REDUCING HOSPITAL READMISSIONS IN THE ELDERLY POPULATION WITH ALZHEIMER'S DISEASE AND RELATED DEMENTIA'S

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Presentation Objectives:

Objective 1: *At the completion of this session, participants will be able to recognize cognitive issues versus non-compliance.*

Objective 2: *At the completion of this session, participants will be able to utilize strategies to determine causes of behaviors in ADRD individuals.*

Objective 3: *At the completion of this session, participants will be to employ strategies to successfully deal with identified issues.*

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- Total annual payments for health care, long-term care and hospice care for people with **Alzheimer's or other dementias** are projected to increase from **$277 billion in 2018** to **more than $1.1 trillion in 2050**. This dramatic rise includes more than four-fold increases both in government spending under Medicare and Medicaid and in out-of-pocket spending.

Alzheimer's Association. 2018 Alzheimer's Disease Facts and Figures. Alzheimer's Dementia 2018.

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- ❑ Health care costs increase with the presence of dementia. People with Alzheimer's disease are hospitalized <u>three times</u> more often than seniors without Alzheimer's.
- ❑ Medicare beneficiaries with Alzheimer's or other dementias are more likely than those without dementia to have other chronic conditions.
- ❑ Average per-person out-of-pocket costs for Alzheimer's and other dementias are almost <u>five times higher</u> than average per-person payments for seniors without these conditions.

Alzheimer's Association. 2017 Alzheimer's Disease Facts and Figures. Alzheimers Dementia 2017;13:325-373.

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- ❑ **The annual cost of unnecessary hospital readmissions is roughly $17 billion for Medicare patients, a 2015 report from the Center for Health Information and Analysis revealed.**
- ❑ **Cognitive impairment, while common in hospitalized elders, is under-recognized, impacts care, and increases risk for adverse health outcomes.**

Boustani, M., Baker, M. S., Campbell, N., Munger, S., Hui, S. L., Castelluccio, P., … Callahan, C. (2010). Impact and Recognition of Cognitive Impairment among Hospitalized Elders. *Journal of Hospital Medicine : An Official Publication of the Society of Hospital Medicine*, *5*(2), 69–75. http://doi.org/10.1002/jhm.589

- ❑ **Nearly <u>one in four</u> hospitalized patients with dementia are readmitted within 30 days**

Ouslander, J; Berenson, R: Reducing Unnecessary Hospitalizations, New England Journal of Medicine, September, 2011; Phelan, E., et al: Association of Incident Dementia with Hospitalizations, Journal of American Medical Association, January 2011; Goodman, D., et al: After Hospitalization: A Dartmouth Atlas Report on Post-Acute Care for Medicare Beneficiaries, Copyright 2011 by the Trustees of Dartmouth College

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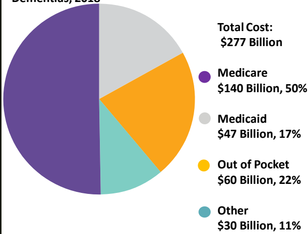
Aggregate Cost of Care by Payment Source for Americans Age 65 and Older with Alzheimer's and Other Dementias, 2018*



*Data is in 2018 dollars.
Created from data from the Lewin Model.A21 "Other" payment sources include private insurance, health maintenance organizations, other managed care organizations and uncompensated care.
Alzheimer's Association. 2017 Alzheimer's Disease Facts and Figures. Alzheimer's Dementia 2018

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Specific Coexisting Medical Conditions Among Medicare Beneficiaries Age 65 and Older with Alzheimer's or Other Dementias, 2013

Coexisting Condition	Percentage of Beneficiaries with Alzheimer's or Other Dementias Who Also Had a Coexisting Medical Condition
Coronary artery disease	38
Diabetes	37
Chronic kidney disease	29
Congestive heart failure	28
Chronic obstructive pulmonary disease	25
Stroke	22
Cancer	13

Alzheimer's Association. 2017 Alzheimer's Disease Facts and Figures. Alzheimer's Dementia 2017;13:325-373

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STOP Avoidable Readmissions

One in five Medicare beneficiaries will leave the hospital today only to return within one month.

Only ½ of the patients hospitalized within 30 days had a physician visit before readmissions.

$100 billion annually

11% of readmissions are due to medication non-adherence, at a cost of nearly $100 billion annually.

Join the Readmissions Network and help to reduce hospital readmission rates by 20% by 2019.

2014

2019

-20%

Source: New England Journal of Medicine, 2009 Centers for Medicare & Medicaid, 2012

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Figure 26. Percentage of long-term care services users with a diagnosis of Alzheimer's disease or other dementias, depression, and diabetes, by sector: United States, 2013 and 2014

Sector	Alzheimer's disease or other dementias	Depression	Diabetes
Adult day services center	29.9	25.5	29.7
Home health agency	31.4	37.9	45.2
Hospice	44.7	22.9	27.6
Nursing home	50.4	48.7	32.4
Residential care community	39.6	23.2	16.9

NOTES: Denominators used to calculate percentages for adult day services centers, nursing homes, and residential care communities were the number of current participants enrolled in adult day services centers, the number of current residents in nursing homes, and the number of current residents in residential care communities in 2014, respectively. Denominators used to calculate percentages for home health agencies and hospices were the number of patients who received care from Medicare-certified home health agencies at any time in 2013 and the number of patients who received care from Medicare- certified hospices at any time in 2013, respectively. See Technical Notes for more information on the data sources used for each sector. Percentages are based on the unrounded numbers.

SOURCES: **CDC/NCHS**, National Study of Long-Term Care Providers and Table 4 in Appendix B.

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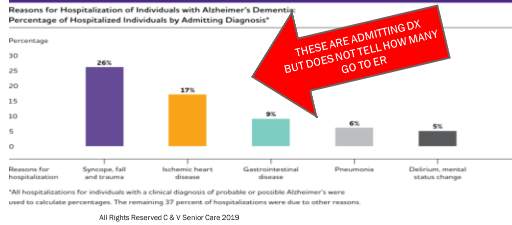
WHY DO PEOPLE WITH DEMENTIA GO TO THE HOSPITAL?



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Cognitive Impairment: Normal Aging versus ADRD

Normal Aging	ADRD
Minor memory lapses or forgetfulness of part of an experience	Misplacement of important items
Occasional lapses in attention or concentration	Trouble doing simple tasks
Appropriate sadness/anxiety	Trouble with arithmetic
Changing interests	Trouble making routine decisions
Increase in cautious behavior	Confusion about month or season
Unimpaired language skills	Mood changes
Slower reaction times	Decrease interest in outside activities
	Denial of symptoms
	ADRD= Alzheimer's Dementia and Related Dementia's

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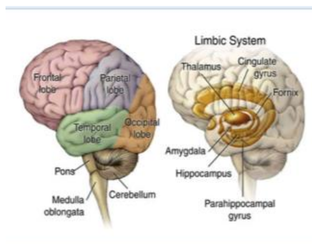
- **First hippocampus –** stores short term memory by middle stage -5 minutes of short term memory NO NEW LEARNING
- **Parietal lobes-** where spatial processing is housed-problems in perception as well as in navigating unfamiliar locations. LIKE GPS
- **Temporal lobes-** control time awareness and language- word finding problems
- **Occipital lobe –** can't identify things that are seen, misuse of objects, trouble understanding and thinking very concrete
- **Limbic** system-emotional roller coaster
- **Hypothalamus –** temperature and appetite control
- **Motor Strip –** walking, sitting up, continence, swallowing



A QUICK TRIP THROUGH THE BRAIN

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Once an Adult.....
- All that we learn going forward

THEORY OF RETROGENESIS The Reversal of Normal Human Development

Twice a Child....
- We repeat again going backwards

Handles Simple Finances	Early Stage Mild Dementia Cognitive Age: 8-12 years old	Requires help with complex tasks: menu planning handling finances,
Selects proper clothing and puts on clothing unaided	Middle Stage Moderate Dementia Cognitive Age: 5-7 years old	Help with selecting and putting on clothes
Goes to the Bathroom unaided	Late Middle Stage Moderately Severe Dementia Cognitive Age: 2-4 years old	Needs help with toileting
Infant/Baby Holds Head up and Smiles	Late Stage Severe Dementia Cognitive Age: Newborn-18mo.	Unable to Hold Head up or Smile

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Stages Of Alzheimer's Disease

Early Stage Lasts 2- 4 years–up to and including dx May live alone or with little supervision	Middle Stage Lasts 2-10 years Longest stage Needs full-time Supervision	Late Stage Lasts 1-3 years Palliative Care May receive Hospice Care
Think about a young adolescent when planning approaches. Consider the judgment and responsibility of an 12 year old deteriorating to that of a 8 year old. Repetition and reminders work at this stage.	Think about a toddler. What is a 7 year old deteriorating to a 2year old capable of doing? How do you supervise a toddler? How much care is needed? Safety issues very important. WHERE HOSPITALIZATIONS START TO INCREASE	Think about an 18 month old to a newborn - what does this age need; how much care is involved; how does baby communicate needs? Total care most likely needed due to total body shut down.

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Middle Stage Abilities

- Able to initiate familiar activity if supplies are available and in reach
- Able to do steps of self care with verbal and tactile cues
- Able to tell stories from past
- Able to read words slowly out loud
- Able to follow slow simple instructions
- Able to speak in short sentences or phrases; able to make needs known
- Able to sort, stack objects and do repetitive behaviors
- Able to sing, move to music, count
- Able to ambulate if no physical disability
- Able to feel and name objects

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Middle Stage Disabilities: 2 - 10 years after dx, longest stage

Who Am I?

- ❑ **Needs full-time Supervision**
- ❑ Problems recognizing family and friends
- ❑ Problems organizing thoughts/ logical thinking
- ❑ Repeats statements and/or movements
- ❑ Trouble dressing –may not want to bathe
- ❑ Increasing disorientation and forgetfulness
- ❑ Visual, depth perception changes
- ❑ Can't find words – confabulates
- ❑ Suspicious, teary, fidgety, irritable, silly
- ❑ **Challenging behaviors become apparent**

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- ❑ AD and ADRD have a profound effect on memory, executive processing and behavior which complicates management of chronic conditions
- ❑ Recognize non-compliance may be a cognitive issue and document with Evidenced based testing

Example: Mini COG or the BIMS (Brief Interview for Mental Status) less than 5 minutes to administer

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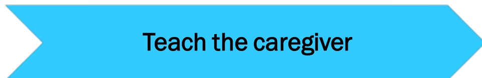
What can we do to educate the caregiver?



- **To enter the world of the individual with Alzheimer's disease.**
- **To understand that world and be willing to change without expectations that the person with AD will change.**
- **What is cognitively/functionally appropriate for the person with AD.**
- **How to communicate effectively**
- **Behavior strategies**
- **Minimize burnout**

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Steps to simplify and manage other chronic conditions:
Caregiver teaching/ Self management/Proactive care:

- Med minders
- White boards
- High visibility clocks
- Cell phone alarms
- Apps that speak reminders
- Environmental Modifications

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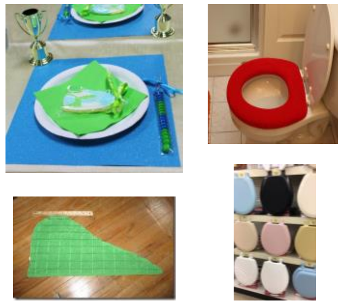
Visual Spatial Changes



- Decreased visual acuity, decreased peripheral vision, depth perception changes, visual field lowers

What Can You Do?

- Use Contrast
- Use tape
- Lower items in house
- Change color of the toilet seat
- Simply, declutter

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MAXIMIZE INDEPENDENCE

- Label objects, drawers, rooms
- Use verbal and tactile cues when instructing
- Use Whiteboards
- Use clocks
- Use devices early
- Replicate routine and familiar order
- Label Walkers, canes
- Declutter

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Specific Challenging Communications/Behaviors That Lead to Hospitalization

- Sleep Disturbances
- Resistance to Care
- Agitation & Aggression
- Wandering
- Unaddressed Pain
- Lack of follow through with medical management
- WHAT SHOULD WE DO? THINK CAUSE OF BEHAVIOR

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Process for Problem Solving: Interventions

Behavior – what, when, how is person behaving?

A. Potential Physical Causes
  a. Pain**-arthritis, UTI, constipation/impaction
  b. Hunger
  c. Dehydration
  d. Fatigue
  e. Unmet physical needs
  f. Depressed

Always consider physical issues – especially pain first. Often times behaviors are a persons way of communicating something.

BEHAVIOR JOURNAL

DATE	BEHAVIOR	TIME OF DAY	What is going on in home?

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STORY OF CAROL

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PAIN

- A detailed assessment at admission and assessed at every assessment
- How is it manifested
  - Behaviors-non-verbal responses, limitations in movement, sleep
  - Activities patient has stopped performing due to pain
  - Verbalization
- Look at History
  - Previous meds
  - Talk with family
  - Arthritis
- Assessments
  - PAINAD
  - FACES

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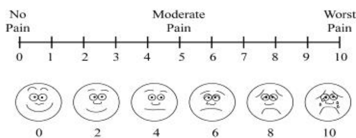
Numeric Pain Scale/FACES Pain Scale



1. (Name of patient) are you having any pain today? 2. Please rate your pain on a zero to ten scale with zero being no pain and ten as the worst pain you can imagine. Point to face that best describes your pain. (Show the patient the pain scale) 3. You have reported a pain score of 6 (> = 4). This is a significant level of pain; I want to discuss this with your doctor or nurse practitioner today.

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Sleep Disturbances

What is the cause?

- Decreased Activity/Boredom
- Sleeping too much during daylight hours
- Upset in the normal routine
- Pain/Discomfort
- Too many stimulants in late afternoon

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Solutions to Encourage Sleep

- ❑ Increase daily exercise, stimulating activities and chores throughout the day
- ❑ Discourage late afternoon napping
- ❑ Ensure morning sunlight, bright light exposure, keep the home well lit in the evening
- ❑ Use weighted blankets or try a body pillow
- ❑ Maintain consistent routine/ Replicate past routine for bedtime
- ❑ Serve large meals early in the day
- ❑ Treat pain prior to bedtime
- ❑ Aromatherapy
- ❑ Soft music, try a back rub, foot or shoulder massage
- ❑ Limit environmental distraction in the evening hours

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Resistance to Care @ Bathing

CAUSES	**RESPONSES**
❑ ***Pain***	❑ **Treat Pain – i.e. medicate with Tylenol ½ -1 hour before bath**
❑ ***Room too cold***	❑ **Keep patient covered; make sure bathroom area warm**
❑ ***Overhead shower – causes fear***	❑ **Sponge bath, use handheld shower, bathe in chair, bed, standing up**
	❑ **Use candy, music or other distraction**

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Bathroom modifications

- ❑ **Visible toilet seat/ bowl (change color of toilet seat to contrast with toilet bowl), purchase illuminated toilet bowl**
- ❑ **Toilet paper that is a different color than the holder, walls and floor**
- ❑ **Install flooring with texture**
- ❑ **Remove glass and mirrors**
- ❑ **Install lighting to ensure room is properly lit.**
- ❑ **Maintain visual organization- commonly used items are clearly visible**
- ❑ **Organize by category e.g.: hairbrush, comb, Cup, toothbrush, toothpaste**

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Bathing tips

- ❑ Create a spa like experience
- ❑ Consider bathing options
- ❑ Seated on toilet covered with warm towel
- ❑ Standing or seated at the sink
- ❑ Use familiar products ex: Ivory soap
- ❑ Bright colored towels/easy for individual to see
- ❑ Label the cupboards and drawers

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Caregiver Education

Teach the Stages of Alzheimer's	Figure out causes of Behaviors

Utilize strategies to solve the behaviors

Increase patient quality of life	Decrease caregiver stress

Increase ability to deal with other co-morbidities

Decrease Hospitalizations Decrease Costs	Increase overall quality of care delivered

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STEPS TO DECREASE THE LIKEIHOOD OF HOSPITALIZATION IN THE ALZHEIMER'S/ DEMENTIA PATIENT

STEP 1 - Assessment and Recognition of cognitive issues

Step 2 - Determine if there is a caregiver to teach

STEP 3 - Appropriate staging of the individual

STEP 4 - Teach caregiver about the disease process and what to expect and how disease impacts management of other comorbidities

STEP 5 - Teach the caregiver to recognize possible causes of challenging behaviors

STEP 6 - Teach the caregiver strategies to manage challenging behaviors

STEP 7 - Teach family based on life story how to maximize the individuals function and give meaning and purpose to their day

STEP 8 - On-call that assess and direct caregivers in the management of their loved ones.

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C & V's goals are to increase staff knowledge, improve staff reactions to behaviors, arm caregivers with a tool box of strategies that they can use to work with challenging clients, decrease need for medications, decrease need for higher resource utilization(ERs, Urgent Care, Hospital), improve outcomes and most importantly increase client's quality of life. We welcome the opportunity to partner with you as move forward with your program initiatives.

Thank you for your participation in todays education

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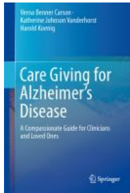
BECOMING AN ALZHEIMER'S WHISPERER: A LOVING AND GENTLE APPROACH TO CHALLENGING BEHAVIORS



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