Medical Transfers of Assisted Living Residents: Analysis of Outcomes

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Aging in place. This phrase has come to be synonymous with assisted living. Yet, the complexity of assisted living residents and the level of care that often is required for these individuals call for systems and processes that enable staff to promptly identify problems and acute condition changes, determine when a hospital or emergency department transfer is necessary, and protect residents' health and safety while respecting their preferences and wishes.

There is a plethora of decisions, policies, and communiqués necessary to make sure that transfer decisions are made in a way that best serves the residents. By conducting an analysis of outcome, as one facility did, it becomes clearer what works and where changes may be beneficial.

Start with a Profile of AL Residents

The typical resident of AL is a single, divorced, or widowed female over 80 years old.[1] A recent hospitalization, fall at home, or spouse's death may precipitate her looking into moving from her own home or other independent setting to an ALF.

A recent report from the Centers for Disease Control and Prevention (CDC) on the health of people over 65 years of age highlighted the multiple chronic illnesses common in older adults (see Figure 1); so it is likely that AL residents have one or more of these conditions—including heart disease, hypertension, and arthritic symptoms. Debilitating conditions such as diabetes, stroke, and respiratory conditions often are contributing factors for elderly individuals considering a move to AL.

In addition to other health problems, a recent study indicated that half of the residents living in AL have some form of memory/cognitive impairment and 25% suffer from depression.[2] Depending on how severe they are, these conditions can significantly affect residents' safety and contribute to other illnesses or conditions.

Put together, the multiple chronic illnesses, including mental changes such as dementia and depression, and advanced age are predictors of continued decline once residents enter an ALF.

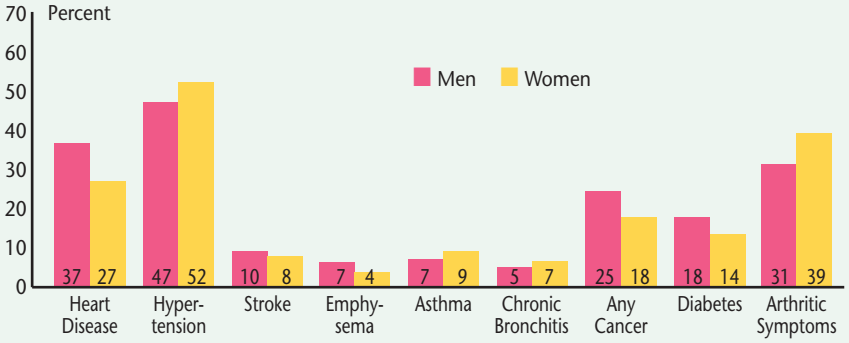
Decisions, Decisions: When to Go Where

As the public becomes more educated about senior living options, fewer people are willing to reside for long periods in a nursing home. Instead, seniors, their adult children, and other designated decision makers are looking to naturally occurring retirement communities,

adult day care, retirement communities, and assisted living facilities as alternatives to the traditional nursing facility (NF). However, it isn't just the well, highly functioning, and cognitively intact seniors that are choosing options beyond NFs. Increasingly, elders with comorbid illnesses, multiple prescriptions, and varying levels of cognitive impairment are entering ALFs, with the expectation that they will stay there for the remainder of their lives. These decisions have an impact on the ALF staff as frailer and more medically complex residents move into AL residences.

Managing the diversity and multiplicity of health problems in AL residents is an industry-wide challenge. AL staff increasingly looks to facility leadership and clinicians—such as physicians, pharmacists, nurse practitioners, and others—to help keep residents safe and happy.

Figure 1. Percentage of People Age 65 and Over Who Reported Having Selected Chronic Conditions, by Sex, 2001-2003



Note: Data are based on a 2-year average from 2001-2002. Data for arthritic symptoms are from 200-2001.
Reference population: These data refer to the civilian noninstitutionalized population.
Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

What Influences Transfer Decisions?

Once a person moves into an AL community, several factors influence when it is appropriate and necessary to send him or her out of the ALF for a higher level of acute care. Some of the important influencing considerations include:

- *Resident's right to age in place.* In recent years, many states have recognized that as AL residents experience health problems, they may choose to stay at the ALF to receive care and/or return to the facility after they receive care and/or rehabilitation services in a hospital or other setting. Previously, if ALF residents had an injury or illness, they would immediately go to a hospital and then transition to a skilled nursing facility (SNF), where they often would continue to reside as a long-term resident.
- *Availability and expertise of nursing and medical care onsite at the ALF.* This also affects how often a resident is sent out for hospital and emergency care. The majority of AL settings now have at least some nursing involvement. However, many only have a nurse onsite or on-call a few hours a week. Other ALFs have a more intensive nursing model and have licensed nurses onsite 24 hours a day. The extent and accessibility of direct nursing assessment and care may be an important factor in deciding when to send a resident out for more urgent or acute care.
- *Level of nursing expertise.* Some ALFs have RNs, while others use LVNs. In addition, some facilities have physician medical directors or primary care physicians who are available to come to the ALF to examine and treat residents. The level and availability of nursing and physician care will influence whether residents need to leave the premises to be examined and treated for illnesses.
- *Prior experiences with the health care system.* Some AL residents have had extensive prior inpatient experience with their local hospitals and skilled nursing facilities. When these experiences have been negative, these residents may refuse transport to hospital emergency departments or NFs.
- *Residents' end-of-life instructions.* There has been a national campaign by the CDC to educate people on the usefulness of advance health directives to detail personal preferences for end-of-life care. Recent media coverage of this issue (ie, the Terri Schiavo case in Florida) has led to increasing numbers of people who have completed explicit advance health directives or living wills addressing their wishes for end-of-life care. AL residents may have Do-Not-Hospitalize (DNH) or Do-Not-Resuscitate (DNR) orders in place. The facility needs to have these documents on file and ensure that staff checks on residents' wishes before making a transfer decision. Facility leadership and staff need to know about the possibility of providing palliative and hospice care as a resident's health declines and he or she is near death.
- *Family expectations.* Most AL residents have family members who are involved in important health care decisions. These individuals may insist that residents be transported to the hospital for all health problems and/or they may request a transfer to a skilled nursing facility when their loved one becomes acutely or terminally ill. Increasingly, AL

staff spends an extensive amount of their time communicating with residents' families regarding health status and changes, medications, physician recommendations, and other care issues.

- *Facility's perceived sense of liability if the resident is not sent to the hospital.* Some ALFs have a policy mandating that any resident who suffers a fall—even a minor one—must be sent out by ambulance to a hospital emergency department for evaluation. At the same time, however, this individual has a right to refuse hospital transfer. Other facilities have a different policy, one that calls for evaluating a resident after a fall and making a case-by-case decision about whether or not hospitalization is necessary.

ALFs must address all of these issues and considerations in determining how they will manage transfers. They also must know about residents' preferences and wishes and communicate policies and procedures to staff, clinicians, residents, and family members.

One AL Company's Experience

One assisted living company, Silverado Senior Living (SSL), has tracked clinical outcomes for many years, including data on resident discharges from their AL communities to acute care settings. These data offer some insight into the effectiveness of transfer policies and decisions.

SSL is a dementia-specialty company that includes a hospice company, home care company, and 12 assisted living communities. Because of the dementia focus, Silverado's model of nursing care in its AL communities is more intensive than many other AL environments. Each SSL location has an RN who is a full-time, onsite director of nursing, plus several LVNs on every shift. A master's level social worker (MSW) onsite is also an important part of the clinical team. Emphasis is on wellness promotion but, predictably, many of the residents have health emergencies necessitating decisions by the staff on whether to send them out for more intensive care.

Due to the extensive involvement by the nursing staff at all of the Silverado communities, as well as Silverado's specialization in dementia, clinical outcomes may vary considerably from other AL companies.

Data collected by SSL for 2004 indicated that 5.1% of its residents living in the company's AL communities were transported to hospitals for emergency evaluation at some point; and the percent of residents transported out of SSL for emergency care has decreased every year for the past five years (see Figure 2).

Fewer people are willing to reside for long term periods in a nursing home.

There are several reasons for this decline. For one, many residents and their families expressed dissatisfaction with their experiences in the hospitals and chose to be evaluated by Silverado's nurses and physicians onsite, rather than go to local hospitals. Silverado also has implemented an extensive education program for their nurses to enable them to more accurately assess residents for injuries and illnesses. As a result, most acute illnesses are assessed early by nurses, who then contact physicians. Treatment begins in the AL, usually preventing the need for hospitalization.

Of the 5.1% of Silverado's AL residents sent to hospital emergency departments for evaluation, 30% returned to SSL the same day, and 70% were admitted for inpatient hospitalization (see Figure 3). Most residents, even if they are admitted for hospitalization, return to Silverado; and over 97% of Silverado's AL residents remain onsite for the rest of their lives.

Silverado Senior Living monitors the reasons that their residents are sent out to hospitals. As indicated in Figure 4, assessment from injuries after falls is the most common reason residents went to the hospital in 2004. Eighteen percent (18%) of medical transfers were for assessment and treatment of possible fracture, and 14% were for laceration repair after a fall. Other common reasons for medical transfer included pulmonary symptoms, infections, seizures, and psychiatric evaluation.

These figures suggest the complexity of health problems that AL residents experience. As residents' health declines, there are multiple points when AL staff must make a decision

Figure 2. SSL Average Temporary Discharge Rate 2001-2004

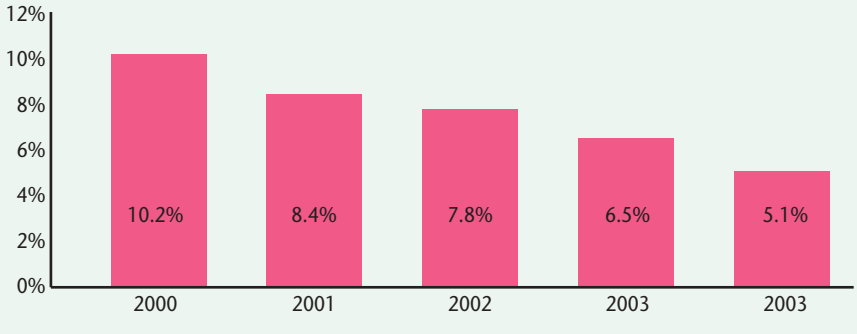


Figure 3. Silverado YTD 2004 Temporary Discharge by Location

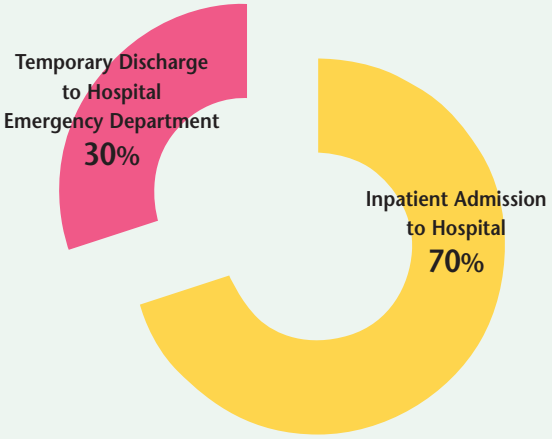
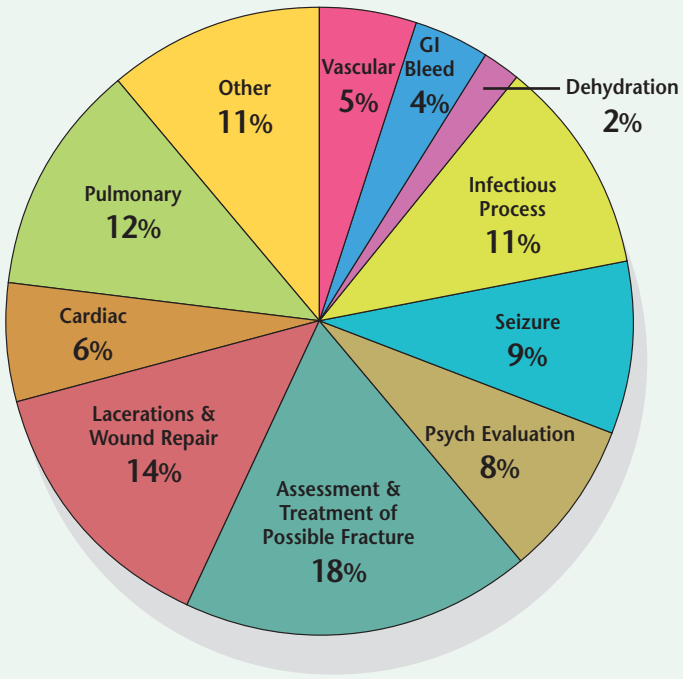


Figure 4. Silverado Senior Living 2004 Medical Transfers by Diagnosis



about when to access the health care system, while trying to balance the resident's wishes and rights.

Silverado has found the clinical data regarding medical transfers to be very useful in guiding its clinical policies and staff educational programs. Every month, extensive clinical data is sent from each of the company's 12 assisted living communities for a quality analysis. In addition to the data regarding medical transfers, other clinical outcome data that is collected includes statistics on falls, fractures, numbers and types of medications, weight loss, skin problems, deaths, and length of stay.

By analyzing this data on a regular basis, Silverado is able to identify monthly trends; and the clinical team in each of its assisted living communities is able to quickly respond to any areas of clinical change. For example, if there are increased numbers of residents with weight loss, a multidisciplinary team will meet to discuss what might be contributing to the weight changes and then implement a plan to address these concerns. Similarly, if there are increased numbers of medical discharges for infections or cardiac problems, the same team meeting would discuss the occurrences and formulate an action plan.

Conclusion

Our rapidly growing population and the lifestyle and residence choices these individuals are making bode well for the assisted living industry, as more of these elders choose ALFs as an alternative to nursing facilities or even staying in their homes. They more frequently are choosing to live—and die—in the friendly and home-like environments of assisted living. The challenge for the AL industry is to develop its wellness and health-related infrastructure to sufficiently support elderly residents throughout the last stages of their lives. One means of promoting this is to understand what residents want—and don't want—in terms of care, when transfers are appropriate and necessary, and how to ensure effective communication on all of these issues among staff, clinicians, residents, and family members. ALC

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