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
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.
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)
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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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.
Common Transitions

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
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
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.
Transitions of Care

- Up to 15% of hospitalizations for persons with dementia are potentially avoidable
- Systems to ensure care coordination during transitions of care are lacking

Why Can Transitions Pose a Problem?

• PLWD, care partner are the only common factors

• Fragmentation in care

• Poor outcomes
Average costs for health care services and prescription medications are higher for persons with Alzheimer’s Disease or related dementias (ADRD) than those without.
Nearly 20% of nursing home residents with ADRD experienced at least one transition in care in the last 90 days of their life.
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
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
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.
Didactic Presentation Q&A
Attendee Location Poll
Case Study Presentation
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
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)
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?
Discussion and Recommendations
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
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.
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.
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
References


- Hirschman KB, Hodgson NA. Evidence-Based Interventions for Transitions in Care for Individuals Living With Dementia. Gerontologist.


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.
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
Additional Information

NHPCO Project ECHO webpage:
https://www.nhpco.org/regulatory-and-quality/quality/projectecho/

For more information:
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