinence events	11.76%	8
Environmental safety (e.g., temperature, lighting)	10.29%	7
Other (please specify)	4.41%	3
Urinary or fecal monitoring in toilets	2.94%	2

27

Are you leveraging passive sensors to determine any of the following? (Select all that apply)

OTHER

Working with client now to implement passive sensor monitoring

Pilots at 2 communities

GUIDE program implementation of bed pad monitoring (sleep tracking, etc) in progress

August

28

What are typically your biggest challenges when introducing new technology or tools? (Select up to 3 answers)

ANSWERS	RESPONSES	
Staff adoption or engagement	64.71%	44
Implementation and integration into workflows	57.35%	39
Training or onboarding time	44.12%	30
Resident cost pass-through (out-of-pocket costs to residents affecting adoption or pilots)	27.94%	19
Leadership alignment or prioritization	20.59%	14
Demonstrating improvement in resident outcomes	17.65%	12
Sustaining long-term use	11.76%	8
Other (please specify)	5.88%	4

28

What are typically your biggest challenges when introducing new technology or tools? (Select up to 3 answers)

A selection of written responses

OTHER

Finding devices that caregivers can keep on them that all tech can be loaded on and works together. We expect caregivers to still carry too many devices. Also senior leaders can't make a decision about what to adopt.

Getting capital partner to support costs

Enough information given to families for them to research prior to implantation