Transitions of Care

Key Issues and Approaches for People with Dementia

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KEY ISSUES WITH DEMENTIA
Financial Cost –
Ave Annual Per-Beneficiary Cost of Care

- **Medicare**
  - Average Cost of Care for Beneficiaries with Alzheimer's Disease and Other Dementias: $18,500
  - Average Cost of Care for Beneficiaries without Alzheimer's Disease and Other Dementias: $5,500

- **Medicaid**
  - Average Cost of Care for Beneficiaries with Alzheimer's Disease and Other Dementias: $9,500
  - Average Cost of Care for Beneficiaries without Alzheimer's Disease and Other Dementias: $1,000
Care Transitions > Poor Outcomes

- Increase risk of fragmented care and poor outcomes
- Hospital-acquired complications, morbidity, mortality and excess health care expenditures

https://doi.org/10.1093/geront/gnx152
Human Cost
Cognitive and functional decline

• **Comorbid illnesses influence dementia progression**
  – Illness exacerbations accelerate functional decline
  – Many conditions – dehydration, UTI, delirium from medication effects – could be prevented or managed earlier

• **PWD do poorly with hospital stays** - are associated with adverse health events such as:
  – Delirium, Falls, Pressure ulcers, Untreated pain
  – Functional decline
  – Caregiver strain/stress
People with Dementia

• Have more care transitions per year than those without dementia

• May be at particular risk of experiencing *preventable* transitions in care because of
  – the large number transitions, comorbid medical conditions and severity of cognitive impairment

2X People with dementia hospitalized twice as often as people without dementia
# PWD Percentage with Specific Coexisting Conditions

<table>
<thead>
<tr>
<th>Coexisting Condition</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Coronary artery disease</td>
<td>38%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>37%</td>
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<tr>
<td>Chronic kidney disease</td>
<td>29%</td>
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<tr>
<td>Congestive heart failure</td>
<td>28%</td>
</tr>
<tr>
<td>COPD</td>
<td>25%</td>
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<tr>
<td>Stroke</td>
<td>22%</td>
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<tr>
<td>Cancer</td>
<td>13%</td>
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</tbody>
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Alzheimer’s Association Facts & Figures 2018: Unpublished data from National 5% Sample Medicare FFS Beneficiaries 2013
Dementia + Chronic Conditions

- 95% of Medicare beneficiaries with dementia have 1+ other chronic conditions
- 77% have 3+ additional chronic conditions
- PWD have greater odds of having potentially avoidable hospitalizations for chronic conditions like diabetes and hypertension
- 15% of hospitalizations for PWD 65+ are potentially avoidable
Hospitalizations

Common reasons for hospitalizations in pwd:

• Falls
• Poor management of co-morbidities
• Seizures
• Ischemic heart disease
• Gastrointestinal disease
• Pneumonia
• Delirium

Focus on what may be preventable
Readmissions

- Dementia is associated with increased risk for readmission
- Medicare beneficiaries with a dementia were nearly 20% more likely to have a readmission with 30 days
Care Transition Challenges in Dementia

Risks for Re-hospitalization

- Poor understanding of discharge instructions, including medications
- May be less able to express their symptoms which can delay decisions to seek treatment
- May not attend follow-up visits
- Poor caregiver understanding of dementia and limitations on capacity (realistic expectations)
- Caregiver burnout
Lack of Awareness and Understanding

Lack of awareness around presence of cognitive impairment

And/or

Lack of understanding of the impacts of cognitive impairment/dementia

Includes awareness & understanding among patient, families and professionals!
What can be done?

APPROACHES
## Review of E-B Interventions – CT/Dementia

<table>
<thead>
<tr>
<th>E-B Care Transitions/Dementia</th>
<th>Type</th>
<th>Setting</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York University Counseling Intervention</td>
<td>Psychosocial, psychoeducational</td>
<td>Home</td>
<td>Delayed time to NH</td>
</tr>
<tr>
<td>Dementia Caregiving Training Program</td>
<td>Psychosocial, psychoeducational</td>
<td>Psych hospital</td>
<td>Delay in institutionalization</td>
</tr>
<tr>
<td>Goals of Care Intervention</td>
<td>Psychosocial, psychoeducational</td>
<td>Nursing home</td>
<td>Reduced hospital and ER visits</td>
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<tr>
<td>Transitional Care Model /Naylor</td>
<td>Care coordination</td>
<td>Hospital to home</td>
<td>Delayed time to rehospitalization</td>
</tr>
<tr>
<td>MIND at Home</td>
<td>Care coordination</td>
<td>Home</td>
<td>Delay in all-cause transitions</td>
</tr>
<tr>
<td>Partners in Dementia Care</td>
<td>Care coordination</td>
<td>Home</td>
<td>Fewer hospitalizations &amp; ER visits</td>
</tr>
<tr>
<td>Geriatrics Team Intervention</td>
<td>Care coordination</td>
<td>Assisted living</td>
<td>Reduced risk of transitions</td>
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</table>
Five Key Elements of Successful Interventions

1. Educating the individual and caregiver about likely transitions in care and ways to delay or avoid the transition;
2. Providing timely communication of information among everyone involved, including the individual, caregiver and care team;
3. Involving the individual and caregiver in establishing goals of care (person-centered);
4. Comprising a strong collaborative interprofessional team; and
5. Implementing evidence-based models of practice.
UCLA Project – Dementia Overlay

- Adapted tools and protocols for dementia caregivers (overlay Coleman/Bridge programs – to prevent readmissions)
- Expand referral criteria to include mid-stage dementia
- Developed Care Transitions Notebook – tool for coaches to use in teaching families
- Trained coaches (5 hour training)
- In-home visit and 3 phone calls in first 30 days after discharge
- Self-reported data indicates ER and hospitalization rates within 30 days of hospital discharge were lower than historical reports

UCLA Resources

Care Transitions Notebook:
Caring for Someone with Memory Loss or Alzheimer’s After a Hospitalization

Notebooks can be downloaded free of charge:
- English, Spanish
- Korean, Armenian

The Coaches training and facilitator guides assist providers as they work with caregivers:
- Care Transitions Coaches Training
- Care Transitions Coaches Facilitator Guide

https://www.alzgla.org/professionals/hospital-home-transitions/
What Can We Do?
Preparation & Prevention

- Educate providers about dementia and its impact on comorbidities
- Promote best practice clinical care to reduce preventable hospitalizations
- Target cognitively impaired individuals who live alone, particularly in falls prevention efforts
- Link individuals to resources
- Refer to family caregiver supports
- Engage in innovations/research to reduce preventable hospitalizations and readmissions

Inform/Educate Clinical Providers

• Diagnosis
• Ongoing Care and Support/Management
• Transitions of Care
• Advance Care Planning
• Palliative Care
• Preparing for Potential Hospitalization
• Delirium
Hospitalization Happens

Hospitalization Happens – Guide to Hospital Visits for Individuals with Memory Loss

- [https://memory.ucsf.edu/sites/memory.ucsf.edu/files/wysiwyg/HospitalizationHappens.pdf](https://memory.ucsf.edu/sites/memory.ucsf.edu/files/wysiwyg/HospitalizationHappens.pdf)

AD Caregiving Tips: Going to the Hospital

- [https://www.bu.edu/alzresearch/files/2010/03/alzheimers_caregiving_tips_going_to_the_hospital_0.pdf](https://www.bu.edu/alzresearch/files/2010/03/alzheimers_caregiving_tips_going_to_the_hospital_0.pdf)
Hospital to Home

A companion notebook for caregivers of people with dementia

https://www.seniorconcerns.org/programs/hospital-home-notebook/

https://www.alzgla.org/professionals/hospital-home-transitions/
Promote Early Advance Care Planning

- Palliative care
- Hospice care
- Advance care directives
References

• Alzheimer’s Association Facts and Figures 2018
• Alzheimer’s Association Policy Brief, January 2017; Reducing Potentially Preventable Hospitalizations for People Living with Alzheimer’s and Other Dementias. [Link](https://www.alz.org/publichealth/downloads/policy-brief-preventable.pdf)
• Callahan, C. et al; Transitions in Care for Older Adults with and without Dementia. Journal of the American Geriatrics Society/JAGS 63:1495–1502, 2015
• Hirschman, Karen et al; Evidence-Based Interventions or Transitions in Care for Individuals Living with Dementia. *The Gerontologist*, Volume 58, Issue suppl_1, 18 January 2018, Pages S129–S140, [Link](https://doi.org/10.1093/geront/gnx152)
• Lin, Pei-Jung, et al; National Estimates of Potentially Avoidable Hospitalizations among Medicare Beneficiaries with AD and Related Dementias. [Link](https://doi.org/10.1016/j.jalz.2016.06.454)
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