Questions and Answers (Q&A): Caring for Individuals with Alzheimer's Disease and Related Dementias

Webinar 3: Care Transitions to And from The Hospital for Individuals with Alzheimer's Disease and Related Dementias

Participants asked these questions during the October 29, 2015, webinar on care transitions to and from the hospital for individuals with Alzheimer's disease and related dementias, webinar 3 in the Geriatric Competent Care Webinar Series, Caring for Individuals with Alzheimer's Disease and Related Dementias. We have edited speakers' responses for clarity. The panel discussion recording, slides, and transcript can be found on the Resources for Integrated Care website by clicking the following link:

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

Featured Speakers:

- Kathryn Agarwal, MD, Section of Geriatrics, Baylor College of Medicine
- Eric Coleman, MD, MPH, Professor of Medicine, Head of the Division of Health Care Policy and Research. University of Colorado Anschutz
- Karen Rose, PhD, RN, FAAN, School of Nursing, University of Virginia
- Alan Stevens, PhD, Center for Applied Health Research, Baylor Scott & White

Managing Care Transitions

Q: Can you speak about any special considerations for hospitals and managing care transitions in rural communities?

Dr. Kathryn Agarwal: I've seen multiple examples of the Interventions to Reduce Acute Care Transfers (INTERACT) program for transitions of care to skilled nursing facilities and rehabilitation units, and I've seen those work very well in rural and in more metropolitan areas. The INTERACT program is a very good communication tool between hospitals and facilities to improve the transitions of care. The Care Transitions Intervention (CTI) is successful in some rural areas, and it's successful in many other places. The other option may be also working with Area Agency on Aging programs that have adopted different care transition interventions that can be helpful. In more rural areas, follow-up phone calls done in a thoughtful and careful way are effective in reaching patients and caregivers. It is important to note, having a group of nurses make these phone calls focused on care transition after the hospital stay to help those patients in a more than merely 'are you feeling okay', but 'have you gotten your medications

filled, if not, how can I help you' is a critical part of the intervention. The calls are actual meaningful ways of trying to help understand the barriers to implementing programs initiated at discharge. It would not be just a simple 'are you happy?' phone call after discharge, but more focused and maybe repetitive phone calls after discharge to try to address the issues. A lot of times patients just aren't able to get the appointment made, and so repeated phone calls can help them plan to get to the follow-up appointments and also get them connected to other community resources. Our groups of nurses that call after discharge are also active in getting patients connected to community resources as well.

Dr. Eric Coleman: The CTI model does work in rural settings. Sometimes you do need to make adjustments just because of the distances. We have had some experience trying to graft this model onto a telehealth experience, and so far, my encapsulated view of telehealth is it certainly has a lot of advantages, particularly when it comes to sharing information and communicating professional to care recipient. I remain unconvinced we can use telehealth for some of the skill transfer behavioral change that we're trying to get to. But we continue to learn, and hopefully we'll have some breakthroughs.

Care Transitions Intervention (CTI) - Coleman Model

Q2: How does the Coleman model apply to people with dementia? How is the person with dementia engaged in addition to family caregivers?

Dr. Gregg Warshaw: The Coleman model for care transitions from the hospital back into the community is especially valuable for adults with pre-existing cognitive impairment. It is critical that the family members and caregivers be fully educated about the key steps in the discharge planning, needed follow-up care, and important warning signs that recovery is not proceeding as planned. The adult with the dementia would be engaged in this process as much as possible considering the stage of their illness.

Dr. Eric Coleman: If an individual has moderate to advanced cognitive impairment, we still would like them to benefit from the CTI, but in that instance, we would ideally try to involve one or more family member or caregivers. Even though we may spend a fair amount of our time coaching the family members, it's not that we turn our attention completely away from the individual with cognitive impairment. There's good data in the literature that suggests individuals even with moderate to advanced dementia can formulate goals that are meaningful to them and that reflect their view of quality of life. And so, the goal setting, which I mentioned is really paramount to the model itself, of course includes the individual as well as their family members. And when possible, we don't make assumptions. We give the individual with cognitive impairment an opportunity to participate but do it in a collaborative way with their family. We don't automatically assume they're not involved in their own care. It's a bit of a

balancing act, trying to do this together, collaboratively. If an individual has moderate to advanced cognitive impairment but does not have an identified family caregiver, they may not be a great fit for this model. On the other hand, if they do have willing, able, and engaged family members, we have learned quite a bit about how to engage both simultaneously, and the goals are really a great way to do that.

Q3: How do you see Aging Life Care Professionals™/Geriatric Care Managers to be of assistance in your model?

Dr. Gregg Warshaw: When available, Geriatric Care Managers can provide excellent care transition services in collaboration with family caregivers.

Q4: Does the CTI have patient outcomes data?

Dr. Greg Warshaw: The CTI (Coleman model) is a well-researched intervention. CTI has documented 20-50% reductions in hospital re-admissions (results very based on pre-intervention re-hospitalization rates). References and more outcomes data are available on the CTI website.

Communication

Q5: Do you have any recommendations for health plan staff who are trying to connect individuals with community resources?

Dr. Karen Rose: It's really important to get to the know the people on these community resource lists by calling them, talking to them, visiting them, figuring out what's present or what they have available. This information maybe on their website, but it isn't always accurate and oftentimes it doesn't really give the details. However, you connect, face to face or over the phone, with these community resources, that's really important so that you really do understand what resources they have. Additionally, this is important to continue because the resources certainly change over time. Funding streams change and even locations change, websites may not even have the right addresses at times. There ought to be a systematic undertaking every six months or every year of going through the list and calling and getting updated information from community resource organizations.

Clinical Management of Alzheimer's Disease, Consideration of Risks and Medication Options

Q6: What effort is being made to encouraging physicians that are prescribing drugs with numerous side effects to instead utilize more holistic treatment?

Dr. Gregg Warshaw: Physicians are increasingly aware of the adverse side effects of medications; especially in older adults and in adults with dementias. It is important that older

adults see their primary care provider (PCP) regularly and that they bring all their prescribed and over-the-counter medications with them to each appointment. The older adult and their caregivers should expect their PCP to review each of the medications for continued need and for possible drug-drug and drug-disease interactions without the need for bringing the patient to the emergency room or other harsher interventions.

There are no drugs specifically developed and tested to treat any specific behavioral symptoms a patient or a caregiver might present to you. There are behavioral symptoms that we can teach the caregiver to deal with in different ways. Medications are quite a controversial issue right now in the context of dementia. We certainly do use them, but it should include a discussion with the patient and the caregiver about their pros and cons.