

Alzheimer's Association
of Southeastern
Wisconsin

Prepared by:

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for

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Analysis of Transitions

&

Treating in Place Practices for Older
Adult Individuals with Alzheimer's
Disease/Dementia

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Overview and Executive Summary

This report highlights selected efforts that should be of interest to those searching for promising practices in addressing the issue of challenging behaviors among those with Alzheimer's or other dementias. Research was conducted by E jj Olson & Associates and included examples noted in an internet search of grey literature as well as telephone interviews with key informants. Grey literature is "that which is produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers."¹ The report is organized in two sections: **A) Literature Review, B) Best Practices.**

In pursuing research and searching for best practice programs, the consultant team found a number of examples of efforts to manage care transitions for older adults but few which focused specifically on issues associated with Alzheimer's disease. While there may be promising practices or successful efforts in the non-pharmacological treatment of Alzheimer's behaviors, the field has not advanced to the level of rigorous testing of approaches. The scientific documentation of the outcomes of programs dealing with people with Alzheimer's or dementia is sparse, with little application of codified criteria. Thus, this search includes information provided by key informants or found in the grey literature which can identify interesting approaches to follow.

What follows is a sample of efforts that relate to some of the key themes and recommendations contained in this report. Specifically, the recommendations to minimize and monitor the use of psychotropic medications, to treat people in place whenever possible and to manage care transitions, are themes consistent with these programs. Still, it should be noted that lessons that can be drawn from research which focuses on older adults, or even studies which focus on those with dementia, may not conclusively transfer to those who have Alzheimer's and exhibit challenging behaviors. Nonetheless, there are some interesting examples which may offer some suggestions to pursue.

The [**Aging and Disability Resource Centers \(ADRC\)**](#) model is an effort to promote the use of more evidence-based strategies in all stages of care transitions. The approach includes five different models: 1) [**Better Outcomes for Older Adults through Safe Transitions \(BOOST\)**](#); 2) Bridge Program; 3) Guided Care; 4) Transitional Care Model; and 5) Care Transitions Intervention. These models emphasize person-centered care and the importance of assisting clients at home, between home and hospital and between hospital and home, or skilled care.² The model was developed by the Administration on Aging (AoA) and Centers for Medicare and Medicaid Services (CMS) in 2003 to build upon and improve transitional care options by implementing a program to "assist individuals in "critical pathways," defined as the times or places when people make important decisions about moving to and from long-term care."³

Applications of some of these models may be found in the following programs: the Illinois Transitional Care Consortium (ITCC); Colorado Care Transitions Program (CCTP); the Awakenings Project; Dane County Human Services Dementia Support Team; and the North Carolina Black Mountain Neuro Medical Treatment Center. Brief summaries are highlighted in the following narrative.

¹ US National Library of Medicine, National Institute of Health. http://www.nlm.nih.gov/nichsr/greylitreport_06.html Examples of grey literature publications include reports, theses, non-commercially published conference papers, government reports, translations, committee reports, working papers, technical specifications and standards, and bibliographies

² http://www.AoA_programs/HCLTC/ADRC_CareTransitions/index.aspx ibid

³ http://www.AoA_programs/HCLTC/ADRC_CareTransitions/index.aspx ibid

The [Illinois Transitional Care Consortium \(ITCC\)](#) is an example of the ADRC's Bridge Program which is evidence based and has shown to have had an impact on understanding of discharge plans; readmissions; physician follow-up; understanding of prescribed medications; access and timeliness of community services; and mortality. The Illinois program includes a consortium of community organizations, hospitals, a research university, and a health care policy organization. The ITCC is a social-work based model of transitional care which serves older adults transitioning from the hospital to the community by linking hospital-based services with the aging network through intensive care coordination.⁴

“The Bridge Model is not specifically focused on clients with dementia or Alzheimer's. However, insofar as it is a psychosocial model focused on accurate comprehensive assessment, connection of appropriate post discharge providers and the social determinants of health that prevent an efficient utilization of those providers, the model is appropriate for any diagnosis facing an older adult. Our social workers thoroughly assess an older adult and make sure they connect to appropriate help. We are part of Rush Geriatrics, but since our model is focused on the post-discharge period, we operate autonomously with older patients from the entire hospital.”

The Bridge Model consists of three intervention phases. Prior to discharge, Bridge Care Coordinators (BBC's) identify older patients who may be at risk for post-discharge complications. Referrals often are identified by hospital discharge planners or by analysis of an integrated risk screen of the electronic medical record. The older adult's hospital room or the internal ARC in the hospital serve as the point of interaction with the BCCs who meet with the older adult and caregiver to identify unmet needs and to set up services prior to discharge. In addition, Bridge Care Coordinators prepare for patient discharge by reviewing medical records and meeting with an interdisciplinary team established within the hospital. BCCs call consumers two days after discharge to conduct a secondary assessment and assist the client on itemized needs such as understanding discharge directions, access to transportation resources, physician follow-up, overwhelmed caregivers, confusion regarding home health care, and accessing medications, etc. Further follow-up is provided when the Bridge Care Coordinator contacts clients at 30 days post-discharge.

The [Care Transitions Program \(CTP\)](#) is an example of the evidence-based ADRC Transition Program concept. It is based in the Division of Health Care Policy and Research, University of Colorado Denver, School of Medicine and utilizes a specific measure to assess the quality of care transitions. This effort has been lauded as a highly successful continuum of care model that facilitates quality programming for individuals with Alzheimer's, their family members, and community institutional settings such as acute, skilled and community-based settings. In addition, it supports patients and families; increases skills among healthcare providers; enhances the ability of health information technology to promote health information exchange across care settings. The CCTP implements system level interventions to improve quality and safety and develops performance measures to gauge the effectiveness of the interventions. The CCTC trains Coaches who in turn train staff of collaborating agencies and organizations. Tools being used to measure success include; the Care Transitions Measure, a 15-item uni-dimensional measure which focuses on patient-centeredness; and The Medication Discrepancy Tool, a new tool for identifying and characterizing medication discrepancies that arise when patients are making the transition between sites of care.⁵

⁴ www.transitionalcare.org Walter Rosenberg, Program Coordinator, Rush University Medical Center Health & Aging

⁵ www.transitionalcare.org Coleman, Eric (April 2003). “Falling Through the Cracks: Challenges and Opportunities for Improving Transitional Care for Persons” *Journal of the American Geriatrics Society* 51 (4): 549–555. doi:10.1046/j.1532-5415.2003.51185.x. PMID 12657078.

The [Awakenings Program of Minnesota](#) is operated by Ecumen of Minnesota and is a pilot project that attempts to reduce and replace dangerous anti-psychotic medications prescribed for Alzheimer's and other skilled care residents. Ecumen is a non-profit organization made up of a diversity of skilled and assisted living facilities throughout the state of Minnesota and is the sponsor of the Awakenings Program.⁶ The Awakening project is being implemented in 15 skilled nursing facilities and is funded by a \$3.7 million dollar grant from the state of Minnesota. The program educates administrators and health care professionals on the dangers of over prescribing these medications and actively engages the nursing home patients and their families by using specific strategies that help to reduce anti-social behaviors. They use a range of professional approaches to reduce anti-psychotic medications prescribed for Alzheimer's residents. Measures being used to track success include: the *Evidence Based Guideline System*, purchased from the University of Iowa; the *Patient Safety Advisory* from Pennsylvania; and the *Alternative Care Plan Interventions Plan*, also developed by the University of Iowa.

The Awakenings program also uses Jolene Brackey's Book "Creating Moments of Joy" and her DVDs to help relationship-building and improve communication among staff and residents, and the Screening Tool of Older People's Potentially Inappropriate Prescriptions (STOPP) as well as a free on-line training site called the CARES Approach.⁷ The program links facilities with key experts and consultants who help educate and advocate for reduced prescription medications for patients. Experts in the areas of pharmaceutical use and psychiatry are included in the implementation of individual care plans and affect the general philosophy of care. Early indications suggest the program is effective in helping to reduce the over-prescribing of anti-psychotic medications for "difficult" patients.

[Dane County Human Services Dementia Support Team](#)

The Dane County Dementia Support Team (DST) was established in 2009. The team works with older adults who have dementia and have been placed at Mendota Mental Health Geriatric Treatment Unit. The team's goal is to develop strategies for ultimate reintegration into the community upon their discharge from Mendota. When older adults with behavioral issues are admitted to Mendota by law enforcement for Emergency Detention (ED), Mendota staff contact Dane County Human Services which in turn contacts the Dementia Service Team. The team includes social workers and nurses employed by South Madison Coalition of the Elderly.⁸ The case manager who works with a DST team is responsible for gathering pertinent information, and working with the older adult and the family or guardian, Mendota staff and related community resources. A physician conducts an assessment and diagnosis and the case manager and staff from the Alzheimer's and Dementia Alliance then develop a person-centered behavior plan. The goal is to minimize the risks and behaviors that often become barriers to reintegration back into the community. The case manager and the Training Specialist use the plan to work with DST and the client, to teach management and integrative skills to family and caregivers, and help assure that all individuals and resources understand the particular needs of the client. If the client meets income standards, cost of the program is covered by The Community Options Program Waiver (COPW).

[Black Mountain Neuro Medical Treatment Center](#) treats dementia patients needing extra care and supervision and is considered the last transition for difficult Alzheimer patients. In 1988, funding was established through the state legislature to create a specific program for the care and treatment of patients with mid to late stages of Alzheimer's disease in order to help care for the most difficult Alzheimer's patients who

⁶ www.ecumen.org/aging-resources/24-ecumen-awakenings-reducing-antipsychotic

⁷ www.caretransitions.org www.hcinteractive.com/BasicsAdvanced and at www.hcinteractive.com/caresprogramdemo/

⁸ coalition@smcelder.com - South Madison Coalition of the Elderly

www.danecountyhumanservices.org - Dane County Human Services: Aging/ Disabilities

may be violent or otherwise too difficult to be placed with others.⁹ The Alzheimer's Program is certified as a nursing facility and serves individuals from throughout the State who have a diagnosis of Alzheimer's disease and whose assaultive or combative behaviors preclude care in traditional nursing home settings. The Center focuses on state-of-the-art treatment of Alzheimer's disease and the management of associated behaviors. The care program is person-centered and involves family members in all facets of the programming. In addition to direct services, the Center provides family and community education in support of effective partnerships regarding dementia and Alzheimer's.

Conclusions and Recommendations

In pursuing research and searching for Alzheimer's best practice programs, the consultant team found a number of examples of efforts to manage care transitions for older adults but few which focused specifically on issues associated with Alzheimer's disease. While there may be promising practices or successful efforts in the non-pharmacological treatment of Alzheimer's behaviors, the field has not advanced to the level of rigorous testing of approaches. Therefore, the scientific documentation, in academic journals, of programs dealing with Alzheimer's or dementia is sparse, with little application of codified criteria. Thus, this report includes information provided by key informants or found in the grey literature which highlights transitions and best practice programs which have been successful in addressing the needs of older adults as well as in some settings for individuals with Alzheimer's. The report is not as comprehensive as desired because of the difficulty in identifying sites which have directly applied some of the proven older adult protocols for individuals with Alzheimer's disease. The report is organized in two sections: **A) Literature Review** of the key research initiatives which focus on transitions and best practice programming for older adults and those individuals with Alzheimer's disease. **B) Best Practice Models** which include program components discussed in the Review of Literature and applied models section.

What follows is a sample of efforts that relate to some of the key themes and recommendations contained in this report. Specifically, the recommendations to minimize and monitor the use of psychotropic medications, to treat people in place whenever possible and to manage care transitions, are themes consistent with these programs. Still, it should be noted that lessons that can be drawn from research which focuses on older adults, or even studies which focus on those with dementia, may not conclusively transfer to those who have Alzheimer's.

Characteristics of the literature and successful models discussed indicate that they: are client-centered; identify critical pathways; have trained staff; develop a plan of action and activities to assist the client and caregivers to manage home, hospital, skilled and community resources; include "in-place" Alzheimer/dementia specific assessments and measurement tools. In addition, they engage cross-disciplinary Mobile Assessment Teams which can include, staff nurses/social workers, psychiatrists/psychologists, and pharmacists who collaborate with hospital and/or skilled care staff, to address the immediate and long term needs of the Alzheimer's client, and establish transition plans that are shared with the individual and care giver and formalized with community agencies. Care Coordinators call clients two days after discharge and 30 days post-discharge. The discussed characteristics of the model above are consistent with the information gathered for this report.

⁹ <http://www.bmcnc.org/>

A) Literature Review: Programs for Individuals with Alzheimer's

In early spring, 2012, The Southeastern Wisconsin Alzheimer's Association in collaboration with the Planning Council for Health and Human Services, and Sue Kelley Consulting L.L.C., established an *Alzheimer's Challenging Behaviors Task Force* made up of a broad spectrum of people and organizations dedicated to improving the needs of individuals with Alzheimer's disease as they **transition** between different settings as well as identifying meaningful **treating in place** models of care for older adults and individuals with Alzheimer's. Ejj Olson & Associates was asked to explore best practice models for both transitions and treating in place strategies. Because most of the research regarding transitions and treating in place relates to older adults, this report identifies those research efforts and also identifies both research and applied best practice sites which specifically address the needs of individuals with Alzheimer's. Many of the research and applied initiatives for older adults are applicable and being used nationally for individuals with Alzheimer's.

Methodology: Using definitions of both transitions and treating in place (below), the consultants used the web, and additional research techniques to identify evolving best practice care models. In addition, key local and national individuals and organizations and governmental and academic leaders in the field of transitions and dementia/Alzheimer's care (see appendix) were identified and contacted by e-mail and telephone. These leaders in the field of aging and dementia shared their insights and contacts relative to the most contemporary thinking regarding transitions and treating in place. The consultants used the following definitions as the basis for the search of best practice models/methodologies.

“Best Practice is a method or technique that has consistently shown results superior to those achieved with other means, and is used as a benchmark. In addition, a "best" practice can evolve to become better as improvements are discovered. Best practice is considered ...the process of developing and following a standard way of doing things that multiple organizations can use. Best practices are used to maintain quality as an alternative to mandatory legislated standards and can be based on self-assessment or benchmarking.”¹⁰

Transitional care refers to the actions of health care providers designed to ensure the coordination and continuity of health care during the movement, called **care transition**, between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness. Older adults who suffer from a variety of health conditions often need health care services in different settings to meet their many needs.

The American Geriatrics Society defines **transitional care** as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location which include (but are not limited to) hospitals, sub-acute and post-acute, nursing homes, the patient's home, primary and specialty care offices, and long-term care facilities.¹¹ It is based on a comprehensive plan of care and specially trained health care practitioners who have current information about the patient's goals, preferences, and clinical status. It includes logistical arrangements, education of the patient and family, and coordination among the health professionals involved in the transition.”¹²

¹⁰ Bogan, C.E. and English, M.J., 1994: Benchmarking for Best Practices: Winning through Innovative Adaptation. McGraw-Hill, New York.

¹¹The American Geriatrics Society - Position Statements - Index

¹² Wikipedia, http://en.wikipedia.org/wiki/Transitional_care

The following **Literature Review** discusses the role Transitions and Treating in Place programs play in addressing the needs of older adults and/or individuals with Alzheimer's disease.

Aging and Disability Resource Centers (ADRC)

Developed by: Administration on Aging (AoA) and (CMS) Centers for Medicare & Medicaid Services¹³

The *Aging and Disability Resource Centers Evidence-Based Care Transitions (ADRCs)* programming was created in 2003 by AoA and CMS in order to build upon and improve transitional care options by implementing a program to “assist individuals in “critical pathways”, defined as the times or places when people make important decisions about moving to and from long-term care. The ADRC was created in order to facilitate and improve the patient's hospital discharge process and to help residents successfully transition out of hospitals and/or long-term care and to return to the community.

Since the initial program, much of the country has adopted person-centered care for transitions and movement from one level of care to another. In 2009, AoA helped fund ADRCs through the “*Empowering Individuals to Navigate Their Health and Long-Term Support Options*” which emphasized helping people transition from one level of care to another. This initiative created the current movement towards “person-centered” or evidence-based models of hospital discharge planning as a key component of ADRC programming.

The *Person-Centered Care Model* is defined as a Person Centered Practice that places the person at the center of their own care and considers the needs of the older person's situation when making healthcare decisions for and with older adults.

Purpose: The *ADRC Evidence-Based Care Transitions Program* identifies, strengthens and helps ADRCs implement “evidence-based” and “person-centered” care transition models which help older adults and persons with disabilities to make decisions on their care and successfully transition to other facilities or back into the community. The intent was to enhance staff, streamline benefits, link individuals with community services and inform federal Agencies and Congress on care transition policy initiatives.

In 2010, the AoA issued awards to 16 states for their successful implementation of six different evidence based care transitional models. The 16 states successfully implemented the following six programs which included: **a) the *Better Outcomes for Older Adults through Safe Transitions (BOOST)*; b) the *Bridge Program*; c) *Guided Care*; d) the *Transitional Care Model*; and e) *Care Transitions Intervention*.**

a) BOOST's Goals are to improve: patient and family preparation for hospital discharge; patient satisfaction with the process; improve the flow of information between the discharging hospital and the patient's outpatient doctors and providers, and to reduce 30 day readmission rates for elderly patients with chronic illnesses.

BOOST's Objectives include: identify high-risk patients on admission and target risk-specific interventions; reduce 30 day readmission rates for general medicine patients; reduce length of stay; improve facility patient satisfaction and H-CAHPS scores; improve information flow between inpatient and outpatient providers

BOOST is a national initiative led by the Society of Hospital Medicine to improve the care of patients as they transition from hospital to home. Project BOOST is led by a national advisory board of recognized leaders in

¹³ http://www.AoA_programs/HCLTC/ADRC_CareTransitions/index.aspx

care transitions, hospital medicine, payers and regulatory agencies. The board is co-chaired by Eric Coleman MD, MPH and Mark Williams, MD, FACP, FHM and includes representatives from the Agency for Healthcare Research and Quality (AHRQ), Blue Cross and Blue Shield Association, Centers for Medicare and Medicaid Services, Centers for Disease Control and Prevention, Institute for Health Care Improvement (IHI), The Joint Commission, and Kaiser Permanente. Medical, pharmacy and nursing professional societies, and patient advocates participate and contribute to Project BOOST's development. The results of this initiative have been successful in that BOOST has met its goals of successfully reducing readmission rates and creating discharge plans that link the patient with hospital resources as well as with the patient's doctors and community resources.

BOOST Components include: a *Comprehensive Intervention Plan*; a *Comprehensive Implementation Guide* that provides step by step instructions to ensure safe transitions between hospital and home; the *Collaboration Program* that allows sites from other states to communicate via Listserv; the *Data Center*, which is an online communication resource center, which allows sites to benchmark data and store program reports; and the *Longitudinal Technical Assistance Program* that provides personal training from experts in the transitional care movement.

BOOST Funding includes a \$1.4 million dollar grant from the John A. Hartford Foundation and current funding is provided by: The Blue Cross Blue Shield Association of Michigan which contributes money to 22 mentor sites, and The California Health Care Foundation which is providing funding for 22 sites.¹⁴

b) The Bridge Program is evidence based and is the first social work based approach to transitional care. The Bridge Program connects social workers with patients in order to better transition them between hospital to home and community-based care. This model has significant flexibility and is applicable in urban, suburban and rural settings. Bridge helps to form partnerships between hospitals and community based organizations (CBOs) and can be implemented by either one. An example of the Bridge Program is The Illinois Transitional Care Consortium (ITCC), which is a consortium of community-based organizations, hospitals, a research university, and a health care policy-advocacy organization. ITCC developed the Bridge Model, which serves older adults transitioning from the hospital to the community by linking hospital based services with the aging network through intensive care coordination.¹⁵

c) Guided Care® Program addresses the growing challenge of caring for older adults with *chronic conditions and complex health needs*. The Program focuses on the transition between hospitals, facilitated by nurses, and care provided at home or in the community. The **Guided Care Nurse** partners with physicians and other medical care providers in a primary care practice to provide coordinated, patient-centered, cost-effective care to patients with multiple chronic conditions. The nurse conducts in-home assessments, facilitates care planning, promotes patient self-management, monitors conditions, coordinates the efforts of all care professionals, smooth transitions between sites of care, educates and supports family caregivers, and facilitates access to community resources.

Guided Care was developed by the Roger C. Lipitz Center for Integrated Health Care at the Johns Hopkins Bloomberg School of Public Health. Guided Care has improved the quality of patient care and physicians' satisfaction and shown a reduction in the use of expensive services, in integrated care delivery systems.¹⁶

¹⁴ http://www.AoA_programs/HCLTC/ADRC_CareTransitions/index.aspx ibid

¹⁵ http://www.AoA_programs/HCLTC/ADRC_CareTransitions/index.aspx ibid

¹⁶ www.guidedcare.org

d) Transitional Care Model (TCM) provides *comprehensive in-hospital planning and home follow-up for chronically ill high-risk older adults hospitalized for common medical and surgical conditions*. The **Transitional Care Nurse (TCN)** follows patients from the hospital into their homes and provides services designed to streamline plans of care, interrupt patterns of frequent acute hospital and emergency department utilization, and prevents health status decline. TCM is a *multidisciplinary model* that includes physicians, nurses, social workers, discharge planners, pharmacists and other members of the health care team in the implementation of tested protocols with a unique focus on increasing patients' and caregivers' ability to manage their care. TCM emphasizes coordination and continuity of care, prevention and avoidance of complications, and close clinical treatment and management, all accomplished with the active engagement of patients and their family and informal caregivers and in collaboration with the patient's physicians. Every patient who participates in TCM receives individualized care guided by evidenced-based protocols.¹⁷

e) Care Transitions Program®: supports patients and families; increases skills among healthcare providers; enhances the ability of health information technology to promote health information exchange across care settings; implements system level interventions to improve quality and safety; develops performance measures and public reporting mechanisms; and influences health policy at the national level. The Colorado Care Transitions Program best exemplifies the Care Transitions Program.¹⁸

Care Transitions Program (CTP) is based in the Division of Health Care Policy and Research, University of Colorado Denver, School of Medicine. The program has funding from The Commonwealth Fund, The Robert Wood Johnson Foundation, and the Paul Beeson Faculty Scholars in Aging. Dr. Coleman, MD, MP is the Program Director and has won an award acknowledging his participation and creation of Colorado's Care Transition Program. Dr. Coleman, in 2012, was selected as a MacArthur Fellow. He and his colleagues designed a specific measure to assess the quality of care transitions that has been acknowledged as being a best practice program.

Care Transitions Program defines: *"care transitions as the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness."* In the course of an acute exacerbation of an illness, a patient might receive care from a specialist in an outpatient setting, then transition to a hospital physician and nursing team during an inpatient admission before moving on to yet another care team at a skilled nursing facility." Each of these shifts from care providers and settings is defined as a care transition.

Care Transitions Program includes and profiles the following program initiatives: *Transitional Care, Care Transitions Intervention Plan, Care Intervention Training, the Care Transitions Measure, and the Medication Discrepancy Tool*; These intervention strategies have been successful and are discussed in the Best Practice Section of this report. Some examples of the diverse programming include: *The Care Transitions Intervention Training which includes The Care Transitions Program®* which offers a training opportunity designed to prepare experienced Transitions Coaches® to train new Coaches in other organizations in the *Care Transitions Intervention®* techniques; *The Care Transitions Measure or Tool (CTM®)*, focuses on patient-centeredness, and useful for the purpose of performance measurement for patients after they are discharged from a hospital setting; *The Medication Discrepancy Tool (MDT®)* is a successful tool for identifying and characterizing medication discrepancies that arise when patients are making the transition between sites of care.

¹⁷ <http://www.transitionalcare.info/Prov-1787.html>

¹⁸ www.caretransitions.org

Program Results have found many of the above interventions successful. Comments from the professionals in healthcare feel this program initiative has created a new continuum of care approach. "Testing of the CTM® has been completed, demonstrating high internal consistency, reliability and applicability for assessment across multiple sites of care (i.e., hospital to home, hospital to skilled nursing facility, skilled nursing facility to home, etc.)" While the testing of the CTM® was done using a post-hospitalization model, this measure is applicable to a variety of settings, including skilled nursing facilities, rehabilitation, and other locations patients are likely to utilize during transitions to a variety of sites.¹⁹

Summary The CCTP reflects a highly successful continuum of care model, with a diversity of program components, that facilitates quality programming for individuals with Alzheimer's, their family members, and with community settings such as acute, skilled and community-based environments. In addition, the program supports patients and families; increases skills among healthcare providers; enhances the ability of health information technology to promote health information exchange across care settings. The CCTP implements system level interventions to improve quality and safety; develops performance measures to gauge the effectiveness of the interventions. The CCTC trains Coaches who in turn relate to and train staff of collaborating agencies and organizations and "markets" an evidenced-based self-management model of care. With the implementation of the Affordable Care Act, organizations are obligated to reduce length of stay of all individuals within their care-giving environment. The federal government has funded 40 communities totaling \$500 million dollars to implement innovative programming. CCTP has contracts with 34 of those communities. When asked to share the names of potential best practice sites CCTC is working with, the response was that they had confidentially agreements which preclude naming the sites.²⁰

Cognitively Impaired Older Adults: From Hospital to Home; American Journal of Nursing Feb., 2005, Mary Taylor, PhD, RN FAAN, ET. Al²¹

In 2005, a study was conducted in Philadelphia that assessed 55 older adults for cognitive impairments that were admitted for acute medical or for surgical events. The study conducted by Mary Naylor, a PhD, RN and a professor in Gerontology and director of RAND, which is a research group associated with the University of Pennsylvania. Three Pennsylvania Hospitals participated in the study. Nurses (RN's) conducted a total of 25 interviews. Interviews occurred during hospitalizations and at 48 hours, two weeks, and six weeks after discharge. Caregivers were also interviewed within the first week of discharge.

Issues: Many older adults are not properly diagnosed with a cognitive disorder until after they receive care from an emergency room visit or hospitalization. Cognitive disorders include delirium, dementia, and Alzheimer's disease. These illnesses greatly impact care and when undiagnosed can lead to more hospitalizations and higher healthcare costs, delayed rehabilitation and even increased mortality rates. Earlier diagnosis of cognitive disorders will help healthcare professionals and caregivers to improve and better design quality care plans.

Required Changes: Healthcare professionals and nurses need to be aware of risk factors associated with not properly identifying cognitive impairment which includes multiple hospitalizations, adverse effects of medications, over medication, and increased mortality rates. There is a need for the use of evidence based care

¹⁹ www.caretransitions.org

²⁰ www.caretransitions.org

²¹ Naylor, Caroline Stephens, MSN, RN, APRN,BC, Kathryn H. Bowles, PhD, RN, & Brian Bixby, MSN, CRNP, RN journals.lww.com/ajnonline/fulltext/2005/02000/cognitively_impaired

plans that include the patient's particular needs and that include him or her and their caregiver in the process. Further education is needed for patients and caregivers on how to deal with this illness. This applies to healthcare professionals and the need for hospital staff to collaborate with the patients' primary caregiver.

Study Interviews identified three critical concerns: 1) A major concern identified was managing and negotiating care with multiple care providers which include, the patient and caregiver, families and friends, and healthcare and social service professionals; 2) it is more difficult to provide correct and appropriate care for the cognitively impaired as their needs were far more complex than those without the impairment; 3) there is a need for better psychosocial support and help in managing the illness during and after hospitalization.

Summary of the initiative indicates that patients and their caregivers need information about cognitive impairment both during their hospital stay and during the two to six week period after discharge. *Unmet needs fell into three categories:* managing and negotiating care, managing their illness, and "psychosocial coping". Also the study identified the critical importance of providing individualized interventions targeting the hospitalization and immediate post discharge period for two to six weeks after their medical event.

Qualitative Analysis: Advanced Practice Nurse-Directed Transitional Care Intervention

This analysis describes the barriers that cognitively impaired individuals face when transitioning between levels of care and discusses the constructive role of advanced practice nurses (APNs) in facilitating positive intervention for cognitively impaired older adults and their caregivers. The study followed cases studies of older adults with a cognitive impairment and their care transition between hospital to home. Working with University of Pennsylvania Health System Hospitals, and the University Of Pennsylvania School Of Nursing, the APN's analyzed the barriers and the successful interventions for the impaired client.²²

Findings: the use of APNs in the transition period between hospitals to home was an effective way to help protect and inform cognitively impaired older adults and their Care Givers (CG) about their post-hospitalization options and to educate them on their particular illness. The Transitional Care Model was effective in providing a more complete treatment plan and addressed issues and barriers that cognitively impaired older adults face when transitioning from hospital to home. *APN intervention* is one type of intervention that can systematically meet the various challenges associated with transitional care for cognitively impaired older adults. Inadequate information from hospital discharge planners and inadequate CG training at hospital discharge are two factors that have been identified by patients and Care Givers as barriers affecting the transition from hospital to home.

Summary of the study describes barriers for cognitively impaired older adults and their care givers and the crucial role of Advanced Practical Nurses (APN'S) facilitating transitional care interventions. Measurement of outcomes for chronically ill cognitively impaired older adults and their family caregiver is critical for ongoing appropriate care. The study's findings support previous research that found that cognitively impaired patients have a complexity of needs that are often not supported by the current system and that there is a need for better care coordination of services particularly after hospitalization.

²² The American Geriatrics Society, 2012, Christopher M. Callahan, MD, (1) <http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2012.03905.x/abstract>

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Christopher M. Callahan, MD, Greg Arling, PhD, Wanzhu Tu, PhD, Marc B. Rosenman, MD, Steven R. Counsell, MD, Timothy E. Stump, MA, and Hugh C. Hendrie, MB, ChB, DSc [Editorial Comments by Drs. Robert L. Kane and Joseph G. Ouslander, pp 980–982]

Transitions in Care for Older Adults with and without Dementia

Christopher M. Callahan, MD, in early 2012, published a paper in the *American Geriatrics Society Journal* that focused on a research study on nursing home care transitions for persons with Dementia.²³ The study used data from *Wishard Health Services Hospital and its eight primary care clinics in Indianapolis, IN. They also studied a Senior Care program, an Acute Care for Elders Unit and geriatric ambulatory care services staffed by faculty of the Indiana University Center for Aging Research.*

Methodology: The study focused on a longitudinal description of transitions in care across all sites of care, local electronic medical record data were merged with data from four additional databases from 2001 to 2008: Medicare claims, resident-level Minimum Data Set (MDS), Outcome and Assessment Information Set (OASIS), and Indiana Medicaid claims. Hospital, home healthcare, and nursing facility use and transitions and mortality from the time of the participant's enrollment through December 2008 were studied. Relationships between dementia diagnosis and nursing home use and care transitions were examined. Only transitions between home, home with home health care, nursing home, and hospitals were included.

Results: First successful clinical study that used a diversity of types of medical records and care giving sites, government programs, and OASIS data for assessments of older adults living in the community. Data shows the complex, interdependent, longitudinal patterns of transitions, of dementia clients, between nursing homes, hospitals, and homes. Health systems and or case management entities must be prepared to provide care plans across sites of care with transitions which include monitoring the movement of dementia individuals out of nursing homes and back into the community.

Summary: The results of the study indicate that care management and other care facilitation organizations for the elderly with dementia must manage patients in the hospital, nursing facility, and their return to home and must assist with coordination and transitions across all the sites over time. The content within each site demands as much attention as coordination of the transitions between care sites. Smoother transitions help to safeguard those with dementia and their caregivers by having standard protocols between all of the sites of care. It is less likely for persons with dementia to get lost in the transition when programs are set up that deal with the specific needs of those with dementia and their transitions of care, particularly post hospitalization. It is important to note that most persons with dementia die in their own home and not in nursing homes as was previously thought.

²³ The American Geriatrics Society, 2012, Christopher M. Callahan, MD, (1) at <http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2012.03905.x/abstract>

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Christopher M. Callahan, MD, Greg Arling, PhD, Wanzhu Tu, PhD, Marc B. Rosenman, MD, Steven R. Counsell, MD, Timothy E. Stump, MA, and Hugh C. Hendrie, MB, ChB, DSc [Editorial Comments by Drs. Robert L. Kane and Joseph G. Ouslander, pp 980–982]

B) Best Practice Models Discussion

The following Best Practice models have been identified by the consultants communicating both by telephone and by computer with professionals in the field. Many of the discussions were exploratory in nature and were often met with ambiguities about the formal Alzheimer's programming in their specific sites. Many of the ADRC protocols and or training materials are considered proprietary in nature so it became difficult to identify exact sites nationally which operationalized the distinct protocols. However, the following sites were identified which contain elements of a "comprehensive Alzheimer's approach to programming."

The Illinois Transitional Care Consortium (ITCC) actually developed the Bridge Model with federal funding and encompasses a broad consortium of health systems, hospitals, a research University, and a diversity of health and human services community agencies. It is a social work based model of transitional care for alder adults who are transitioning from hospital to community resources with intensive management by the hospitals and the aging network. Page 15

The Care Transition Program (CTP) is a classic example of the ADRC Transition Program concept. It is funded by the federal government, the State of Colorado and foundations who have championed its model of care. CCTP has developed a diversity of protocols such as: Transitional Care; Care Transitions Intervention; Care Transitions Intervention Training; the Care Transitions Measure; and the Medical Discrepancy Tool. Page 16

Project C.A.R.E. ("Caregiver Alternatives to Running on Empty") uses a family consultant model to provide consumer-directed respite care and comprehensive support to caregivers of individuals with dementia/Alzheimer's disease. Page 18

Awakenings of Minnesota is a one-year-old pilot project that attempts to reduce and replace dangerous anti-psychotic medications prescribed to Alzheimer's and other skilled care patients. Page 19

Dane County Human Services Dementia Support Team works with older adults who have dementia/Alzheimer's related behaviors and health issues secondary to dementia who have been placed at Mendota Mental Health Geriatric Treatment Unit, in order to develop strategies for ultimate reintegration back into the community upon their discharge. Page 20

North Carolina Black Mountain Neuro Medical Treatment Center treats Alzheimer's/dementia clients needing extra care and supervision and is considered a best practice model that effectively addresses transitions for Alzheimer's clients. Page 21

The Illinois Transitional Care Consortium (ITCC)

The Illinois Transitional Care Consortium (ITCC), is a Best Practice of the Bridge Program. ITCC is a consortium of community-based organizations, hospitals, a research university, and a health care policy-advocacy organization. ITCC developed the Bridge Model, a **social-work based** model of transitional care that serves older adults transitioning from the hospital to the community by linking hospital based services with the aging network through intensive care coordination.²⁴

The Care Consortium is composed of a variety of institutions and organizations which include Community Based Organizations (CBO's) such as: *Aging Care Solutions, Shawnee Alliance for Seniors and Solutions for Care: Hospitals which include; Adventist LaGrange Memorial Hospital, Memorial Hospital of Carbondale, Herrin Hospital, MacNeal Hospital, Rush University Medical Center: Research and Evaluation and Policy Institutions which include; University of Illinois at Chicago, School of Public Health and Health & Medicine Policy Research Group.*

ITCC Participates in the Community-Based Care Transitions Program. In partnership with AgeOptions, the suburban Chicago Area Agency on Aging and Aging & Disability Resource Center, ITCC is currently participating in the Community-based Care Transitions Program. With 6 community-based organization and hospital partnerships, AgeOptions is serving as the central administrator. ITCC members Aging Care Connections, Rush University Medical Center and Health & Medicine Policy Research Group are providing program management support.

Bridge Model is the first social work based approach to transitional care. It is evidence based and has shown an impact on: understanding of discharge plan; readmissions; physician follow-up; understanding of prescribed medications; access and timeliness of community services; mortality.

“The Bridge Model is not specifically focused on clients with dementia or Alzheimer's. However, since it is a psychosocial model focused on accurate comprehensive assessment, connection of appropriate post-discharge providers and the social determinants of health that prevent an efficient utilization of those providers, the model is appropriate for any diagnosis facing an older adult. Our social workers thoroughly assess an older adult and make sure they connect to appropriate help. We are part of Rush Geriatrics, but since our model is focused on the post-discharge period, we operate autonomously with older patients from the entire hospital.”

Bridge Model and its basic elements, is flexible and is used in urban, suburban and rural environments. The Bridge Model facilitates partnerships between hospitals and community based organizations (CBOs) and can be implemented by either a hospital or in a CBO setting.

The Bridge Model (Bridge) is a social work based transitional care model designed for older adults discharged from an inpatient hospital stay to their home/community. By utilizing intensive care coordination during a

²⁴ www.transitionalcare.org

Walter Rosenberg, Program Coordinator, Rush University Medical Center Health & Aging (Coleman, Eric (April 2003). “Falling Through the Cracks: Challenges and Opportunities for Improving Transitional Care for Persons with Continuous Complex Care Needs”. *Journal of the American Geriatrics Society* 51 (4): 549–555. doi:10.1046/j.1532-5415.2003.51185.x. PMID 12657078.)

hospital stay which continues after discharge from the hospital, older adults can safely transition back to their home and community.

The Bridge Model consists of three important and critical intervention phases:

Pre- discharge: While in the hospital setting Bridge Care Coordinators (BBC's) identify older patients who may be at risk for post-discharge complications. Referrals often are identified by hospital discharge planners or by analysis of an integrated risk screen of the electronic medical record. The older adults hospital room or the internal ARC in the hospital, serve as the points of interaction with the BCCs who meet with the older adults and/or their caregivers to identify unmet needs and to set up services prior to discharge. In addition, Bridge Care Coordinators prepare for patient discharge by reviewing medical records and/or meeting with an interdisciplinary team established within the hospital.

Post-discharge: Research data indicates that after an older adult returns home, the individual and family care givers can become confused. BCCs call consumers 2 days after discharge to conduct a secondary assessment and assist the client on itemized needs. These needs can include; understanding discharge directions, access to transportation resources, physician follow-up, overwhelmed caregivers, lack of and/or confusion regarding home health care, accessing and/or understanding medications, etc.

Follow-up: The Bridge Care Coordinator contacts clients at 30 days post-discharge.

Summary: Master's prepared social workers, called Bridge Care Coordinators (BCCs) coordinate post-discharge older adult care and integrate, while the patient is in the hospital, Aging Resource Centers (ARC) staff and services. The hospitals provide space for the ARCs so that older adults and their caregivers can explore community resources, health information and care giving materials. The social workers and the ARC's help develop community care plans prior to hospital discharge.

The Care Transition Program (CTP)

The Care Transitions Program is based in the Division of Health Care Policy and Research, University of Colorado Denver, School of Medicine.... Eric A. Coleman, MD, MP Director²⁵

The Care Transitions Program defines the term: "care transitions" as the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness. For example, in the course of an acute exacerbation of an illness, a patient might receive care from a specialist in an outpatient setting, then transition to a hospital physician and nursing team during an inpatient admission before moving on to yet another care team at a skilled nursing facility." Each of these shifts from care providers and settings is defined as a care transition.

The program has funding support from The Commonwealth Fund, The Robert Wood Johnson Foundation, and the Paul Beeson Faculty Scholars in Aging. Dr. Coleman is the Program director and has won an award acknowledging his participation and creation of the Care Transition Program. Dr. Coleman, in 2012, was selected as a MacArthur fellow. Dr. Coleman and colleagues designed a specific measure to assess the quality of care transitions that has been acknowledged as being a best practice program.

²⁵ www.caretransitions.org

The Program is profiled on their website and has information in the following categories: *Transitional Care*, *Care Transitions Intervention Training*, *the Transitions Measure*, and *the Medication Discrepancy Tool*. Below is a summary of each of these categories.

Transitional Care is a set of actions designed to ensure the coordination/ continuity as health care patients transfer between different locations or different levels of care within the same location.

The Care Transitions Intervention Plan is a four month program where individuals are paired with a transitional coach in order for them to learn better self management skills and to ensure their needs are met between transitions. The program was found to be successful at ensuring more comfortable transitions and helped to provide the individual with additional life skills.

The Care Transitions Intervention Training is a program developed to train professionals in Care Transitions Interventions. For more information check the website. *The Care Transitions Program*® offers a training opportunity designed to prepare experienced Transitions Coaches® to train new Coaches in the Care Transitions Intervention® within their present employing organization.

The Care Transitions Measure is a 15-item uni-dimensional measure, the *Care Transitions Measure (CTM)*®, is consistent with the concept of patient-centeredness, and useful for the purpose of performance measurement and subsequent public reporting. CTM is a survey of patients needs after they are discharged from a hospital setting. This measure also exists as a 3-item survey that predicts patient's return to the ER and or hospital.

The Medication Discrepancy Tool (MDT)® is a new tool for identifying and characterizing medication discrepancies that arise when patients are making the transition between sites of care.

The MDT® was developed to fill the gap in the identification and categorization of transition-related medication problems, to facilitate resolution of these problems by describing appropriate action steps at either the patient or system level, and to lead to a single reconciled list of medications, irrespective of the number of prescribers involved. It is expected to fill an important gap in national efforts to promote patient safety.

Program results indicate that the CTC has been successful and has helped create a new philosophy of care. "Testing of the CTM® has been completed, demonstrating high internal consistency, reliability. and applicability for assessment across multiple sites of care (i.e., hospital to home, hospital to skilled nursing facility, skilled nursing facility to home, etc.). The measure also demonstrated the power to discriminate between: 1) patients discharged from the hospital that did/did not experience a subsequent emergency visit or re-hospitalization for their index condition, and 2) health care facilities with differing levels of commitment to care coordination." While the testing of the CTM® was done using a post-hospitalization model, this measure is applicable to a variety of settings, including skilled nursing facilities, rehabilitation, and other locations.²⁶

Summary: The program supports patients and families; Increases skills among healthcare providers; enhance the ability of health information technology to promote health information exchange across care settings; implements system level interventions to improve quality and safety; develops performance measures and public reporting mechanisms; and influences health policy at the national level.

²⁶ Eric Coleman, April 2003, "Falling Through the Cracks: Challenges and Opportunities for Improving Transitional Care for Persons with Continuous Complex Care Needs" Journal of the American Geriatrics Society 51 (4): 5449-555

Project C.A.R.E. ("Caregiver Alternatives to Running on Empty")

*North Carolina Division of Aging and Adult Services (DAAS); Duke Aging Center Family Support Program; Mecklenburg County Department of Social Services, and three local Area Agencies on Aging*²⁷

North Carolina's Project C.A.R.E. ("Caregiver Alternatives to Running on Empty") is a best practice program, one of three in the country that uses a family consultant model to provide consumer-directed respite care and comprehensive support to caregivers of individuals with dementia/Alzheimer's disease. Through the integration of dementia-related services and the development of family-centered and caregiver-focused community care networks, Project C.A.R.E. helps create a seamless, coordinated delivery system that is responsive to the needs, values and preferences of Alzheimer's families. The program's main objective is to increase quality, access, choice, and use of respite and support services for low-income rural and minority families caring for a person with dementia at home. Project C.A.R.E. is primarily funded through North Carolina State funds with supplemental funding provided by the federal Administration on Aging's (AoA) Alzheimer's Disease Supportive Services Program. Project C.A.R.E. staff and partners are currently exploring options to expand Project C.A.R.E. into additional counties with the ultimate goal of statewide implementation.

Background: Project C.A.R.E. is administered through the *North Carolina Division of Aging and Adult Services (DAAS)* with expert consultation and technical assistance provided by the *Duke Aging Center Family Support Program*. Project C.A.R.E. is implemented at the local level through Family Consultants. The program is currently based within the *Mecklenburg County Department of Social Services*, and *three local Area Agencies on Aging*. The Project C.A.R.E. staff at *Park Ridge (based in Hendersonville)* serves as the program's statewide training and technical assistance resource. There are currently five program sites set up to serve 40 counties.

Project C.A.R.E. employs Family Consultants with expertise in Alzheimer's disease and other types of dementia. The Consultants visit the homes of referred or self-referred dementia caregivers in crises and offer timely, individualized assessment, guidance, counseling, support, advocacy, coaching and education. Their aim is to match families with the most appropriate and preferred local respite and community services tailored to their unique situation and needs. Through Project C.A.R.E., caregivers may spend up to \$1800 per year (reduced from \$2500 in previous years) toward respite services. Families are able to choose among a full continuum of consumer-directed care options, including adult day services, group respite, private or agency in-home care, and overnight residential respite.

Summary: Project C.A.R.E. creates a seamless, coordinated delivery system that is responsive to the needs, values and preferences of Alzheimer's families by integrating dementia-related services and developing family-centered and caregiver-focused community care networks. Project C.A.R.E.'s main objective is to increase quality, access, choice, and use of respite and support services for low-income rural and minority families caring for a person with dementia/Alzheimer's at home. The program employs Family Consultants with expertise in Alzheimer's disease and other types of dementia. Project C.A.R.E. is administered through the

North Carolina Division of Aging and Adult Services (DAAS) with expert consultation and technical assistance provided by the *Duke Aging Center Family Support Program*. The model of care is implemented in 5 sites which serve 40 counties in North Carolina and is one of three examples of this model in the United States.

²⁷ www.ncwdhhs.gov/aging/ncprojectcare.htm North Carolina Division of Aging and Adult Services (DAAS); Duke Aging Center Family Support Program; Mecklenburg County Department of Social Services, and three local Area Agencies on Aging.

Awakenings Program of Minnesota

Awakenings Program sponsored by Ecumen Skilled Nursing Facilities and uses a diversity of screening and program implementation tools.

The **Awakenings Project** is a one-year-old pilot project that attempts to reduce and replace dangerous anti-psychotic medications prescribed to Alzheimer's and other skilled care patients. **Ecumen** is a non-profit organization made up of a diversity of skilled and assisted living facilities throughout the state of Minnesota. Ecumen began in 1862 when the Lutheran Church began providing foster care and by the beginning of the 20th century the organization began serving older adults. In 1923, the organization incorporated under the name "The Board of Christian Service" and in the early 1960s the organization became the Board of Social Ministry. In 2004, the name was changed to Ecumen, which means "home" in Greek, whose mission is to meet older adults' housing and service needs in a creative and empowering manor.

The Awakening Program is being implemented in 15 Ecumen skilled nursing facilities in Minnesota and is funded by a \$3.7 million dollar grant from the state of Minnesota. The program received a three-year grant through the Minnesota Department of Human Services in 2010.²⁸

Background: In 2007, an audit showed that one in seven nursing home residents were given an anti-psychotic medication. Often these medications are used to control anti-social behaviors. This practice of over prescribing anti-psychotic medication has resulted in the deaths of many Alzheimer's patients from being given the wrong medication or by having a dangerous drug interaction with other prescribed medications.

The **Awakenings Program** is helping patients at 15 skilled care Ecumen Facilities to reduce their use of anti-psychotic medications by using specific strategies that help to reduce anti-social behaviors. The program educates administrators and health care professionals on the dangers of over prescribing these medications. The program actively engages the nursing home patients and their families in the process.

Methodology: The program encourages alternative care plan interventions, which are an *Evidence Based Guideline System purchased from the University of Iowa and made available at every one of the 15 skilled care facilities. Other educational materials and plans used in the process include: the Patient Safety Advisory from Pennsylvania, the previously mentioned Alternative Care Plan Interventions Plan, and evidenced based guidelines developed with federal funding by the University of Iowa and the John A. Hartford Center of Geriatric Evidence (HCGNE). The program also used Jolene Brackey's Book "Creating Moments of Joy" and her DVDs to help relationship building and improve communication between staff and with residents. The Awakenings Program also used a free on-line training site called the CARES Approach.* The program links facilities with key experts that help educate and advocate for less prescription medications for patients. Often the facility will have experts in the areas of pharmaceutical use and psychiatry who play a role in the implementation of individual care plans and add to an overall philosophy of care.

The Awakenings program has been found to be effective in helping to reduce the over-prescribing of anti-psychotic medications for "difficult" patients. The program keeps records on each patient's favorite hobbies, color, etc in order to humanize care and use these interests to help manage behavior. Stephanie Johnson, a registered nurse and participant in the program, said "We try to look at the behaviors as more of a way for them

²⁸ www.ecumen.org/aging-resources/24-ecumen-awakenings-reducing-antipsychotic

to tell us what they need.” This philosophy has *resulted in a change of culture* in these facilities that see the patient and their family members as active participants in their care.

Summary: The Awakenings Program has been successful in reducing the use of anti-psychotic medications for Alzheimer's patients and helping them maintain a more active life. The program uses enhanced activities that individual residents are interested in instead of relying on psychiatric medications to control their behavior. This helps the Alzheimer Patients move away from the need for psychiatric drugs and helps them to re-engage with the world and to better connect with family members. The Awakenings Program has also been very successful in enhancing relationships between patients and staff.

Awakenings have created a culture change in treatment and the view of what an Alzheimer patient needs and on how to treat them as participants in their own care. Awakenings have been successful in its first year and the program has been extended for two more years. The main goals of the program are now focusing on year two and will continue the momentum from year one, by continuing to work towards facility-wide Ecumen culture change. In addition it will work towards reducing unnecessary medications by using the Screening Tool of Older People's Potentially Inappropriate Prescriptions

In order to build care programs for residents, The Awakenings Program used the following experts: Dr. Tracy A. Tomac, a psychiatrist from Regions Hospital, they contracted with the Associated Clinic of Psychology (ACP) in Minneapolis for telephone consultation with a behavioral psychologist or psychiatrist if needed, and Joe Litsey, a consultant pharmacists. The Awakenings Program was able to successfully match these experts with the appropriate sites that needed their specific guidance or expertise.

Dane County Human Services Dementia Support Team

Introduction: In 2009, Dane County Human Services established the Dementia Support Team (DST) which includes the South Madison Coalition of the Elderly, the Alzheimer's and Dementia Alliance of Wisconsin, Dr. Kim Petersen MD, and Dane County Human Services.²⁹ The focus of the team is to work with older adults who have dementia/Alzheimer's related behaviors and health issues secondary to dementia who have been placed at Mendota Mental Health Geriatric Treatment Unit, in order to develop strategies for ultimate reintegration back into the community upon their discharge.

Mission: The DST's mission is to accept older adult referrals from Dane County Human Services who have been admitted to Mendota Mental Health Geriatric Treatment Unit and /or at risk of being admitted to the unit. The DST works collaboratively with staff to help develop a comprehensive plan to assist the individual and related family members to successfully integrate the individual back into the community with appropriate support services and resources upon their discharge from Mendota.

Methodology: Usually, older adults with behavioral issues are admitted to Mendota by law enforcement for Emergency Detention (ED). Mendota staff then contact Dane County Human Services that in turn contacts the Dementia Service Team's staff which includes case managers made up of social workers and nurses employed by South Madison Coalition of the Elderly. The case manager who works with a DST team, is responsible for gathering pertinent information, works with the older adult, their family/guardian, Mendota staff and related

²⁹ South Madison Coalition of the Elderly. www.danecountyhumanservices.org - Dane County Human Services: Aging/ Disabilities

community resources. Dr. Petersen MD does an assessment and diagnosis and the case manager and staff from the Alzheimer's and Dementia Alliance then develop a person centered behavior plan which minimizes the risks and behaviors that often become barriers to reintegration back into the community. The case manager and the Training Specialist uses the person centered behavior plan to work with DST and the clients, to teach management and integrative skills to family, caregivers and community resources to help assure that all individuals and resources understand the particular needs of the client. This comprehensive approach fosters successful community placements.

Cost Effectiveness of Program: the Community Options Program Waiver (COPW) covers the cost of the DST. Upon discharge, the case manager may follow the client for up to 30 days. If the client meets income standards of the COP waiver program, cost of the program is covered by COPW. If they do not meet the income criteria, and they want to continue services, it would require private pay. It is anticipated that the Centers of Excellence program will provide skills for evidenced based best practices to assure a level of care that will reduce Mendota placements.

Summary: The Dementia Support Team is a collaborative effort to address the needs of older adult individuals with dementia/Alzheimer's who are placed in a State of Wisconsin Mental Health Center with a Geriatric Treatment Unit. Both county and state government together with two non-profit social service organizations have developed a team approach to assure that individuals placed in the geriatric unit are discharge as soon as possible to a responsive community setting which provides the resources and services in a compassionate yet effective home-like setting.

Insights: A model collaborative program between two levels of government and two non-profit social services agencies which are effectively targeting individual's with dementia/Alzheimer's to assure compassionate, appropriate, and effective community placement and care upon discharge from a Mental Health Center using a person centered plan.

North Carolina Black Mountain Neuro Medical Treatment Center

The State of North Carolina is renowned for its care for individuals with dementia, in particular, its care for the most vulnerable. Many dementia patients need extra care and supervision and the Black Mountain Treatment Center is the last transition for difficult Alzheimer patients. **The Black Mountain Neuro-Medical Treatment Center** (BMTC) is a state-sponsored facility (*DHHS – Division of State Operated Healthcare Facilities*) with a specialized dementia program located in Black Mountain, NC.³⁰ The facility was originally a satellite facility of Western Carolina Center in 1977 and became its own facility in 1982. Black Mountain was the fifth Developmental Disability and Alzheimer's Center in the state of North Carolina.

Background: In 1988, funding was established through the state legislature to create a specific program for the care and treatment of patients with mid to late stages of Alzheimer's disease in order to help care for the most difficult Alzheimer's patients that may be violent or otherwise too hard to be placed with others. The Alzheimer's Program is certified as a nursing facility and serves persons from throughout the State who have a diagnosis of Alzheimer's disease and whose assaultive or combative behaviors preclude care in traditional nursing home settings. The BMTC provides state-of-the-art treatment of Alzheimer's disease and the management of associated behaviors.

³⁰ <http://www.bmcnc.org/>

The center accepts Medicare, has 163 Medicare beds, is owned by a governmental agency, and is not a continuing care community. In 2004, the facility created The **Specialized Developmental Disabilities** program to meet the needs of older adults that have specific medical needs. Black Mountain Treatment Center has gotten high marks by US news, which is a website that ranks health care centers. Black Mountain got the highest marks for and passed a health inspection with top honors. It also received five stars for quality measures. Quality measures that were rated include care provided to patients and BMTC received top marks in many other areas as well.

The BMTC is renowned for its treatment of patients with mid to late stages of Alzheimer's disease. The care program is person centered and involves family members in all facets of the programming. The *Black Mountain Neuro-Medical Treatment Center* is recognized for its excellence in care and treatment. In addition to direct services, the Center provides family and community education in support of effective partnerships regarding dementia and Alzheimer's. It is important to note that the State of North Carolina advertises and supports this facility and properly funds its programming.

Conclusions and Recommendations

In pursuing research and searching for Alzheimer's best practice programs, the consultant team found a number of examples of efforts to manage care transitions for older adults but few which focused specifically on issues associated with Alzheimer's disease. While there may be promising practices or successful efforts in the non-pharmacological treatment of Alzheimer's behaviors, the field has not advanced to the level of rigorous testing of approaches. Therefore, the scientific documentation, in academic journals, of programs dealing with Alzheimer's or dementia is sparse, with little application of codified criteria. Thus, this report includes information provided by key informants or found in the grey literature which highlights transitions and best practice programs which have been successful in addressing the needs of older adults as well as in some settings for individuals with Alzheimer's. The report is not as comprehensive as desired because of the difficulty in identifying sites which have directly applied some of the proven older adult protocols for individuals with Alzheimer's disease. The report is organized in two sections: **A) Literature Review** of the key research initiatives which focus on transitions and best practice programming for older adults and those individuals with Alzheimer's disease. **B) Best Practice Models** which include program components discussed in the Review of Literature and applied models section.

What follows is a sample of efforts that relate to some of the key themes and recommendations contained in this report. Specifically, the recommendations to minimize and monitor the use of psychotropic medications, to treat people in place whenever possible and to manage care transitions, are themes consistent with these programs. It should be noted that lessons that can be drawn from research which focuses on older adults, or even studies which focus on those with dementia, may not conclusively transfer to those who have Alzheimer's.

Characteristics of the literature and successful models discussed indicate that they: are client-centered; identify critical pathways; have trained staff; develop a plan of action and activities to assist the client and caregivers to manage home, hospital, skilled and community resources; include "in-place" Alzheimer/dementia specific assessments and measurement tools. In addition, they engage cross-disciplinary Mobile Assessment Teams which can include, staff nurses/social workers, psychiatrists/psychologists, and pharmacists who collaborate with hospital and/or skilled care staff, to address the immediate and long term needs of the Alzheimer's client, and establish transition plans that are shared with the individual and care giver and formalized with community agencies. Care Coordinators call clients two days after discharge and 30 days post-discharge. The discussed characteristics of the model above are consistent with the information gathered for this report.

Published Resources

Project C.A.R.E. (Caregiver Alternatives to Running on Empty) Selected Publications: ³¹

- *"Providing Dementia-Specific Services to Family Caregivers: North Carolina's Project C.A.R.E. Program", Dr. Chris M. Kelly and Dr. Ishan Canty Williams, Journal of Applied Gerontology, Vol. 26 No. 4, August 2007.*
- *"Implementing Systems and Sustained Change in Long-Term Care: The Experience of Alzheimer's Disease Demonstration Grants to States (ADDGS) Programs", AOA-ADDGS National Resource Center, RTI International, Executive Summary and Full Report*
- *"All on the Family: Informal Caregiving in America", Anne J. Tate, Masters Thesis, The University of North Carolina at Chapel Hill, School of Journalism and Mass Communication, January 2005.*
- *"Dementia-Specific Respite: The Key to Effective Caregiver Support", North Carolina Medical Journal, Jan/Feb 2005.*
- *Other Duke Family Support Program educational resources utilized by Project C.A.R.E.:*
 - *Home Is Where I Remember Things: A Curriculum for Home and Community Alzheimer Care*
 - *Pressure Points: Alzheimer's and Anger*
 - *You Are One of Us: Successful Clergy/Church Connections to Alzheimer's Families*
 - *Steps to Success: Decisions about Help at Home for Alzheimer's Caregivers*
 - *Caring for People with Alzheimer's Disease: A Manual for Facility Staff*

³¹ www.ncwdhhs.gov/aging/ncprojectcare.htm North Carolina Division of Aging and Adult Services (DAAS); Duke Aging Center Family Support Program; Mecklenburg County Department of Social Services, and three local Area Agencies on Aging.

Individual Resources

The following individuals are only a small sample of the many people who served as resources for this document. We thank all individuals who provided insights regarding their innovative Alzheimer's and related older adult program initiatives.

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