

PULLING IT ALL TOGETHER for people facing dementia

Report and discussion of a grant project
combining a variety of resources from

- Acute and primary medical care to
- Community based services

to foster earlier detection, diagnosis and care
coordination for people facing dementia



Dementia Care Transitions



METROPOLITAN
AREA AGENCY
on A.G.I.N.G.

Funded by a Community
Service/Services
Development Grant

From the Minnesota
Department of Human Services

and by in-kind
contributions from
project partners

Minnesota Dementia Project History

State funded (CS/SD) grants

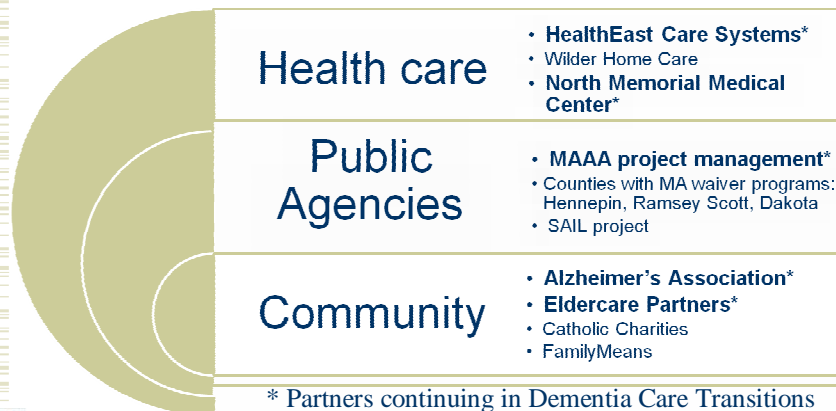
Build on successes of national Chronic Care Network for Alzheimer's Disease (CCN/AD) created evidence-based tools to support a **Care Model** in primary care

www.nccconline.org

- ♦ 2004-2008 - Hospital-based Dementia Identification project provided screening for dementia in electronic assessments.
- ♦ **2008-2010 - Dementia Care Transitions** project - Promoting continued efforts to build bridges across medical and non-medical service communities to benefit people with dementia



Partners in Dementia ID Project



* Partners continuing in Dementia Care Transitions



Implementation of Memory Loss Screening – on admission to acute care

Required:

1. Engagement/support of hospital leaders
2. Training of staff
3. Basic memory loss screen included
 - a. question about memory; b. nursing observation
4. 25% of screens positive for signs/symptoms
5. Opportunities to improve care/outcomes



Hospital responses system includes:

1. Nursing protocols for optimizing quality of care
2. Physician order set
3. Interdisciplinary team response
4. Discharge planning to include:
 - a. Referral to primary clinics for follow-up
 - b. Education/community resources/referrals
5. Further training of staff: tools for improving hospital care and transitioning to next setting



Developing a primary care clinic response system includes:

- ◆ Training of clinic staff
- ◆ Protocols for action when hospital refers patients with positive memory loss screens
- ◆ Procedures for referring patients/caregivers to community resources for education, caregiver support and coaching



Putting the pieces together - a case study -

Madeline is a 76 year old woman who was hospitalized for pneumonia 1 week ago and is being readmitted after falling at home, where she lives with her husband Floyd. Madeline's daughter, Kathy, is currently living with them because Madeline was weak and slightly confused after her first hospitalization. Her daughter has noticed her mother repeats questions and comments throughout the day, has gotten behind in paying her several bills, and is having difficulty remembering to take her antibiotic, which is a new pill for her. Madeline still drives to church and the grocery store, which the daughter is concerned about. Madeline denies any memory problems. Her daughter has asked the nurse caring for Madeline, "Do you think my mother could have dementia?"



	Hospital Plan of Action	
	North Memorial Medical Center	HealthEast
Screening Patients	All patients Admission Database Geriatric Clinical Nurse Specialist Prioritizes consults	All over 70 years of age Admission Nurse Assessment
Communication to the Team	Consult note; Verbal discussion with team members Daily rounds	Daily in Rounds Attending Physician
Day to day Case Management / Care Management	Geriatric Clinical Nurse Specialist for pts with delirium and dementia. Case Managers will be involved	Care Navigation Model Rounds team acts on barriers to care progression and barriers to discharge
Determine discharge plan of care and post discharge plan of care	RN, SW and/or Case Manager OT referral- Cognitive testing Hospitalist	RN and SW Care Manager collaborate with rounds team, Primary Care Provider
Hand Off, Community Partners Alzheimer's Association Eldercare Partners	Phone call to Alzheimer's Association or other community resources by Geriatric Clinical Nurse Specialist	Electronic inside HealthEast continuum Phone, email, fax

	Clinic Plan of Action	
	North Memorial Medical Center	HealthEast
Initial Screen	Patients 70 years and older; Question, Observation, Red Flags	Pending Implementation
Follow Up Appointment and Communication	RN working with MD at 2 North Clinics	2 days post discharge, Clinic Care Manager (CCM)
Differential diagnosis by Primary Care Provider (PCP)	2 MD's currently	Hospital follow up or appointment specifically for Memory Loss
Establish the Plan of Care (POC)	Collaboration with MD and Home Care (RN, OT, SW)	Collaboration of PCP, CCM and Home Care
Communicate the POC	Developing system	PCP and CCM through Care Navigation Model
Lessons Learned	Awareness clinic staff Depression Need more physicians Need hospital to clinic connection	20 months = short time Educate many people Need a Clinic screening question



Community Partners Services for Madeline & Family

- ◆ 92% of LTC Provided by Family & Friends
- ◆ Educate Family & Link to Community Resources
- ◆ Caregivers Receiving Services Report
 - higher levels of self-care
 - reduced burden
 - improved understanding of disease
 - increased ability to provide care for longer periods of time



Alzheimer's Association

- ◆ Referral to Alzheimer's Association
- ◆ Information Helpline
- ◆ Other Services





Alzheimer's Association

- ◆ In-Person Care Consultation
- ◆ Family Meeting
- ◆ Family Memory Care
- ◆ Further Referrals



Eldercare Partners

- ◆ Caregiver Assessment
- ◆ Identification of Burden, Stress & Uplifts
- ◆ Goal Setting
- ◆ Community Resources
- ◆ Ongoing Support, Education & Information





Eldercare Partners

- ◆ Information
- ◆ Community Resources
- ◆ Caregiver Calendar of Events



Lessons Learned

- ◆ Serviceable Moment
- ◆ Referral from Medical Staff
- ◆ Fax Referral
- ◆ Connection back to Medical System
- ◆ Improved Care Management
- ◆ Linking to Community Resources is a Team Effort





Contacts for Dementia Care Transitions Project

- **Judy Cline** – Metropolitan Area Agency on Aging
 - 651-917-4632 – judyc@tcaging.org
- **Mary Cadieux** – HealthEast Care Systems
 - (651) 326-5297 – mfcadieux@healtheast.org
- **Susan Schumacher** – North Memorial Medical Center
 - (763) 520-7224 – susan.schumacher@northmemorial.com
- **Heidi Haley-Franklin** – Alzheimer’s Association
 - (952) 857-0527 – heidi.haley-franklin@alz.org
- **Krista O’Connor** – Eldercare Partners
 - (651) 234-2251 – krista.oconnor@darts1.org

