



Post-Hospital Transitions: Special Considerations For Individuals With Dementia

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Transitions of care refers to the actions involved in coordinating care for patients as they move through the health care system. The clinical goal during a transition is to communicate the care most-recently received and the needs for aftercare and beyond. Communication across settings and practitioners is paramount, as is the patient's and family's understanding of the illnesses and clinical requirements for ongoing management.

Several post-hospital transition programs have demonstrated reductions in rehospitalization and lower costs for medical patients.¹⁻⁴ The focus of these programs has been the medical discharge and "hand-off" process; interestingly, most studies have excluded individuals with cognitive impairment. Only recently have tailored aftercare services focused on comprehension of discharge instructions⁵ and other vulnerabilities⁶ that individuals with cognitive impairment may have following medical hospitalization.⁷

The vulnerable population of cognitively impaired individuals has a heightened need for coordinated aftercare. Perhaps most demonstrative is the psychiatric hospitalization for behavioral disturbance in dementia; this situation requires complex aftercare for many reasons: 1) cognitive impairment limits the ability of the patient to participate; 2) dementia-related behaviors may result in active resistance to aspects of the post-hospital plan; 3) in-hospital improvement in dementia-related behaviors may be in-part or in-full due to behavioral or environmental interventions rather than pharmacotherapy, and communication of these interventions across settings can be cumbersome; 4) co-morbid medical and psychiatric care needs may require multiple specialty consultants and associated treatments may have cross-specialty effects; 5) federal, state and institutional policies may impose unforeseen barriers regarding access to specific aftercare services; and, 6) family caregivers often lack the resources (time, economic, cognitive or emotional, and additional family members) to triage follow-up tasks and solve new dilemmas.

Evidence suggests that individuals with cognitive impairment are at heightened risk for both medical and psychiatric hospitalizations. Psychotic disorders in a large Medicare sample comprise the second-highest rate of 30-day rehospitalization (24.6%), just behind heart failure (26.9%).⁸ For elderly psychiatric inpatients, cognitive functioning is predictive of overall functioning,⁹ and social factors,¹⁰ including family functioning,¹¹ are predictive of rehospitalization. One recent report suggests that acute care and critical care medical hospitalization is associated with a future diagnosis of dementia.¹²

Additional evidence highlights economic concerns regarding individuals with dementia. Alzheimer's disease is the fifth-leading cause of death for Americans over 65 and its death rate has been rising.¹³ An estimated \$148 billion annually is attributable to Alzheimer's disease, not including \$94 billion in non-compensated services provided by family caregivers.¹³ The top 10% of Medicare beneficiaries with all-cause dementia account for 50% of all dementia-related Medicare costs;¹⁴ and the driving factors in the high-utilization of health care by individuals with dementia are inpatient and emergency treatment.^{14,15}

Improving transitional care for patients with cognitive impairment may have benefits beyond the patient and health care system. Family caregivers also suffer risks related to care-recipient hospitalizations. In 1999, Schulz reported a 63% higher mortality risk for stressed spousal caregivers.¹⁶ In other studies, caregivers report worse health than non-caregivers,¹⁷ engage in fewer health-promoting behaviors¹⁸ and have worse medication compliance.¹⁹ Caregiving for a hospitalized patient is an independent risk factor for caregiver death and dementia caregivers have the highest risk,²⁰ possibly due to poor self-care combined with distress while faced with dementia-related behavioral problems in care recipients.²¹

The process of improving transitional care may be particularly cumbersome when the patient has cognitive impairment. Consensus guidelines (2009) regarding best-practice for medical hospital aftercare, based on input from more than 30 stakeholder representatives at the 2007 **Transitions of Care Consensus Conference (TOCCC)**,²² recommended, by order of importance:

1. All transitions must include a transition record.
2. Transition responsibility must be established.
3. Clinicians' communication must be coordinated so that post-hospital treatments can be delivered.
4. The patient and family must be involved in ownership of the transition record.
5. A communication infrastructure must exist.
6. Timeliness must be considered.
7. Medical communities and institutions should adopt national standards regarding transitions of care.

Though the TOCCC guidelines were developed without specific attention to dementia, the recommendations are relevant. The first step, as applied to post-hospital dementia care,

is increased use of a formal transition record. A transition record, shorter than the complete discharge summary, contains essential elements as detailed in the TOCCC report,²² including:

- Principal diagnosis and problem list;
- Medication list including over-the-counter medications, allergies, and drug interactions;
- Emergency plan and contact number and person;
- Treatment and diagnostic plan;
- Prognosis and goals of care;
- Test results/pending results;
- Clear identification of the medical home and/or transferring coordinating physician/institution;
- Patient's cognitive status;
- Advance directives, power of attorney, and consent;
- Planned interventions, durable medical equipment, and wound care; and,
- Assessment of caregiver status.

For examples, see the University of Colorado Health Sciences Center's Care Transitions Program: <http://www.caretransitions.org/index.asp>, or Rhode Island's Continuity of Care form: <http://www.health.ri.gov/forms/continuityofcare/Form.pdf>.

When preparing a transition record or other hospital discharge documents for individuals with dementia, special considerations may include:

- Identify the primary caregiver(s) for the patient;
- Determine if the caregiver understands all discharge instructions;
- Assess the caregivers' and patient's resources and capacity to complete the discharge instructions;
- Consider visiting nursing for medical as well as mental health follow-up for individuals returning home;
- Schedule follow-up appointments with both psychiatric and medical providers;
- Include a plan for management of potential behavioral disturbance; and,
- Give particular attention to safety concerns.

In Rhode Island, Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for RI, was one of 14 states awarded a Medicare contract to expand the National Patient Safety Initiative to include a care transitions component: the Safe Transitions Project. The interventions focus on patient discharge from the hospital. Goals include improving communication across healthcare settings; making systematic changes in hospitals, nursing homes, and home health care agencies to promote more coordinated transitions; and teaching patients to better self manage their medical conditions, with the ultimate goal of improved clinical outcomes and reduced hospital readmission rates.

Quality Partners has two patient level interventions targeted at Medicare Fee-For-Service patients: Coaching and Project RED (Re-Engineered Discharge).²³ The Coaching intervention is anchored on Coleman's four pillars—medication

self management, use of a personal health record, timely follow up, and recognition of red flags that should prompt more urgent evaluation¹—and occurs primarily in the patient home. Project RED utilizes a computerized educator animation, is done in the hospital prior to discharge, and uses the **National Quality Forum (NQF)** discharge checklist. Both Coaching and Project RED are individualized to each patient.

Patients coached by Quality Partners have an improved 30-day re-hospitalization rate compared to patients who are offered coaching but decline. These patient-level interventions are also designed to train staff in the hospitals and the community to eventually replace the Quality Partners team, with an aim toward sustainability. Quality Partners projects' initial design was to not enroll participants with clear cognitive impairment; however, experience with the interventions has allowed inclusion of selected individuals when a capable caregiver is directly involved.

For more information on the Safe Transitions Project, and other projects at Quality Partners please visit their website: <http://www.qualitypartnersri.org/>.

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