Dementia and Transitioning From Assisted Living to Memory Care Units: Perspectives of Administrators in Three Facility Types

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About 5 million people have Alzheimer’s disease or a related disorder (ADRD), with 7.7 million expected by 2030 and 16 million by 2050 (Alzheimer’s Association, 2008; Hebert, Scherr, Bienias, Bennett, & Evans, 2003). Assisted living facilities (ALFs) are an increasingly popular choice for families of relatives with ADRD who can no longer manage their care at home. Estimates of ALF residents with moderate-to-severe dementia range from 23% to 42% (Kuhn, Kasayka, & Lechner, 2002; Zimmerman et al., 2003). “Aging in place” is a major ALF feature (Chapin & Dobbs-Kepper, 2001; Wilson, 1996). However, ALFs may not provide the most appropriate level of care for those who progress to severe dementia.

This study examines transitioning residents with ADRD from ALFs to memory care units (MCUs) from the perspective of administrators of three distinct ALF types: freestanding ALFs, those with MCUs, and those with MCUs as part of continuing care retirement communities (CCRCs). We examine how the administrators decide that a resident requires an MCU, the influence of the ALF organizational structure and processes on the decision, and how the ALFs handle the transfer.

Purpose: This study examines transitioning residents with Alzheimer’s disease or a related disorder (ADRD) from assisted living facilities (ALFs) to memory care units (MCUs) from the perspective of three ALF organizational models: freestanding ALFs, ALFs with MCUs, and ALFs in continuing care retirement communities (CCRCs) with MCUs. Design and Methods: In-depth interviews were conducted with 37 ALF administrators, representing the three ALF types. Grounded theory identified major themes. Thematic analysis organized content. The constant comparison method compared themes among ALF types. Results: Administrators in freestanding ALFs were notably more likely to discuss transfer policies on admission. CCRCs with MCUs were more likely to make multidisciplinary decisions. In ALFs with MCUs, typically, the administrator and the director of nursing or resident care coordinator decided. In all ALFs, challenges included family resistance and denial of deficits, although there was notably less resistance in freestanding ALFs. CCRCs were much less likely than ALFs with MCUs to have trial admissions. Implications: ALF administrators may reduce family resistance to the MCU transfer by maintaining ongoing dialogue with family, discussing transfers at admission, conducting periodic resident reassessments, and providing opportunities for families to learn about ADRD.

Key Words: Alzheimer’s disease, Dementia, Dementia care units, Continuing care retirement communities, Residential care, Special care units

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third ALF type exists in CCRCs, which provide a range of living arrangements for the resident’s remaining life in return for a substantial initial financial commitment (Krout, Moen, Homes, Oggins, & Bowen, 2002). Residents are assured of living in one of the CCRC’s settings even after physical or cognitive decline, although daily or monthly rates may increase if the resident must move to the CCRC’s MCU, where staff-to-resident ratios are higher. Many CCRCs include ALFs and also MCUs (hereafter CCRCs with MCUs). There were 1,900 ALFs in CCRCs in 1999 (Golant, 2004). This number may be increasing, given that CCRCs grew from 3,304 in 1999 to 4,466 in 2006 (U. S. Census Bureau, 1999, 2006). A 2006 survey found that 32% of ALFs were freestanding, 24% had MCUs, and 17% were in CCRCs (Assisted Living Federation of America, 2006).

Only two studies have used in-depth interviews with ALF administrators to examine residential transitions for individuals with ADRD. Aud (2002) interviewed 14 administrators in one metropolitan area about reasons for discharging residents with dementia to skilled nursing facilities (SNFs); this study did not address organizational types. Mead, Eckert, Zimmerman, and Schumacher (2005) conducted interviews at three ALFs in one state; transition decisions varied with facility size, but in all facilities, the administrator had a pivotal role in determining transitions. Several studies have used other methods to examine ALF organizational structure and transitions. In a primarily quantitative survey of 1,251 ALF administrators, researchers asked short-response questions about willingness to retain residents with moderate-to-severe cognitive impairment; ALFs in a care continuum were significantly more likely than freestanding ALFs to retain them (Hawes, Phillips, Rose, Holan, & Sherman, 2003). Another study interviewed 12 ALF administrators, categorizing ALFs into four subgroups: freestanding, associated with a CCRC, in a SNF, and in independent living communities (Utz, 2003). That study evaluated how closely ALFs matched 10 criteria developed in 2002 by the Assisted Living Federation of America to guide ALF operations. No differences were found, possibly due to the small sample.

Munroe and Guihan (2005) examined administrators’ concerns about transitioning residents in five ALFs, concluding that relocation policies were not always fully disclosed at admission. Even when families were initially informed of conditions that could result in discharge, there was still confusion and conflict at the time of transitioning. Another study examining residents’ and administrators’ perspectives in 10 ALFs found that transitioning was handled case-by-case (Frank, 2001). Several other studies examined transitioning but were limited to SNF transfers (Aud, 2002; Kopetz et al., 2000; Rosenberg et al., 2006).

This study extends research in this area using in-depth interviews, with a notably larger number of administrators from three ALF organizational types (N = 37) to examine potential differences. Interviews were conducted with administrators from three ALF types in South Carolina: freestanding, those with MCUs, and those in CCRCs.

**Design and Methods**

**Conceptual Model**

The conceptual model is based on Donabedian’s quality assessment framework of structure–process–outcomes (Donabedian, 1988). Although created to measure medical care quality, this model has been applied to long-term care (Collier & Harrington, 2008). “Structure” refers to components of the specific setting: human resources, material resources, and organizational structure. In the current study, organizational structure refers to the three ALF types. Human resources vary among these ALF types. CCRCs employ professionals in many roles not typically present at other ALF types, including social workers and occupational therapists. ALFs with MCUs also have an MCU director. Amenities (i.e., material resources) may also differ among the ALF types but are not a critical differentiating component of our model. Structure influences ALF operations and care delivery. In a CCRC, ALF residents with deteriorating medical conditions may be cared for in the community’s SNF, whereas the only option in other ALFs might be hospitalization. For an acute illness, a CCRC resident may be seen by a wellness nurse, whereas a resident at another ALF might have to travel to visit a physician. Structure also influences service delivery. For example, ALFs with MCUs may provide interactions between the residents of the ALF and the MCU, with programming that serves both. “Processes” are operational measures, such as treatments and procedures that are completed or recommended in the health care setting. Variations in processes among ALF types include use of trial admission and gradual transition...
from ALF to MCU (Kelsey, Laditka, & Laditka, 2008). Care processes also include periodic assessment methods used to determine resident care needs. If they exceed the ALF’s capabilities, transfer to another care level may be recommended. Assessment methods may include standardized tests, informal measurements, and medical referrals.

Our goal was to determine how organizational structure and processes might influence the transfer decision and its results or “outcomes.” In a prior study (Kelsey et al., 2008), this process appeared to vary by ALF type, although that study was limited to a small sample. CCRCs used a multidisciplinary approach, whereas freestanding ALFs and ALFs with MCUs used less formal methods. Some administrators described using a “dyad” approach, typically involving the administrator and the director of nursing or the resident care coordinator making the final decision after consulting with physicians and occasionally direct care staff. The Donabedian model suggests that the likelihood of successful outcomes can be increased by effective processes. One indicator of a successful outcome is if the family member of the person with ADRD is supportive and pleased with the transition. Our focus was to determine how structure and process differ among the three ALF types and how they contribute to satisfactory transitions. We examine the process of determining when a person with ADRD needs to transition, who is involved in this decision, and how the transition is managed.

Sample

This study includes administrators in one state, South Carolina, with 483 ALFs. Of these, 61 have separate MCUs. Details of South Carolina’s ALFs have been published (Kelsey et al., 2008). Administrators were identified with two comprehensive ALF directories (South Carolina Department of Consumer Affairs, 2007; South Carolina Department of Health and Environmental Control [SC DHEC], 2008). We sought to interview at least 12 administrators in each ALF type. We believed that this number would provide data “saturation,” at which point additional interviews would be unlikely to alter the results meaningfully. Although operational guidelines and regulations are the same for all South Carolina ALFs, sampling represented the state’s three distinct regions (Coastal or Low Country, Midlands, and Upstate). A purposive sample of freestanding ALFs, ALFs with MCUs, and ALFs in CCRCs was contacted based on their locations in the three regions and assuring that each facility had more than 15 beds (Rosenblatt et al., 2004; Zimmerman et al., 2005). CCRCs without MCUs were excluded because they are closely aligned with freestanding ALFs. We also excluded the one South Carolina ALF with an attached SNF and MCU. Administrators were contacted by telephone until 11–14 were interviewed in each region, with at least three administrators representing each ALF subgroup in each region. One administrator at a CCRC declined to be interviewed, as did one at an ALF with an MCU.

Survey Measures

The authors developed an in-depth interview script (Kelsey et al., 2008). To ensure that questions were clear and appropriately sequenced, the survey was pretested with one former ALF administrator and one gerontologist familiar with ALFs and MCUs. The script, summarized in Table 1, consisted of open-ended and semi-structured questions, which encouraged respondents to speak at length about transfers. The script included several questions about participant and ALF characteristics (data not shown). All interviews were audio recorded with participants’ permission. Recordings were transcribed verbatim into Microsoft Word. To ensure accuracy, transcripts were then compared with the recordings word for word. The study was approved by the Institutional Review Board at the University of South Carolina.

Analytic Procedures

Descriptive statistics summarized characteristics of the administrators and ALFs. The transcribed interviews were entered into ATLAS.ti (v.5.0) software that facilitates qualitative data analysis (Muhr & Friese, 2004). Grounded theory identified major themes; thematic analysis organized content (Strauss & Corbin, 1998). A codebook, developed from the interview content, was used to categorize and organize concepts. The “axial coding” process was performed to connect code categories and to identify relationships that could reasonably be taken to represent common themes (Strauss & Corbin). Triangulation was used to minimize researcher bias (Patton, 1990), with both the first and the second authors independently interpreting and analyzing the interviews. The constant comparative method (Boeije, 2002) was used to compare the ALF types.
Results

Characteristics of ALFs and Administrators

The average interview was 26 min (range: 15–53 min). Table 2 shows characteristics of respondents and ALFs. Thirty-one administrators were executive directors. All were involved in transfer decisions. Average years as an ALF administrator was 6.28; average at the current facility was 4.24. Twelve facilities were freestanding ALFs, 13 were ALFs with MCUs, and 12 were in CCRCs, all of which had MCUs. The average number of beds was 55. Twenty-five ALFs had MCUs, including ALFs with MCUs and CCRCs with MCUs, averaging 20 beds. Table 2 also shows bed size by facility type: CCRCs had the largest average bed size, and more beds in their MCUs, than did ALFs with MCUs.

The sample had 13 ALFs in the Midlands, 12 in the coastal area or Low Country, and 12 in the western portion or Upstate. The ALF types were fairly evenly distributed among the regions. Twenty-seven ALFs were in metropolitan statistical (urban) areas and 10 in more rural areas (U. S. Census Bureau, 2007).

Thematic Analysis Results

The sections that follow describe themes and subthemes identified, and similarities and differences among ALF types.

Procedures Used for Admissions With a Dementia Diagnosis.—Possibility of future transfer discussed with family. Administrators from all ALF types said that they discussed the possibility of transfer to another level of care with the family on admission. Representative responses from the different ALF types were:

- Our routine policy is that I do discuss at admission, if they are diagnosed as dementia, that their length of stay can be from one month to six months to a year. I can’t guarantee that. (freestanding ALF)
- If there’s already a diagnosis of dementia … they certainly are made aware of that … level of care and that … they have access to that level of care if it becomes necessary. (ALF with MCU)
- When I meet with them and I see they have dementia … I always address with them the possibility that the family member … is going to be at some point changing the level of care and more than likely, will end up in our dementia unit. (CCRC with MCU)

Preadmission assessment. Administrators in all ALF types said that they conducted preadmission assessments, although not all administrators mentioned such assessments. Conducting assessments was mentioned by 83% administrators of ALFs with MCUs and by 69% of CCRCs with MCUs. Only 41% of administrators in freestanding ALFs mentioned conducting such assessments. Representative comments included: “We can really just screen, and if somebody has those behaviors that we feel like we cannot address, then we would not take them” (freestanding ALF); “We have an assessment that’s performed by our RN … and she does a detailed assessment before we can admit a resident” (ALF with MCU); “If they are unable to come here … then I go out in the community and assess them at their homes or sometimes they’ve been in other facilities or [the] hospital and I always do an assessment, which includes meeting with the family” (CCRC with MCU).

Table 1. ALF Administrators Discussion Guide

1. Tell me how you work with families when there is a diagnosis or suspected diagnosis of dementia on admission to the ALF.
2. Do you have a routine policy of discussing potential transfer to memory care units or another level of care for residents of families when they are first admitted to your ALF? [If “yes”: Tell me about your approach to discussing this.]
3. Tell me about how you decide that a resident needs to be moved to a memory care unit or another level of care due to dementia.
4. Does there tend to be a single event that triggers you to initiate this process? [If “yes”: Tell me more about that.]
5. Tell me what process you use to come to your decision to transfer to the memory unit.
6. Describe how you tell the families that their relative needs to move to a memory care unit or another level of care.
7. Tell me how families typically react to this news.
8. When you consider transitioning a resident, are there any financial considerations that play a role in the decision of families, or in your decision? [If “yes”: Tell me more about that.]
9. If you could implement some changes into your assisted living community regarding transitioning residents, what would they be?

Note: ALF = assisted living facility.
ALFs with MCUs did so; only one third of administrators in CCRCs with MCUs reported trial admissions. Administrators of the first two facility types explained: “We like to do a trial basis for 30 days. It’s an agreement between us and the family that if it doesn’t work in the 30 days they have a backup plan to move their loved one to a different facility” (freestanding ALF); “We have had trial periods where they come in and just see how they would adapt to the situation” (ALF with MCU).

Policies for Transfer From ALF.—ALFs without standardized policies. About half of the ALFs, across types, did not have formal transfer policies. A majority of administrators at ALFs with MCUs and CCRCs with MCUs discussed transfer policies; nearly all freestanding ALF administrators did so, although not necessarily for every resident: “It is covered in the interview and pre-admission discussion. I won’t say that it’s routine for every single resident. If a resident has really no signs of dementia it may not come up” (freestanding ALF).

ALFs with standardized policies. Administrators of all ALF types discussed transitions at admission if their ALF had a standardized policy. Freestanding ALFs more commonly reported these discussions than other ALF types: “At the time of admission through the contract … they are told that [transfer] could happen and that we can’t guarantee that we could care for them.” “We let them know, the certain things the residents will have to continue to be able to do for themselves and the behaviors that they have to continue not to have in order to stay in assisted living” (CCRC with MCU). Only a few administrators provided written transfer information: “There is some written material for them that if they become to the point that we cannot take care of them, then we will facilitate them in finding proper placement” (freestanding ALF).

Reasons and Triggers for Transferring Out of ALFs.—Four themes were identified. The first three were mentioned frequently by all ALF types.

Wandering or elopement. Many said that leaving the building or premises without anyone’s knowledge, hereafter referred to as wandering or elopement, might trigger an MCU move. “If they get out and they don’t know where they are, then we have to make sure that we get them in the secured wing … we won’t keep them” (ALF with MCU).
MCU). In freestanding ALFs, this might trigger a transfer to another facility: “If there is a risk of elopement ... we start the transition of moving the resident out to another facility that can meet the resident’s needs.”

**Behavioral and safety issues.** Behavioral issues mentioned frequently included agitation, combativeness toward staff or other residents, and pillaging. Administrators of all ALF types commented that personal safety concerns could trigger a transfer: “… when we find that they’re more combative or they’re more argumentative or they’re plundering another resident’s room” (ALF with MCU); “… if they start getting more aggressive ... we will have them reassessed” (CCRC with MCU). Most administrators initiated transitions only after multiple repetitions of a single behavior or combined events: “It’s really a combination, in most cases, of behavioral and physical” (freestanding ALF).

**Increased care needs.** Administrators frequently described declining ability to perform ADLs independently and the need for multiple staff members to help the resident as transfer triggers: “If their ADL status goes down drastically ... then we make the decision to give the family a 30-day notice and give us time to find placement” (freestanding ALF); “When I find out that we just literally cannot provide them ... the care they need, then I’ll always look at a move” (CCRC with MCU).

**Difficulty socializing.** Difficulty or inability to socialize or participate in activities was mentioned most frequently in ALFs with MCUs. One administrator of a CCRC with MCU gave an example of a resident who lacked initiative to participate in activities, which improved after the MCU move: “In her case, again, it was like coming back alive. So instead of sleeping all the time, she’s now completely engaged.”

**Decision Making for Transfers.** —Five subthemes were identified regarding decision making for transfers.

**Family meetings.** This was the most prominent and consistent theme among all ALF types. Administrators explained their philosophy of contacting family members as the first transition step: “I get the family included if we notice change and discuss any options” (CCRC with MCU); “First of all, what we do is we call them [the family] and we request a family conference” (ALF with MCU).

**Medical consultations.** Administrators of all ALF types commonly used medical consultations in the transfer process to rule out other medical conditions that might acutely affect the resident’s functional ability. “We always get a check up to make sure they don’t have a urinary tract infection and there’s nothing else that’s going on that could be causing the behavior” (free standing ALF). “We have a physician that comes monthly to evaluate the residents and ... she will make a recommendation as to moving as well” (ALF with MCU).

**Informal assessment.** Administrators in all ALF types frequently mentioned use of informal assessments in decision making. Informal assessments included a number of processes, including “talking among each other” and “observations by caregivers” (CCRC with MCU). Written notes and reporting were also mentioned: “We write them [behaviors] down on care plans or progress notes, just for the charting purposes” (ALF with MCU). Administrators also mentioned their need to confirm staff observations: “I might monitor them instead of the staff coming back and telling me what they were doing. I might have to see it for myself” (ALF with MCU).

**Formal assessments.** Administrators at ALFs with MCUs and CCRCs with MCUs reported using formal assessments with more frequency than those at freestanding ALFs. For example, an administrator of a CCRC with MCU said, “All new admissions must participate in the [testing] process ... we will have upon admission a baseline as to the individual’s health status, their social functioning, and throughout their stay we will do formal updates, so that we can show through this standardized tool exactly where the resident is functioning. And this will be an instrument that will help us in that process [of transitioning].”

**Staff conferences.** Administrators in 40% of the ALFs that were part of CCRCs or had MCUs reported using multidisciplinary team approaches. No administrators at freestanding ALFs reported this. CCRC administrators described a more formal and multidisciplinary team approach than that used by ALFs with MCUs. Administrators at CCRCs spoke of staff conferences that included: housekeeping director, food services manager, admissions coordinator, marketing director, physician, activity director, nursing director, social worker, and the executive director, along with input from the direct care staff. Teams often met on a regular basis (e.g., biweekly) to discuss residents and to develop strategies to manage physical or cognitive
decline. In contrast, administrators in ALFs with MCUs described dyadic staff conferences, usually involving the administrator and the director of nursing or the resident care coordinator, who discussed each case and made a decision with input from a physician, MCU director, and frequently from direct care staff.

**Challenges and Cooperation Encountered in Transitioning.**—Administrators highlighted two challenges associated with transitioning; these themes were mentioned more often by ALFs with MCUs and CCRCs with MCUs than by freestanding ALFs.

*Family resistance and denial of cognitive deficits.* Family resistance was mentioned by about half of administrators; however, those in freestanding ALFs mentioned this theme much less frequently. Despite this finding, administrators from two freestanding ALFs reported the only instances of extreme lack of cooperation from families when a request was made to transition a resident. One of these administrators said, “She [daughter] called all the way up to the Governor’s office trying to get her mom to stay here and eventually the company won. It was a fight.” An administrator in a CCRC with MCU said, “Invariably, when it comes time for them to move, even from an independent cottage [or] from assisted living, it’s a very difficult move”; “There have been some that just don’t feel like their parents or loved one is ready and they will say, ‘no, I just don’t think they’re ready for that yet.’” Many spoke about family members who denied cognitive deficits: “My Mom, she’s not that far yet.” That’s almost always the initial reaction we get” (ALF with MCU).

*Financial considerations.* Increased costs played a role in family resistance to transitioning, particularly in CCRCs with MCUs and in ALFs with MCUs. Administrators often spoke about the importance of cost in family decisions: “I will always help the family, assist them in finding another facility that has a secured unit for their loved one where they’ll be safe and they can afford it” (CCRC with MCU); “The secure unit is more expensive, because there’s more staff per resident there … . Yes, families definitely consider the cost” (ALF with MCU).

Four administrators at freestanding ALFs and one at an ALF with MCU reported that residents moved to SNFs instead of MCUs because of costs. Assuming that the family qualifies, South Carolina will support SNF stays with Medicaid funding, making an SNF an attractive alternative to an MCU when costs for a given family become unmanageable. As one freestanding ALF administrator noted:

> Where most of the assisted livings and memory care are privately owned and you pay up front … . I have had a couple of residents who had to move … due to finances. They had to be moved to a skilled facility.

An administrator at an ALF with MCU stated that cost alone accounted for a resident’s move to a smaller board and care home. Another administrator at a CCRC with MCU said they would help a family find a more affordable MCU, if needed.

**Approaches Used to Discuss Transitioning With Families.**—*Maintain ongoing dialogue.* About half of the administrators emphasized cooperation from families during the transition. They attributed the cooperation to good communication and familiarizing families with transfer policies on admission. Most mentioned the importance of keeping families informed: “By the time it’s time for the transfer into the skilled dementia unit, the family is well aware that person … is needing to go” (CCRC with MCU); “We keep them informed. That’s part of our job with the family that there [are] no surprises from us” (ALF with MCU); “I feel like we have good success with transfers because it’s not a shock. Because when I call the family to say: ‘Alright, the time has come. We do need to move your mom,’ they’re ready because they know that I’ve already been talking to them” (CCRC with MCU).

*Clarify behavioral concerns.* ALFs with MCUs used this approach to discuss transitioning with family members most frequently: “I go over … their behaviors, things that I’m concerned about with their safety and with their well-being” (ALF with MCU).

*Emphasize positive aspects of care in MCUs.* Administrators from all ALF types mentioned this theme with similar frequency, often emphasizing the positive aspects of MCUs compared with ALFs: greater care, better staffing ratio, and more appropriate activities. Among their comments were: “They can provide more care, more one-on-one and more activity geared to dementia, Alzheimer’s” (freestanding ALF); “We feel a smaller environment would be more appropriate for them, one
where there’s more one-on-one care and attention” (ALF with MCU); “The programming, the activities, the whole unit is set up to really enable them to be more successful in that unit” (CCRC with MCU).

Review care documentation with families. Although mentioned by administrators at CCRCs with MCUs, this theme was more frequently mentioned by administrators from ALFs with MCUs: “We actually show how many minutes for each level ... how few activities of daily living that they’re capable of doing on their own and how long it’s taking for a caregiver to actually go in and either calm them down or help them get dressed.”

Facility Approaches to Family Resistance.— Suggest family hire companion. Administrators of all ALF types recommended hiring companions (also known as sitters) to family members, as a short-term solution for those resisting transfers: “I offer a sitter. I try to give [them] many different options before I actually move them” (CCRC with MCU); “If the resident was really aggressive or kept wandering away, we would probably just use the sitters as a bridge to get them to a memory care unit” (freestanding ALF).

Offer semiprivate room to defray costs. This suggestion was mentioned primarily by administrators at ALFs with MCUs and occasionally by administrators from CCRCs with MCUs, as a means of helping families afford the MCU. An administrator at an ALF with MCU said: “We do have two or three of our apartments that can be used as a roommate situation if the families of both are interested. That is a cost-cutting measure.” An administrator from a CCRC with MCU said she helped a couple remain together by converting a single room into a suite for two, which they could afford.

Continue dialogue with family. When families resist the MCU transition, administrators of all ALF types said continued communication with families may help. Those at ALFs with MCUs reported this approach most often. Comments included: “I try to talk to the family every three days to try to follow up” (ALF with MCU); “I’ve found that if you’re communicating with the family members from the beginning to the end, go with them, walk them through the transitioning ... holding their hands and being there for the family ... it makes it a lot smoother for everyone” (CCRC with MCU).

Transition to MCU gradually. This strategy was suggested only at ALFs with MCUs and CCRCs with MCUs. Administrators described various gradual transition methods that were satisfactory to family members and effective for residents: “I’ll let them go back there [to the MCU] for a little while, eat a meal, then bring them back to their room and transition them like that ... Eventually we have the resident moved” (ALF with MCU); “They may, they might start with an activity, then after a few activities, then the next step is they would maybe stay for lunch. And just gradually it becomes the norm for them to be a part of that [the MCU]. That becomes their world” (CCRC with MCU).

Changes Suggested in the Transitioning Process.—Offer educational programming on ADRD for families. Administrators of all ALF types said that it is useful to offer families educational materials and opportunities to learn about ADRD to increase their acceptance of the transition: “Learn as much as they can about Alzheimer’s disease and what to look for and what to expect” (CCRC with MCU); “I think they just need more information before the family gets into assisted living, and I think it would be easier for them to see the different levels that their family member may go into. I think if they were more prepared it wouldn’t be so hard for the transition” (ALF with MCU).

Increase awareness of benefits of MCU. Administrators in all three ALF types mentioned the need to familiarize families in advance about MCU benefits. “The biggest thing is educating people ... [so] they understand that it’s not a social stigma. It’s something that’s an illness that we have to deal with everyday ... they’re in an area where they’re safe” (ALF with MCU); “We’re very proud of our memory support unit ... We have more activities ... But families just don’t see their Mom as requiring that type programming” (CCRC with MCU).

Add MCU or increase MCU capacity. Administrators in some freestanding ALFs said adding an MCU would enhance their residential community and eliminate the need to relocate residents. Similarly, some administrators at ALFs with MCUs and CCRCs with MCUs regretted not having enough beds: “The biggest [need] would be to build another memory care unit” (CCRC with MCU); “We would love to have more dementia
The ALFs studied are in South Carolina, a southern state with distinct economic and cultural regions that have been understudied. The study provided an in-depth perspective on ways that administrators or other facility personnel make the transfer decision and examined how administrators prepare families for the transition. The interview script used in this study can facilitate comparisons with findings from previous related studies.

A new finding of our study is that there were differences in the transitioning process among the ALF types. Formal and multidisciplinary team approaches were used most commonly by ALFs that were part of CCRCs and least by freestanding ALFs. These results are consistent with a previous study using a much smaller sample of ALF administrators in all three ALF types represented in this study (Kelsey et al., 2008). The findings of this study are also consistent with a study of freestanding ALFs (Mead et al., 2005). Less than half of administrators in freestanding ALFs reported resistance to transitioning, whereas most administrators in the other ALF types reported such resistance. Nonetheless, two examples of a high level of family resistance came from freestanding ALFs when family members refused to cooperate with transitioning even after receiving discharge notifications from the state regulatory agency governing ALFs in South Carolina. These rarer examples from freestanding ALFs may be due to the major relocation involved when residents move from ALFs. The fact that such resistance was rare in freestanding ALFs may result from the fact that their administrators discussed transfers during admission more frequently than those in the other ALF types. This would not be surprising because freestanding ALFs usually cannot continue to provide care as dementia progresses. A common financing model for CCRCs provides a “life contract” to residents, supporting transfers to appropriate levels of care on the same campus without additional cost. In CCRCs with this model, administrators may feel less compelled to ensure that all details of such transitions are described at admission. For the same reason, families considering a CCRC may be less likely to inquire about costs of MCUs or other more costly services. However, financing models for CCRCs vary (Commission on Accreditation of Rehabilitation Facilities, 2007). The CCRCs in our study provide a set of core services in the life contract but charge for additional costs of memory care. Thus, the resistance to memory care transitions even in CCRCs may be due in part to concerns about greater cost.

Preadmission assessments were conducted in the majority of ALFs with MCUs, in nearly all CCRCs with MCUs, but in less than half of the freestanding ALFs. Trial admissions were less common in CCRCs because they are structured to transition residents as their care needs change. Gradual transition was used in ALFs with MCUs and CCRCs with MCUs; the structure of freestanding ALFs does not permit gradual transition.

A number of similarities were found among administrators of all ALF types. About half of respondents across ALF types said that their facilities had standardized transfer policies. About three quarters said that they discussed transferring residents from the ALF at admission, whether or not there was a formal policy. Major triggers for transfer in all ALF types were elopement, disturbing behaviors, and increased care needs (Aud, 2002; Hawes et al., 2003; Kopetz et al., 2000; Mead et al., 2005; Munroe & Guihan, 2005; Rosenberg et al., 2006).

As for challenges encountered in transitioning, many administrators emphasized family resistance. However, a number of administrators said that they had not experienced resistance and attributed its lack to good communication with families, including familiarizing families with transfer policies at admission. A new finding is that the greater cost of MCUs, mentioned by half of the respondents, plays an important role in family resistance to transitioning. This was relevant even for CCRCs, despite their life contracts with residents, because the daily or monthly rates for MCUs in CCRCs are greater than the rates outside the MCU.
Collectively, these findings support the usefulness of Donabedian’s (1988) structure–process–outcome model and suggest that the unique structures of the ALF types influence the transfer process. ALFs with affiliated MCUs were able to introduce residents with ADRD to the MCU gradually. They could also provide social interaction among residents of the ALF and the MCU to foster familiarity with the MCU prior to transitioning. The presence of an MCU on the same campus or in the same building allowed CCRCs with MCUs and ALFs with MCUs to offer alternative solutions to financial concerns that were not feasible for freestanding ALFs, such as a room shared by an ALF resident and her or his spouse in the MCU. Yet, despite the need to transfer residents with ADRD from the freestanding ALF, administrators at these facilities reported less resistance from family members. The opportunity to hire a companion, offered by all ALF types, provides only a short-term alternative to MCU placement. The average hourly cost of a companion in South Carolina is $15 (MetLife Mature Market Institute, 2008a). If 24-hr companions are needed over an extended period, the cost would greatly exceed the extra cost of an MCU (MetLife Mature Market Institute, 2008b).

ALFs with MCUs were more closely aligned in their “dyadic” approach to decision making with the “multidisciplinary” method used by CCRCs with MCUs than they were with freestanding ALFs, where executive directors often made the transition decision. A theme mentioned by one third of the administrators of freestanding ALFs involved adding an MCU to reduce the disruption of transfers to residents and families. In this case, it was anticipated that changing the ALF structure and the transfer process would improve the outcome. Similarly, administrators at the ALFs with affiliated MCUs and CCRCs with MCUs discussed the need for more MCU beds. By enlarging their facilities (structure), they felt that the transitioning process would be enhanced and acceptance by family members (outcome) would be improved. Process appears to play a role in this finding: administrators at freestanding ALFs reported recognizing the potential for a later transition at admission and discussed it thoroughly at that time, thus increasing the likelihood of a favorable outcome.

Several limitations are acknowledged. Administrators were from one relatively small, rural, southeastern state. All the CCRCs in this study provided an ALF and an MCU. Not all CCRCs in South Carolina or the nation have MCUs. The results may not be generalizable to ALF types other than the three represented in this study. The generalizability of the findings might also be affected if the ALFs studied more closely resembled family-run board and care homes than professionally run facilities. No administrators in the study suggested that their ALFs were family owned; 68% of the facilities had parent organizations; websites describing the remaining facilities provided no indication of family ownership. The study included only ALFs with more than 15 beds; this criterion has been used previously to identify professional ALFs (Rosenblatt et al., 2004; Zimmerman et al., 2003).

In another area, regulations regarding admitting or discharge criteria might influence the transitioning process. ALFs typically do not admit residents with either medical conditions that require daily nursing attention or notable behavioral problems; in South Carolina, regulations do not permit them to admit such residents (SC DHEC, 2008). This provides a degree of control for variation in residents’ health and behaviors at admission. South Carolina also identifies “serious aggressive, violent, or socially inappropriate behavioral symptoms” as indicating a need for ALF discharge and a higher level of care (SC DHEC, 2002). Administrators did not refer to this requirement; however, their statements suggest that such behaviors would trigger discharge even in the absence of the regulation. Thus, the results in this regard may characterize ALF practices beyond South Carolina, even in states that may not require discharges in these circumstances.

One strength of the study is that all the ALFs required residents to pay privately for their services, as is the case for almost all ALFs in the United States. This study feature provides a useful degree of control for the socioeconomic status of residents and their families, as well as for the financial circumstances of the ALFs. Thus, the results are unlikely to be confounded by public long-term care insurance arrangements, such as Medicaid.

We did not specifically ask administrators of ALFs with MCUs or CCRCs to provide information about charges for different levels of care, although they often said that services in addition to those used on entry were provided on a fee-for-service basis. It would be useful for future research to examine the threshold of additional cost at which families begin to resist the memory care transition and how various charge levels may affect families differently.
Findings suggest several practice implications. Regular communication between ALF personnel and families may reduce resistance to transitioning. Providing families with clearly defined and written residency agreements that clarify reasons for transfers, routinely reviewing these policies with new residents and their families, and maintaining regular contact with families, including discussing behavioral changes that might trigger a transfer, can reduce misunderstanding about the need for MCU transitions. In another area, conducting baseline and periodic cognitive status assessments with a standardized protocol may help families understand the need for an MCU transition and provide regular contact between administrators and family members. For ALFs with affiliated MCUs, our findings suggest that gradually transitioning residents to MCUs can help residents and families adjust. Educational programs for families of residents with ADRD may help families learn about ALFs and ADRD progression (Gitlin et al., 2003) and provide opportunities to become familiar with MCUs. These practices and programs may help reduce stigma associated with MCUs, help families understand the benefits of MCUs, reduce family resistance, and help families recognize changes in their family member and be more receptive to transitioning.

The findings also suggest several useful areas for future research. The strong association between the greater cost of MCUs and the family resistance to transfers is of interest from the perspective of public policy. It warrants further study, informed through in-depth interviews with administrators and family members. Future research should also examine the appropriateness of resident transfers. This research would include interviews with direct care staff in the transferring ALF, analysis of the health and emotional well-being of the resident before and after the transfer, and interviews with administrators in the receiving MCU.

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