Geriatric-Competent Care: Caring for Individuals with Alzheimer’s Disease and Related Dementias

Care Transitions to and from the Hospital for Individuals with Alzheimer’s Disease and Related Dementias
Overview

- This is the third session of a four-part series, “Geriatric-Competent Care: Caring for Individuals with Alzheimer’s Disease and Related Dementias.

- Each session will be interactive (e.g., polls and interactive chat functions), with 60 minutes of presenter-led discussion, followed by 30 minutes of presenter and participant discussions.

- Video replay and slide presentation are available after each session at: www.resourcesforintegratedcare.com
Care Transitions to and from the Hospital for Individuals with Alzheimer’s Disease and Related Dementias

■ Developed by:
  - The American Geriatrics Society
  - Community Catalyst
  - The Lewin Group

■ Hosted by:
  - The Medicare-Medicaid Coordination Office (MMCO) Resources for Integrated Care
Continuing Education Information

■ Accreditation:
The American Geriatrics Society is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

■ Continuing Medical Education (CME):
The American Geriatrics Society designates this live educational activity for a maximum of 1 AMA PRA Category 1 CreditTM.

■ Continuing Education Credit for Social Workers:
The National Association of Social Workers (NASW) designates this webinar for a maximum of 1 Continuing Education (CE) credit.

NOTE: The following states do not accept National CE Approval or National NASW Programs: Idaho, Michigan, New Jersey, New York, Oregon, West Virginia
Support Statement

This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) to ensure beneficiaries enrolled in Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated, coordinated care to Medicare-Medicaid enrollees, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar series.

To learn more about current efforts and resources, visit Resources for Integrated Care at:
www.resourcesforintegratedcare.com
Webinar Planning Committee and Faculty Disclosures

The following webinar planning committee members and webinar faculty have returned disclosure forms indicating that they (and/or their spouses/partners) have no affiliation with, or financial interest in, any commercial interest that may have direct interest in the subject matter of their presentation(s):

■ Planning Committee:
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■ Faculty:
  - Kathryn Agarwal, MD
  - Karen M. Rose, PhD, RN, FGSA, FAAN
  - Alan B. Stevens, PhD
  - Eric Coleman, MD, MPH
Introductions

- Kathryn Agarwal, MD, Assistant Professor of Medicine, Baylor College of Medicine
- Karen M. Rose, PhD, RN, FGSA, FAAN, University of Virginia School of Nursing
- Alan B. Stevens, PhD, Director, Center for Applied Health Research
- Eric Coleman, MD, MPH, Professor of Medicine and Head of the Division of Health Care Policy and Research, University of Colorado Anschutz Medical Campus, Director of the Care Transitions Program
Webinar Outline/Agenda

- Polls
- Improving care of individuals with dementia admitted to the hospital
- Transitions of care: Empowering families in the process
- The Care Transitions Intervention® at Baylor Scott & White Health
- Q&A
- Post-Test
- Evaluation
Webinar Learning Objectives

Upon completion of this webinar, participants will be able to:

■ Describe some of the common care transitions experienced by persons with dementia and the associated risks for this population

■ Identify important strategies to prevent adverse outcomes due to poor transition planning or execution

■ Name key features of several current evidence-based models for care transitions
Improving Care of Individuals with Dementia Admitted to the Hospital

Kathryn Agarwal, MD
Objectives

At the end of this presentation, the learner will:

■ Be able to state common hazards for elderly individuals in the hospital
■ Be familiar with benefits of programs to avoid hospitalization
■ Be able to describe 3 models of care beneficial to individuals with dementia in the hospital
■ Be able to state 3 key quality issues for hospitalized individuals with dementia
Impact Of Hospitalization

■ Hospitalization: a pivotal event

■ Hospital fosters dependency and exposes patients to many risks/complications

■ “Hospital stay may yield functional decline despite cure or repair of condition for which they were admitted.”

What happens in the hospital?

- Polypharmacy & Interventions
  - Multiple new medications, interactions, side effects

- Bed Rest and Immobility
  - Medical issues, patient and nursing preference, delirium, negligence

- Restraints & Risks for Falls
  - Urinary catheters, IV poles, high beds with rails, physical restraints, lack of assistive devices for walking

- Malnutrition & Dehydration
  - Insufficient help with meals, restrictive diets
  - Insufficient attention to hydration status

- Lack of stimuli (hearing aids, glasses, dentures)
Increased Risk for Patients with Dementia

- **Hospitalization** and **delirium** in elderly individuals with Alzheimer’s Disease (AD) are independent risk factors for cognitive decline, institutionalization, and death. *(Annals Internal Medicine 2012, Fong)*
  - 1 in 8 hospitalized AD patients with death, institutionalization, cognitive decline

- Cognitive Impairment – greatest risk factor for prolonged hospital stays *(JAGS 2006, Lang)*

- AD patients with average length of stay (LOS) 10.4 days vs 6.5 days for non-AD in a sample of >78,000 patients*
  - 8 common diagnoses – all with 3-4 day longer LOS

Cognitive Impairment is Invisible – Dementia and Delirium are not Recognized and Documented

- Dementia is often not mentioned in the medical record of individuals with dementia
  - 64% overlooked in Canadian Study of Health and Aging
  - 79% overlooked in Indiana study

- Nurses and physicians fail to recognize delirium in 32-66% of cases

Sternberg SA et al. JAGS, 2000
Ely et al JAMA 2001;286:2703-2710
Ely et al CCM 2001;9:1370-1379

Boustani M. et al. JGIM, 2005
McNicholl JAGS 2003;51:591-598
Inouye SK, Arch Intern Med. 2001;161:2467-2473
Avoiding Hospitalization

- **Hospital at Home Programs**
  - Receive hospital level of care at home
  - Well-established in England, Canada, Australia
  - Few successful programs in US – Hopkins
  - Pilot programs reduced costs by 30% while providing equal outcomes and less complications [http://www.hospitalathome.org/](http://www.hospitalathome.org/)

Avoiding Hospitalization

- Do Not Hospitalize Orders
  - Form of Advance Directive (POLST/MOLST)
  - May be most useful in nursing home settings
  - Coordination with hospice
  - Reasonable option for frail individuals with end-stage conditions such as advanced dementia
  - May need to be overturned if severe symptoms unable to be managed for comfort – example: broken hip, acute abdominal pain

- Should be discussed with individuals with a comfort goal who have good caregiver system in place
Models of Care for Frail Elders

- Dementia Friendly Hospitals
- Acute Care for Elderly (ACE) Units
- Hospital Elder Life Program (HELP)
- Geriatric Emergency Rooms
Dementia Friendly Hospitals

- The Alzheimer’s Association developed educational opportunity focuses on impacting the care of individuals with cognitive impairment by offering practical, interactive and dementia-specific training to hospital personnel
  - Includes training on recognition and understanding of dementia
  - Teaches communication techniques to use with individuals who are confused
    - Extensive communication training
  - Provides essential elements for comfort and safety
  - Involves caregivers and identifies that individuals with AD need assistance

  - Free information online, assistance from local chapters available
  - Free educational modules, slides, videos
Acute Care for Elderly Unit Model

- Focus on maintaining level of function, prevention of iatrogenic problems, and pharmacy review
  - First published 1995 – NEJM – Landefeld

- Summary of ACE Unit Trials
  - Functional decline not an inevitable consequence of hospitalization
  - Evidence for decreased length of stay (LOS) and costs
  - Without significant increased costs, we can return more individuals to home at a higher level of function

- ACE Units provide better care for individuals with dementia
  - Focus on cognitive function – protocols to prevent delirium
    - Should be restraint-free with plans to manage confused patients
    - Example: Delirium Room at St Louis University
  - Focus on physical function – Nursing/therapy to increase mobility
  - Increased interdisciplinary care
HELP – Hospital Elder Life Program

- Model of care to prevent delirium and improve outcomes in hospitalized elders
  - Developed by Sharon Inouye, MD
  - www.hospitalelderlifeprogram.org
  - Inouye, SK, et al. NEJM. 1999

- Hospitals register and train to become official HELP sites

- Over 200 current sites – volunteer-delivered interventions

- Showed reduction of delirium incidence by up to 40% in medical patients > age 70 (NEJM 1999)

- Requires significant hospital commitment

- Focus is on prevention of delirium – typically unit-based
Geriatric Emergency Rooms

- Guidelines for Geriatric Emergency Rooms (ERs) – 2013
  - American College of Emergency Physicians, Society for Academic Emergency Medicine, American Geriatrics Society, Emergency Nurses Association

- ER sits at “crossroads between inpatient and outpatient care”

- Standardized guidelines for staffing, education, protocols, equipment
  - All staff should have geriatric training
  - Medical director should have substantial training and 8 hours of continuing medical education (CME) per year
  - Geriatrics consultation frequently available
  - Discharge protocols to improve communication to all providers
  - Monitor quality measures like use of urinary catheters, restraints, admit rates
  - Specific equipment and environmental changes to support older adults
Key Quality Issues

- Identification / involvement of caregivers
  - Electronic Medical Records
  - Signs in rooms and chart

- Increased mobility and prevention of functional decline
  - Not placing urinary catheters in ER/hospital automatically
  - Mobility as a vital sign
  - Extensive use of physical and occupational therapy and nurses’ aides to increase mobility

- Geriatrics services available
  - Geriatrics resource nurses (NICHE Program)
  - Geriatrics physician / nurse practitioner consultative services
Key Quality Issues (continued)

- **Delirium Recognition**
  - Education regarding delirium superimposed on dementia
  - Nurses screening for delirium
  - Provider education on delirium

- **Ability to manage confused patients (delirium or dementia)**
  - Restraint-free setting
  - Use of sitters/delirium room
  - Use of behavioral techniques
  - Use of chair alarms and wander guards to encourage out of bed mobility
Key Quality Issues (continued)

- **Delirium Prevention**
  - Hearing amplifiers and glasses available
  - Pharmacy efforts to limit inappropriate medications
    - Non-pharmacologic sleep protocols
    - Modifications to order sets for older adults
    - Warnings and limits on Beers Criteria/inappropriate medications
  - Involvement of caregivers
    - Rooms to encourage presence of caregivers
    - Visiting hours
  - Day-night cycle awareness
    - Efforts to decrease noise and disturbance at night
    - Lights and involvement in day
    - Out of bed for meals
Key Quality Issues (continued)

- **Transitions of Care**
  - Strong collaborative efforts to communicate with care providers outside hospital
  - Discharge education to involve caregivers
  - Establish appointments prior to discharge
  - Follow-up programs in home/skilled nursing facility (SNF) to ensure optimal transitions
    - Phone calls
    - Care Transitions Intervention

- Protocols / processes to improve communication
  - Shared EMR across settings
  - Shared physician/provider groups
  - INTERACT (Interventions to Reduce Acute Care Transfers)
Transitions of Care: Empowering Families In the Process

Karen M. Rose, PhD, RN, FGSA, FAAN
Family Caregivers Provide the Bulk of Care for Persons with Dementia

- Treat them with respect!
- Handle with care!
What do Families Want?

- To be informed
- To be heard
- To be “ready”
- To know what supportive services are available and how to access them
How to Keep Families Informed

■ What is the plan for discharge:
  - When?
  - Where?
  - Under what circumstances?

■ Honest communication about care recipient needs and an assessment of who is best able to provide care for the person with dementia

■ Sensitivity to the needs of families—these discussions are critical and complex
How to Hear Families

- Ask them for their opinions!
  - What will work? What won’t?
  - What are their supportive services? How often and for how long?

- Summarize discussions and restate decisions at every meeting; provide written documentation so that all providers are in-the-know

- Enlist assistance from social workers, other supportive staff (e.g., chaplains and other therapists)
How to Help Families Be Ready

- Communicate early and often! In person and in writing.
- Plan for the “what if….” situations
- Help them organize a patient file to take with them to all appointments (current list of medications, chronic medical conditions, follow-up appointment dates, blank paper to document any new information that they receive)
- Discuss realistic expectations about roles of family members in an atmosphere that promotes guilt-free discussions
How to Help Families Be Ready (cont’d)

- Provide families with a sense of “best practices” for visiting a provider:
  - 2 sets of eyes/ears are better than 1
  - Suggest that families write down questions they have in advance of their visit
  - Help families anticipate care recipient needs (toileting, eating, transfer needs while en route and before/after provider visits)
“What if” situations

■ Provide parameters for commonly occurring scenarios—delirium? falls? incontinence?
  - Describe these potential occurrences in terms that family members can understand
  - Help families think through their “game plan” for these
  - When do they need to call their provider? Which provider do they call?
Supportive Services for Family Members

- Linking to community resources is critical for families
  - Area Agency on Aging, including Meals on Wheels
  - Alzheimer’s Association
  - Respite services (in-home and facility-based)
  - Volunteer services (churches, organizations, universities?)
  - Adult day care settings, if appropriate
  - Senior Navigator and other web-based sources of information
Special Needs: Transferring from and back to an Assisted Living or nursing home setting

- Communicating with receiving setting is critical to ensure best transition possible
- Be explicit about medication changes
- Provide documentation of advance directives and any other special needs of recipient and family
Special Needs: Transferring home with home health care providers

- Families need to know the parameters of the assistance they can expect:
  - What types of services will they be receiving?
  - For how long?
  - What is the family’s role in arranging this?
  - Do they have a choice of providers?
Special Needs: ANY setting

- Clear communication, documentation, about ANY changes in medications, advanced directives, wound care, feeding, and toileting
Caring for the Caregiver

- It’s everyone’s job to assess how the caregiver is coping/managing with their own care

- Creating a supportive, non-threatening, guilt-free atmosphere is key to family caregivers

- Reinforce notion that the best care for the care recipient is not always provided at home

- Listen, listen, listen
Adjusting to the “new normal”

- Help families see the “big picture” of dementia
  - Progressive, debilitating disease
  - Care needs will change
  - Likely, will need to enlist assistance as time goes on, either through formal or informal means
  - Help them embrace “palliative” versus “curative” ways of thinking, as appropriate to the situation
The Care Transitions Intervention® at Baylor Scott & White Health

Eric Coleman, MD, MPH
Care Transitions Intervention ®

Designed to encourage and support older patients and their family caregivers to assert a more active role during care transitions

(c) Eric A. Coleman, MD, MPH
Why do patients need a Care Transitions Coach?
The Care Transitions Intervention (CTI)®

- Developed by Eric A. Coleman, MD, MPH
  - University of Colorado Denver
  - Evidence-based, patient-centered 30 day intervention

- Designed to impart skills and confidence to patients and family caregivers during care transitions

www.caretransitions.org
The CTI® Model

- A Transitions Coach is the vehicle to build skills, develop confidence and provide tools to support self-management

- Intervention Focus
  - Setting a personal health goal
  - 4 Pillars
    - Personal Health Record
    - Medication review/self-management
    - Identifying ‘red flag’ symptoms
    - Follow up with Primary Care Provider

- One hospital visit, One home visit, Three phone calls
Personal Health Record

- A patient generated record of information important to the patient and family at this time of transition:
  - Health goal as verbalized and written by the patient
  - Medication list and questions for a healthcare professional
  - List of red flags and action plans
  - Questions for primary care provider and specialist(s)
  - Medical history (including information about most recent hospitalization)
  - Personal, caregiver, provider contact information
Medication Review

- Coach-facilitated interaction with patient on medications and discharge instructions:
  - Patient self report of all medications and supplements being taken and how
  - Patient reading of medication bottles
  - Patient review of medication instructions on the hospital discharge instruction sheet

- Coach integrates the three sources of information and engages patient in identification of discrepancies and action planning to address problems

- Patient is coached to create a written list of medications as they are currently being taken and questions resulting from discrepancies to be addressed by a healthcare professional
Red Flags

- Patient self report of signs and symptoms related to health conditions

- Patients are coached to monitor and identify changes in signs and symptoms, *including any that may have led to the recent hospitalization*

- Red Flags as reported by patient and identified action plans are written in the PHR by the patient

- Coach encourages patient to seek out additional information on Red Flags from healthcare providers
PCP Follow Up Appointment

- Coach and patient review progress on personal health goal and problem-solve potential next steps
- Coach reviews upcoming medical appointments (labs, PCP, specialists) based on patient self report and review of discharge instructions
- Coach encourages patient to attend all appointments with the Personal Health Record in hand
- Coaching techniques are used to facilitate action and success
  - Patient practices how to ask questions of the doctor and/or nurse
  - Coach and patient practice (role-play) how to call a medical office to schedule appointments within prescribed time frame
  - Patient is coached how to navigate local healthcare systems such as making same-day appointments and stressing the importance of discharge instructions when talking with scheduler
Case Study
Female patient, 63
Hospitalized for sepsis due to a UTI
Hospital visit 1/3/12, Discharged 1/4/12

Home Visit (1/6/12)
- Goal: Get back to volunteering at the library
- Introduced use of PHR
- Eleven medication discrepancies identified
- Unable to get appropriate follow-up appointment
  - Called back with Coach and was able to get lab appt/ follow up visit scheduled for <2 weeks after discharge and an appt. to establish care with PCP
- Reviewed ‘red flags’ and steps to take if symptoms return

Phone Call 1 (1/20/12)
- Follow up on goal and coached patient on continued use of PHR
- Reviewed results of follow up visit
  - Medication review (see screen shot)
- Coached patient on continuous communication with Dr. as needed (prescribed medication was too expensive; Dr. did not give a different medication)

Phone Call 2 (1/27/12)
- Follow up on goal progress, continued use of PHR, and attending follow up appointments
- Patient noticed she was experiencing ‘red flags’ and thought she was getting another UTI
  - She called for an appointment, but couldn’t get in
  - Coached patients on after hours appointment availability of same-day appointments
  - Review of medical records indicated she was seen at clinic and given medication (see screen shot)
Female patient, 63
Hospitalized for sepsis due to a UTI
Hospital visit 1/3/12, Discharged 1/4/12

1/28/12 Clinic Visit

CHIEF COMPLAINT:
UTI.

HISTORY OF PRESENT ILLNESS:
This is a 64-year-old white female with recurrent UTIs who presents today with a 3-day history of dysuria. She is also reporting frequency and urgency. She denies any hematuria. She states that she has some pelvic pain and low back pain as well as some right-sided flank pain. She reports some nausea, but no vomiting. She denies any fever, but she does have some chills at night. She states this is about her 9th or 10th UTIs in the past year.

ASSESSMENT/PLAN:
UTIs:
days:
symptoms:
plan:

1/17/12 Follow Up Visit

1/17/12 Follow Up Visit has not sought treatment. We discussed this with her at length and told her that most of her problems could be related to her sleep apnea. These include her headaches as well as her severe fatigue. Also, there were significant discrepancies in the discharge summary medications versus what the patient is actually taking. During her hospitalization, she had developed some acute renal insufficiency and her diuretics were stopped, and she has remained off them. Her medications were reconciled.

MEDICATIONS:
1. For hypertension, metoprolol 50 mg twice a day.

Phone Call 2 (1/27/12)

- Follow up on goal progress, continued use of PHR, and attending follow up appointments
- Patient noticed she was experiencing ‘red flags’ and thought she was getting another UTI
  - She called for an appointment, but couldn’t get in
  - Coach educated her on the availability of same-day appointments at the weekend clinic
  - Review of medical records indicated she was seen at clinic and given medication (see screen shot)
Role of Family Caregivers in Transitional Care

- Presence of a family caregiver (CG) during the initial contact with a patient
  - Associated with 5-fold increase in intervention completion compared to patients without a CG present
  - Male patients were nearly 8 times more likely to complete if CGs were present during recruitment

CTI® Model Enhanced to Include Family Caregivers

- Family caregivers goal setting has been incorporated into the CTI model

- Delivery of intervention adjusted based on
  - Engagement of the family caregiver
  - Family caregiver’s ability to anticipate next steps to implement the care plan

- Evidence demonstrates model is effective as measured by increase in activation, identification of medication errors and discrepancies, CTM-3 scores, and goal attainment

WELCOME TO THE CARE TRANSITIONS PROGRAM®

Health Care Services for Improving Quality and Safety during Care Hand-offs. The Care Transitions Program is under the direction of Eric A. Coleman, MD, MPH

- What is transitional care?
- What is the Care Transitions Intervention®?
- How do I get Care Transitions Intervention® training?
- How can I assure that my family gets the best possible care?

www.caretransitions.org
Questions

The post test is now open. The post test must be completed by 2pm ET in order to receive CME or CE credit.

The evaluation is now open. The evaluation must be completed by 5pm ET in order to receive CME or CE credit.
Thank you for joining our webinar. Please take a moment to complete a brief evaluation on the quality of the webinar.

If you are applying for CME/CE credit, you must complete the evaluation as well as the post-test at this time.

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