**Geriatric-Competent Care Webinar Series**

*This is the text version of* Geriatric-Competent Care Caring for Individuals with Alzheimer’s disease Session III *which contains the same information as the slide presentation and was prepared to meet 508 compliance standards.*

**Slide One**

**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

October 29, 2015

**Slide Two**

**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](http://www.resourcesforintegratedcare.com/)

**Slide Three**

**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

**Slide Four**

**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

**Slide Five**

**Supporting 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**](http://www.resourcesforintegratedcare.com/)

**Slide Six**

**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:

Gregg Warshaw, MD

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-Faculty:

Kathryn Agarwal, MD

Karen M. Rose, PhD, RN, FGSA, FAAN

Alan B. Stevens, PhD

Eric Coleman, MD, MPH

**Slide Seven**

**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

**Slide Eight**

**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

**Slide Nine**

**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

**Slide Ten**

**Improving Care of Individuals with Dementia Admitted to the Hospital**

Kathryn Agarwal, MD

**Slide Eleven**

**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

**Slide Twelve**

**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.”

Creditor, *Ann Int Med* 1993

**Slide Thirteen**

**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)

**Slide Fourteen**

**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

*\*Lyketsos. Am J Psychiatry 157:5, May 2000*

**Slide Fifteen**

**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 Boustani M. et al. JGIM, 2005*

*Ely et al JAMA 2001;286:2703-2710 McNicholl JAGS 2003;51:591-598*

*Ely et al CCM 2001;9:1370-1379 Inouye SK, Arch Intern Med. 2001;161:2467-2473*

**Slide Sixteen**

**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/>

*B. Leff, L. Burton, S. L. Mader et al., "Hospital at Home: Feasibility and Outcomes of a Program to Provide Hospital-Level Care at Home for Acutely Ill Older Patients," Annals of Internal Medicine, Dec. 2005 143(11):798–808.*[*http://www.commonwealthfund.org/publications/newsletters/quality-matters/2011/august-september-2011/in-focus*](http://www.commonwealthfund.org/publications/newsletters/quality-matters/2011/august-september-2011/in-focus)

**Slide Seventeen**

**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

**Slide Eighteen**

**Models of Care for Frail Elders**

-Dementia Friendly Hospitals

-Acute Care for Elderly (ACE) Units

-Hospital Elder Life Program (HELP)

-Geriatric Emergency Rooms

**Slide Nineteen**

**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

-<http://www.alz.org/stl/in_my_community_62183.asp>

Free information online, assistance from local chapters available

Free educational modules, slides, videos

**Slide Twenty**

**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

**Slide Twenty-One**

**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](http://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

**Slide Twenty-Two**

**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

**Slide Twenty-Three**

**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

**Slide Twenty-Four**

**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

**Slide Twenty-Five**

**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

**Slide Twenty-Six**

**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)

**Slide Twenty-Seven**

**Transitions of Care: Empowering Families in the Process**

Karen M. Rose, PhD, RN, FGSA, FAAN

**Slide Twenty-Eight**

**Family Caregivers Provide the Bulk of Care for Persons with Dementia**

-Treat them with respect!

-Handle with care!

**Slide Twenty-Nine**

**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

**Slide Thirty**

**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

**Slide Thirty-One**

**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)

**Slide Thirty-Two**

**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

**Slide Thirty-Three**

**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)

**Slide Thirty-Four**

**“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?

**Slide Thirty-Five**

**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

**Slide Thirty-Six**

**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

**Slide Thirty-Seven**

**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?

**Slide Thirty-Eight**

**Special Needs: ANY setting**

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

**Slide Thirty-Nine**

**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

**Slide Forty**

**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

**Slide Forty-One**

**The Care Transitions Intervention®; Eric Coleman, MD, MPH**

**Slide Forty-Two**

**Care Transitions Intervention ®**

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

**Slide Forty-Three**

**Why do patients need a Care Transitions Coach?**

**Slide Forty-Four**

**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](http://www.caretransitions.org/)

**Slide Forty-Five**

**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

**Slide Forty-Six**

**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

**Slide Forty-Seven**

**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

**Slide Forty-Eight**

**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

**Slide Forty-Nine**

**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

**Slide Fifty**

**Case Study**

[Image of cartoon]

**Slide Fifty-One**

**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)

**Slide Fifty-Two**

**Female patient, 63 Hospitalized for sepsis due to a UTI Hospital visit 1/3/12, Discharged 1/4/12**

**Slide Fifty-Three**

**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

*Epstein-Lubow G, et al. Caregiver presence and patient completion of a transitional care intervention. Am J Manag Care 20:e349-444, 2014.*

**Slide Fifty-Four**

**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

*Coleman EA, et al. Enhancing the care transitions intervention protocol to better address the needs of family caregivers. J Healthc Qual 37:2-11, 2015.*

**Slide Fifty-Five**

**The Care Transitions Program**

[www.caretransitions.org](http://www.caretransitions.org)

**Slide Fifty-Six**

**Questions**

-The post test is now open. The post test must be completed by 2pm EST 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.

**Slide Fifty-Seven**

**Evaluation Form and Post-test**

-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.

-Video replay and slide presentation are available after each session at: [https://www.resourcesforintegratedcare.com](https://www.resourcesforintegratedcare.com/)