PROJECT ECHO MINISERIES:

BEST PRACTICES IN DEMENTIA CARE

Hosted in collaboration with the
Alzheimer's Association

Seven weekly sessions
Thursday, 3 – 4 p.m. ET | March 7 – April 18

nhpco.org/projectecho

Transition and Coordination of Services

March 28, 2024

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Disclosures

Disclosure

The faculty and planners for this educational event have no relevant financial relationship(s) with ineligible companies to disclose.

Data Collection

In order to support the growth of the ECHO® movement, Project ECHO® collects participation data for each ECHO® program. Data allows Project ECHO® to measure, analyze, and report on the movement's reach. Data is used in reports, on maps and visualizations, for research, for communications and surveys, for data quality assurance activities, and for decision-making related to new initiatives.

Evaluation

Please complete program evaluation materials following each session.

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Ground Rules and Video Teleconferencing Etiquette

- This is an all share-all learn format; judging is not appropriate
- Respect one another – it is ok to disagree but please do so respectfully
- Participants – introduce yourself prior to speaking
- One person speaks at a time
- Disregard rank/status
- Remain on mute unless speaking and eliminate or reduce environmental distractions to improve sound/video quality
- Use video whenever possible; make eye contact with the camera when you are speaking
- **Do not disclose protected health information (PHI) or personally identifiable information (PII)**

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Today's Agenda

- Introduction of Faculty – NHPCO Team
- Didactic Presentation – Faculty
- Case Study Presentation – Faculty
- Discussion – Session Participants, Faculty, and NHPCO Team
- Key Takeaways – Faculty and NHPCO Team
- Closing Remarks – NHPCO Team

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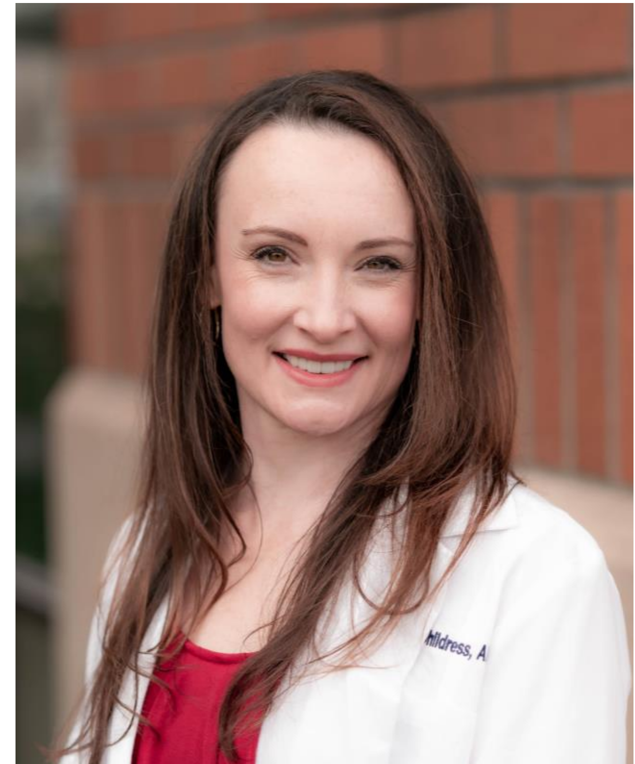

Didactic Presentation

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Learning Objectives

After today's didactic, you will be able to:

- Discuss the factors influencing transitions in care for people living with dementia (PLWD).
- Describe ways that Palliative Care clinicians can help patients and care partners achieve optimal outcomes related to transitions in care.
- Explain how the Dementia Care Practice Recommendations can apply to the work of Palliative Care and Hospice clinicians.

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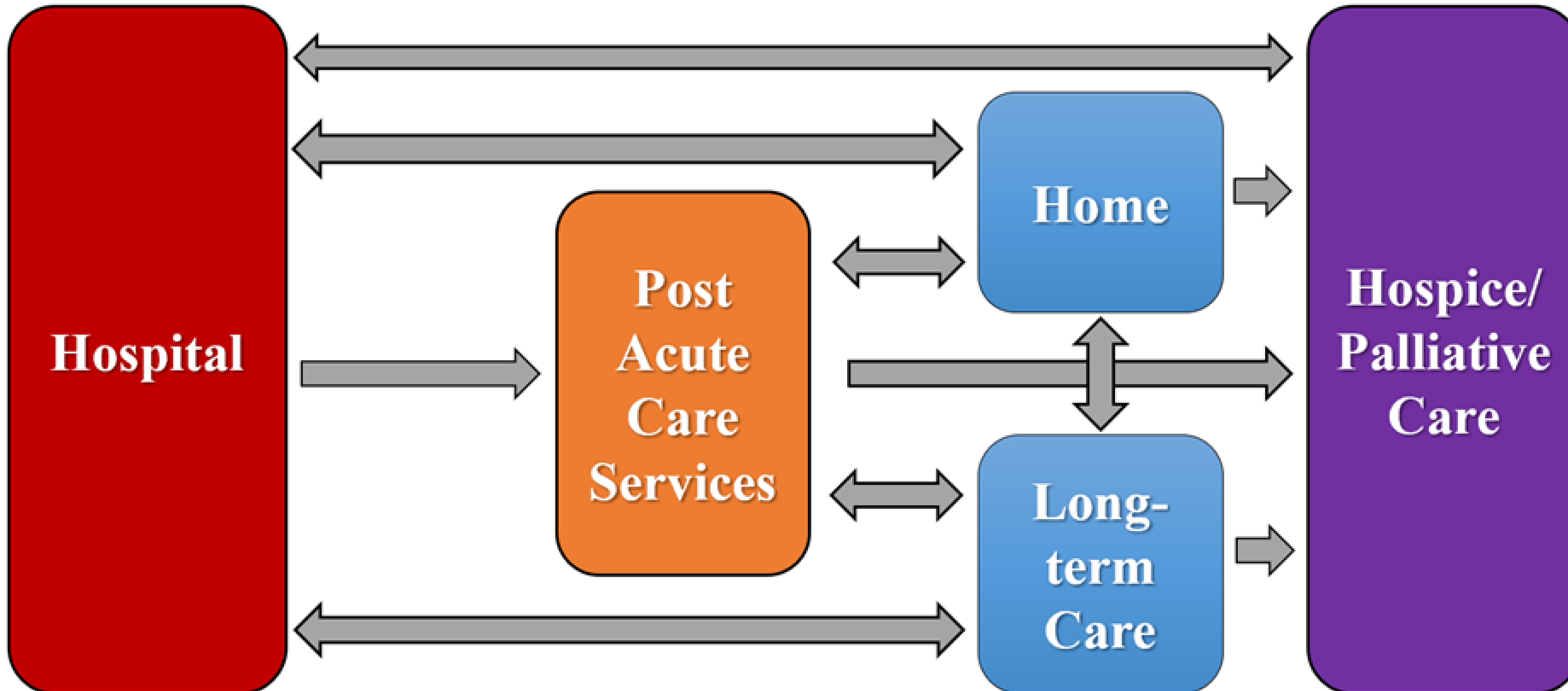
Common Transitions



Hirschman & Hodgson. (2018). The Gerontologist, 58(suppl_1):S129-S140.

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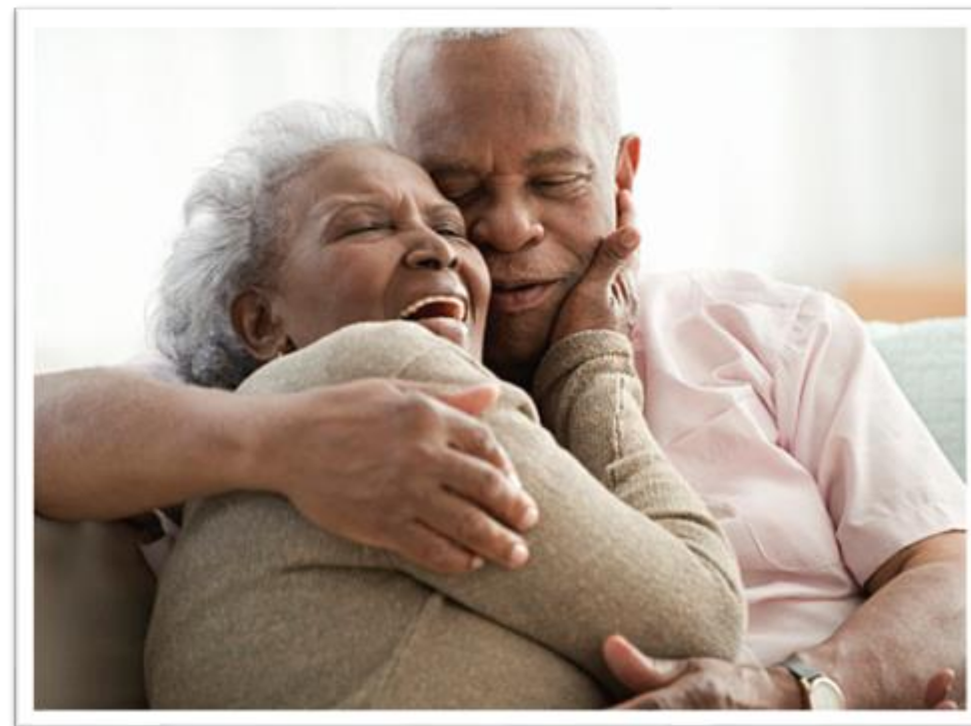
Where People are Living When They Have Dementia

- 64% live at home, up to 59% die at home
- 19% in residential care (assisted living, memory care, adult family homes)
- 17% in long-term care (nursing homes)
- Those living at home are typically:
  - Younger
  - Partnered
  - Of racial/ethnic minority group
  - Less educated
  - Lower income



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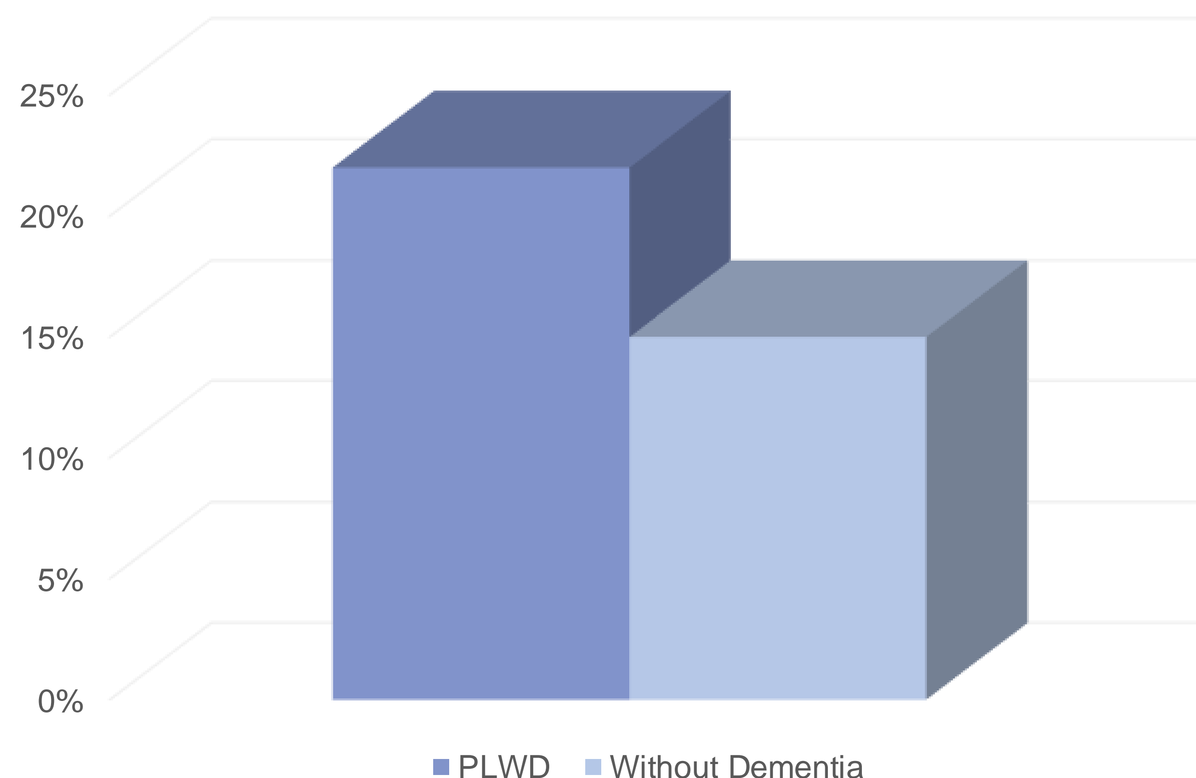
Transitions Between Care Settings

- Older adults with dementia have greater:
  - Nursing facility use
  - Hospital and home health use
  - Overall transitions in care

- Transitions frequently occur between nursing facilities, home and hospital



Alzheimer's Association. 2023 Alzheimer's Disease Facts and Figures. Alzheimers Dement 2023;19(4). DOI 10.1002/alz.13016.

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Transitions of Care

- PLWD who live in residential or long-term care are more likely to experience frequent transitions in care
- Individuals with behavioral and psychological symptoms of dementia (BPSD) have high rates of care transitions and poorer outcomes

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Transitions of Care

- Up to15% of hospitalizations for persons with dementia are potentially avoidable

- Systems to ensure care coordination during transitions of care are lacking

Matsuoka T, Manabe T, Akatsu H, et al. Factors influencing hospital admission among patients with autopsy-confirmed *dementia. Psychogeriatrics. 2019;19(3):255-263.*

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Why Can Transitions Pose a Problem?

- PLWD, care partner are the only common factors
- Fragmentation in care
- Poor outcomes

Costs of Care and Transitions

Average costs for health care services and prescription medications are higher for persons with Alzheimer's Disease or related dementias (ADRD) than those without.

Table 16

Average Annual per-Person Payments by Type of Service for Health Care and Long-Term Care Services, Medicare Beneficiaries Age 65 and Older, with and without Alzheimer's or Other Dementias, in 2022 Dollars

Payment Source	Beneficiaries with Alzheimer's or Other Dementias	Beneficiaries without Alzheimer's or Other Dementias
Inpatient hospital	$7,316	$2,738
Outpatient events	2,876	2,263
Medical provider*	5,936	3,832
Skilled nursing facility	3,694	372
Nursing home	13,623	527
Hospice	2,328	136
Home health care	1,863	275
Prescription medications**	4,811	3,245

*"Medical provider" includes physician, other provider and laboratory services, and medical equipment and supplies.

**Information on payments for prescription medications is only available for people who were living in the community, that is, not in a nursing home or an assisted living residence.

Created from unpublished data from the Medicare Current Beneficiary Survey for 2018.[258]

Alzheimer's Association. 2023 Alzheimer's Disease Facts and Figures. Alzheimers Dement 2023;19(4). DOI 10.1002/alz.13016.

Transitions in Care at the End of Life

Nearly 20% of nursing home residents with ADRD experienced at least one transition in care in the last 90 days of their life.

Hirschman KB, Hodgson NA. Evidence-Based Interventions for Transitions in Care for Individuals Living With Dementia. Gerontologist. 2018;58(suppl_1):S129-S140.

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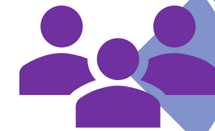
Dementia Care Practice Recommendations

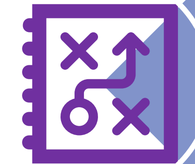
Prepare and educate persons living with dementia and their family caregivers about common transitions in care

Ensure complete and timely communication of information between, across and within settings

Evaluate the preferences and goals of the person living with dementia along the continuum of transitions in care



Create strong interprofessional collaborative team environments to assist persons living with dementia and their care partners/caregivers as they make transitions



Initiate/Use evidence-based models to avoid, delay, or plan transitions in care

Prepare and Educate

- Discuss anticipated transitions, ways to reduce transitions
- Assess informational needs of family caregivers about common transitions

Ensure Complete, Timely Communication

- Between, across, within settings
- Careful attention to ensure safe “handoffs”
- Finding timely and standardized ways to share medical records and advance care planning forms

Establish Preferences and Goals of Care

After any hospitalization or other significant change requiring a transition in care

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Create an Interprofessional, Collaborative team

Use Evidenced-Based Care Models

- Focus on care coordination and psychosocial/ psychoeducational interventions
    - Avoid unnecessary transitions
    - Delay or support moves from the community

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Summary

- People living with dementia are at high risk of frequent transitions of care, including at the end of life.
- Every transition of care increases the possibility of poor outcomes.
- Utilization of the Dementia Care Practice Recommendations can help reduce care transitions and improve outcomes when transitions occur.
- Palliative Care and Hospice teams are well-positioned to implement the DCPR related to care transitions.

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Didactic Presentation Q&A

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Attendee Location Poll

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Case Study Presentation

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Situation

RJ is a 93 year old male with vascular dementia diagnosed in the last 6 months, likely present since his CVA approximately 2 years prior.

Multiple transitions of care in the last year, most recently to memory care two weeks ago and an ED visit for pneumonia and HF one week ago.

Goals of care are comfort:

- Avoid hospitalization if possible
- Avoid medication if possible except for comfort

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Background

PMH: Atrial fibrillation, CVA, HOH, osteoarthritis, eczema, depression, BPH (vascular dementia, PAD)- *no meds*

Summary of Situation:

- Following the CVA he was not doing well at home, family eventually moved him to an independent senior apartment. Self-isolating, yelling at staff, frequent falls, not eating well, poor self-care.
- **May**- Hospitalized after found in apartment stating "I feel like I'm going to die". Refused all care in the hospital, planned discharge with Hospice but didn't meet criteria.
- **June**- Moved into assisted living, frequent falls continued, significant issues with itching (appeared multi-factorial), frequently agitated. *Dx: vascular dementia*
- **October**- Fell, sustained head laceration
- **Early November-** Multiple falls, itching worsening again but refusing treatment
- **Mid-November**- Moved to memory care, multiple falls with wrist fx right before move
  End of November- ER for PNA and HF
- **Early December**- Developed concerning toe wound, discussed active decline with family (wt up due to HF, still eating)

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Assessment

Resident now has multiple, worsening, life-limiting conditions with frequent transitions of care and does not desire curative intervention.

- What clues existed that possibly indicated a relatively brisk rate of decline/likely care transitions?
- What opportunities existed to decrease transitions in care?
- What education or resources might have been helpful for this patient's family?

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Discussion and Recommendations

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Discussion and Recommendations

- Earlier diagnosis of dementia could have allowed for more comprehensive care planning.
- Discussion with knowledgeable healthcare professional prior to move to the independent senior apartment could have identified the need for a higher level of care, thus preventing hospitalization and another transition to AL.
- Referral to comprehensive Palliative Care services after May hospitalization:
  - Would have provided robust interprofessional support for family and patient
  - Likely improved quality of life for the patient
  - More seamless transition to Hospice

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Key Takeaways

- Palliative Care clinicians are well-situated to support PLWD and their care partners in optimizing transitions of care.
- The focus of Palliative Care (person-centered and goal-concordant care) aligns perfectly with the strategies identified in the Dementia Care Practice Recommendations to reduce transitions of care.
- The interprofessional construct of Palliative Care and role of Palliative Care clinicians in promoting ideal communication between members of the care team positions them well to reduce fragmentation of care and poor outcomes from care transitions.

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Key Takeaways

- Palliative Care clinicians can provide connections to support and resources in the community, enhancing quality of life for care partners and PLWD while also potentially reducing care transitions.

- Timely referrals to Hospice can reduce care unnecessary transitions at the end of life.

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Caregiver Support

- Alzheimer’s Association in-person support groups
  - Peer-or professionally led groups for caregivers, individuals living with Alzheimer's and others dealing with the disease
  - Many locations offer specialized groups for children, individuals with younger-onset and early-stage Alzheimer's, adult caregivers and others with specific needs
- Message boards/online community
  - ALZConnected®
    - A free online community/message boards for everyone affected by Alzheimer's or another dementia
  - Individuals living with Alzheimer’s, caregivers, family members and friends can ask questions, get advice and find support
- 24/7 Caregiver Helpline- 800-272-3900

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Session Evaluation and Certificate of Completion

- Your feedback is valuable as we plan upcoming sessions! Please complete the Project ECHO Dementia Care Miniseries Post-Session Evaluation

- Project ECHO sessions are not accredited for continuing education, but we are able to offer a confirmation of completion for participants who attend at least five live sessions and complete all session evaluations as well as a final miniseries evaluation

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Upcoming Sessions

Date: April 4

Topic: Reimbursement, Regulatory, and Quality

Date: April 11

Topic: Building and Supporting an Empowered Workforce

Date: April 18

Topic: Summary and Wrap-Up

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Additional Information

NHPCO Project ECHO webpage:

https://www.nhpco.org/regulatory-and-quality/quality/projectecho/

For more information:

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