What can assisted living (AL) facilities do to improve transitions of care both into and out of their facilities?

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Transition of care is an important issue for all health care entities. The National Transitions of Care Coalition (NTOCC; www.ntocc.org) was formed in 2006 to bring together thought leaders, patient advocates, and health care providers from various care settings who are dedicated to improving the quality of care coordination and communication when patients are transferred from one level of care to another. By definition, an AL facility needs to assist residents so that accurate care and medical information is received *and* assimilated into their care plan *prior* to their admission to the facility. Decisions related to equipment, location, special needs (dietary, for example), medication administration, and more need to be incorporated into the admission process for each resident. Often, residents require a new clinician to provide medical care for them, especially if they are from another location or now are unable to travel to their usual physicians. To accept these types of patients, facilities need to have an established means of providing a clinician (MD, DO, NP, or PA) to care for these residents. The availability of the clinician is sometimes urgent because residents' transitions from other settings are often due to 'urgent' situations such as dementia-related psychosis. In instances like this, the clinician is often delivered a patient with inappropriate pharmacology who will require frequent clinician visits for effective management. The point here is that AL residents are not usually stable. Communication and accurate information are vital for successful transitions.

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There is room for improvement in both the anticipated transfers between AL facilities and acute care or ambulatory care offices of doctors or other health care providers AND with urgent, acute change of status moves. In the former, more planned transitions, family or other caregivers can play an important role in ensuring that updated information about medications, activity or dietary changes, and current treatments can pass in both directions. In the latter crises, there often is not the time to have such information collected and ready to go out with the resident via ambulance or other transport. In such circumstances, preparation in advance of an immediately available packet of information is invaluable. In the same fashion that some residents keep their advance directives (eg, living will or resuscitation wishes) posted or wear a medical alert bracelet, the immediate access to the most utilitarian health records about medications should be kept up-to-date. Future advances in electronic health information data transfers between levels of care hold the promise of improving this aspect of transitions in care.

A second major gap I see as a primary care geriatrician caring for AL residents who are returning from acute care settings or who have been "making the rounds" of various subspecialists is the need to more effectively communicate the priorities of care between settings. What are the current goals of proposed treatments? Which interventions offer the greatest benefit and therefore deserve immediate attention and effort? Having a third party present to help advocate for the resident who is making such moves between settings can be an important aid to address both concerns.

Vicki Anensen-McNealley, PhD, MN, RN
Director of Assisted Living, Washington Health Care Association

Whether moving in or moving on, two factors play a huge role in the successful transition of care: emotional support and communication. Before customers decide to move in, it is important to ensure that they understand what it is they are buying. Services that are included in the price, along with services that may be needed in the future or additional costs, are best shared upfront, both verbally and in writing. Carefully supporting the customer and his or her family through this emotional as well as physical transition—a remarkable and memorable part of one's life—will pave the way for a satisfied stay. Continued discussions as the resident's condition changes will demonstrate focused support on the resident's needs as they too change.

Unfortunately many residents will find themselves transitioning to higher levels of care. When the time comes to move on to another setting, communication, and emotional support become even more imperative as many residents and their families face the unknown. Careful planning and thorough sharing will enable residents and their families to make informed decisions about the future of their care as well as their lives.

David Kyllo
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National Center for Assisted Living (www.ncal.org) members from across the country asked residents for their advice on making a successful transition into an AL community, and published our findings in a consumer guide called "Moving into an Assisted Living Residence: Making a Successful Transition."

We recognize that moving is difficult for residents on an emotional level. Orienting and preparing individuals to move into an AL community is essential. Simple support such as giving them advice about how much furniture to bring, identifying what kind of assistance they'll need on moving day, and explaining what to expect on their first day helps allay anxiousness. New residents can also become overwhelmed with downsizing their homes. Veteran residents suggest that incoming residents consider renting a storage space for those hard-to-part-with personal items so they can avoid rushing the decision about what to do with them.

Focus group questionnaires developed by NCAL also asked residents about how staff should treat them during their initial few days in the residence. Among the findings was that residents asked staff to avoid what has become known as "elder speak." The residents explicitly said not to use terms of endearment like "honey," "hon," "dear," or "patient." They want to be treated like "normal people." Residents want staff to ask them their names, and then ask how they want to be addressed—by their first or last name or by a nickname. They also want staff members to get to know them and listen to them. Other recommendations included:

- Reassure new residents that the AL residence is their new home.
- Offer to show new residents around the building to help orient them to their new home.
- Introduce new residents to current residents.
- Offer to escort them to the dining room and activities during their initial few days of living in a community.
- Be knowledgeable about that community's daily activities and operations.

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One of the biggest challenges facing physicians, pharmacists, and nurses, is getting a truly accurate medication history from the previous care setting. Now with Medicare Part D, the multiple programs of retail pharmacies, generics, and over-the-counter medications, it is like herding the "medication cats" together! Certainly relying on elderly patients' recollection of what they have or are now taking is not feasible. The family may not be totally reliable either because sometimes their loved one has not told them about medications or supplements they may be taking.

Try to gather the facts and information on the various sources: local pharmacy prescriptions (whether cash or through the Medicare Part D benefit), mail order purchases, samples from physicians, over-the-counter supplements and remedies, and any others. Likewise, when transferring your resident to another setting, make sure that you have provided a comprehensive list of all medications and supplements that they have been taking. It will be important for that care setting to know exactly what they can expect and predict when it comes to carrying out future plans of care involving medication use. As always, if you have questions, your pharmacist can help you navigate the issues, and possibly prevent an adverse drug event.

Sandi Flores
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One of the greatest challenges we have in AL is convincing residents to transition to a different level of care. Both residents and families often do everything possible to convince the AL community to retain the resident. Often one of the best actions we can take is to reassure the resident we will coordinate services, so that the resident is able to return as quickly as possible to the home within the AL facility.

Staff need to ensure pertinent information such as current medications and treatments are transferred to the new setting, including a history of medications with adverse reaction issues. For residents diagnosed with dementia, staff must include successful behavioral interventions and actions that help avoid overuse of psychoactive medications in the new setting.

It is critical that lifestyle and functional information is passed along to the new location so the resident's strengths are not diminished in the new setting. For example, sending their adaptive devices, such as special eating utensils and mobility devices is important. Comfort items like talking books and personal belongings are also appreciated.

Additionally, after the transition to another level of care has taken place, a designated staff person should regularly visit the resident to retain the relationships. ALC

If you wish to respond to any of the experts' comments, please send an e-mail to experts@AssistedLivingConsult.com.