DEMENTIA CAPABLE CARE TRANSITIONS–BETTER CARE AND BETTER OUTCOMES

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Persons with dementia and their care partners experience exceptional challenges receiving dementia capable healthcare and related community-based care transition services during and after a hospital stay. This is the case although persons with dementia are hospitalized nearly twice as often as their peers who are cognitively healthy.[1] During a hospital stay, persons with dementia are at higher risk for "delirium, falls, dehydration, inadequate nutrition, untreated pain and medication-related problems."[2] They are also "more likely to wander, to exhibit agitated and aggressive behaviors, to be physically restrained, and to experience functional decline that does not resolve following discharge."[2] Yet hospitals and emergency departments do not routinely assess older individuals for cognitive issues, even when patients are unreliable reporters of their medical history, have difficulty answering questions or defer to family to respond, fail to follow instructions or are told of memory issues by their caregivers.

Best practices in hospital care and home transition for patients with dementia have been shown to reduce readmission rates, and mitigate the potential for poor outcomes, such as medication errors, infections and falls, as well as the care risks during transitions that include inability to understand or follow discharge instructions and medication schedules, failure to effectively communicate with caregivers about managing complex care and high burden for caregivers following the hospitalization.[3] Unfortunately, evidence-based care transition models have routinely excluded patients with dementia, and often have limited interactions with caregivers.

Nevada Senior Services has developed a comprehensive array of services that serve as a model of a successful dementia capable system. Over the past decade, the organization has embraced a strategy called Hospital2Home to support individuals living with dementia, along with their care partners. The details of this program, outlined here, serve as an example of a successful best-practice program offering dementia capable care to patients, and achieving better outcomes for these patients when they transition from hospital to home.

BETTER HOMECARE BEGINS IN THE HOSPITAL

On any day, as many as 25 percent of elderly hospital patients may have dementia, often without a documented or recorded diagnosis.[4] These patients frequently seek hospital or emergency department care due to dementia-related complications, including challenging behaviors, chronic or acute illnesses and accidents or falls. Unfortunately, "dementia increases the burden on acute care systems and is associated with excessive use of nursing resources, higher complication rates and longer stays."[5] However, a knowledgeable hospital staff is in the ideal position to recognize and address the needs of patients with cognitive impairments before they become an unmanageable burden. Hospital2Home staff are trained to be alert to the following:

1. Admission to a hospital or emergency department visit can present an opportunity to identify individuals living alone with dementia, including those who would benefit from more intensive community supports and persons in potentially unsafe situations. These patients can be unaware of services, lack financial resources to pay for care and/or possess limited insight into their changing cognitive capacity. Hospitals can work with direct care staff to recognize common signs of dementia; this is especially critical for individuals living alone without family or a support network.

2. Persons with moderate to severe dementia are more likely than those without cognitive impairments to have co-morbidities that result in hospitalization, such as coronary artery disease, stroke, diabetes and cancer. Throughout the middle and later course of dementia, there can be an exacerbation of symptoms, including challenging

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behaviors. In many instances, behaviors are the precipitating cause of a trip to the emergency room. Caregivers often experience high levels of stress during and after hospitalization of their loved one, intensified by repeated hospital stays.

3. The majority of persons living with dementia will experience behavioral and psychological symptoms over the course of their illness. Care partners are often challenged to understand the cause, and effectively address common behaviors, particularly aggression, agitation and psychosis. Behavioral symptoms result in more frequent contact with healthcare professionals and emergency department visits. Once there, individuals are at risk for inappropriate referrals to psychiatric facilities, pharmacological treatments, restraints and nursing home placement.

4. Persons aging with intellectual and developmental disabilities (I/DDs) with Alzheimer's disease (AD) and AD-related dementias (ADRD) or those at high risk of ADRD often experience the onset of dementia earlier than the general population. Diagnosing dementia in this population can be a difficult and complicated process, especially when conducted in a hospital setting. This is often compounded by the fact that more than 25 percent of individuals with I/DDs live with their aging parents, who are often in poor health due to the stress of long-term caregiving.[6] Physicians are challenged in making this more complex diagnosis, as dementia is manifested in areas of functioning that may already be impaired by the developmental disability. Without a formal diagnosis, individuals with I/DDs are less likely to be connected with dementia capable resources.

HOSPITALS BUILD THE FOUNDATION FOR BETTER HOME CARE OUTCOMES

Hospital2Home's Dementia Capable Care Transitions program was developed to address challenges that persons with ADRD and their care partners experience in receiving inpatient healthcare and related community-based care transition services during and after a hospital stay.

The goal. The goal of the project is improving the healthcare outcomes for persons with ADRD and their care partners, by implementing an innovative delivery system known as Care Transitions for Persons with Dementia, utilizing an integrated instrumentality of evidence-based models. A system of care, connected to an integrated seamless post-hospitalization toolbox of evidence-based/informed resources, is at the core of this innovative approach.

The objectives. The objectives of the project are as follows: 1) deliver an evidence-based care transition model and post-care transition services to persons living with ADRD and their care partners, within a community-based dementia capable framework, 2) offer short-term intensive respite services to care partners following hospital discharge and 3) provide dementia capable education and training to hospital staff.

Outcomes. Targeted outcomes include enhancement of an evidence-based care transition model in conjunction with post-care transition services, to improve healthcare outcomes for persons with ADRD and their caregivers through these six factors: 1) reduced readmission rates, 2) decreased caregiver burden, 3) decreased caregiver depression, 4) decreased falls rate, 5) increased self-rated health, 5) increased caregiver coping and 6) enhanced patient–caregiver activation.

DEMENTIA CAPABLE EDUCATION MODEL

Older adults with dementia are more likely to have poor outcomes when hospital staff, especially those with direct contact (including nurses, social workers and nursing assistants), lack knowledge and training in caring for these patients and supporting their caregivers. One study demonstrated the positive impact of dementia training on the knowledge, confidence and attitudes of hospital staff.[7] Hospital2Home's dementia capable education program is designed to support and educate hospital staff and caregivers.

The Hospital2Home program includes an informative seminar for clinicians and healthcare management, "Thinking about Thinking," that addresses the key role cognition plays in patient success in the acute care environment.

Additionally, the respite coach serves as a dementia capable advocate, an integral part of the care transitions team. Certified nursing assistants/respite coaches are trained using a specialized dementia-specific curriculum. Dementia capable education is delivered by the educator/trainer, and tailored to hospital staff, for example, emergency department personnel, social workers, discharge planners and nurses.

Dementia capable training also addresses the needs of caregivers. Hospital2Home offers a 90-minute workshop for caregivers, "Thoughtful Hospitalization," to prepare caregivers for possible hospitalization, and to help them understand caregiver rights. It is widely recognized that the individual with ADRD and the caregiver benefit from a range of supportive services, including person-centered planning, evidenced-based interventions and other programs over the course of the illness.

POST-CARE TRANSITION SERVICES

Hospital2Home offers an innovative post-care transition

service following the 30-day evidence-based care transitions program. Post-care transition planning is conducted by the care transitions specialist at the 30-day post-assessment for ongoing and individualized support to enhance care. Person-centered plans are developed, and can be modified based on goals and needs, for example, changing symptoms, co-occurring health conditions, behavioral and psychological symptoms of dementia (BPSD) and caregiver support and education.

OUTCOMES

Hospital2Home has completed 1.5 years of operation since launch. Results to date have been impressive.

Medicare Readmission Rate:H2H< 1 percent
Southern Nevada >35 percent
Currently, seven participating hospitals and 39 participating organizations.
188 referrals to date, currently averaging five to seven referrals per week.

GLEANINGS

Discharge Challenges (n=54)

Delayed Community Resources	72 percent
Insufficient Home Support	67 percent
Unsafe Physical Home Environment	50 percent
Poor Primary Care Utilization	37 percent
Discharge Plan Confusion	30 percent

Referrals for Supports (n=55)

Caregiver Support	96 percent
Respite Care	69 percent
Home Modification	35 percent
Personal Care Assist	31 percent
Durable Medical Equipment (DME)	25 percent

Problem Landscape (n=55)

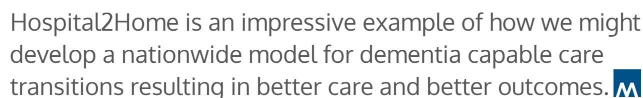
Dementia Education	76 percent
Obtaining Respite	65 percent
Caregiver Stress	60 percent
Caregiving Skills	60 percent
Dementia – Changes/Stages	45 percent
Public Benefits	42 percent

CONCLUSIONS

Nevada's Hospital2Home program is designed to build dementia capability, and reduce the impact of service gaps, by adding a dementia component to an existing evidence-based transition model. The program strives to provide post-care transition person- and family-centered planning for connections to community services, to partner with hospitals for education and training on dementia-specific practices and to provide intensive respite for caregivers following a hospitalization.

Hospital2Home has proven to be highly effective in reducing hospital readmissions of persons with cognitive impairment. It has also provided, for the first time, a developing picture of the challenges faced by persons with cognitive impairment and their family caregivers as they interface with the healthcare delivery system. The roadmap suggested by the data provides useful data for effective post-discharge follow-up and program development.

Hospital2Home is an impressive example of how we might develop a nationwide model for dementia capable care transitions resulting in better care and better outcomes.



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