Learning Objectives

- Illustrate the interaction between cognitive impairment and care transitions
- Differentiate the goals of rehabilitation vs. long-term care in care planning for cognitively impaired patients
- Apply clinical practice guidelines for cognitive impairment to your organization's baseline care planning process

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Care Transitions: Hospital to SNF

- Most SNF stays originate with a discharge from acute care
  - Acute event causing hospitalization requires rehabilitation in post-acute phase
  - Many PAC patients may be unable to live in their prior homes
  - Medicare Part A FFS/other skilled payers require qualifying hospital stay
- Ineffective transition between care settings can increase risk for rehospitalization
  - Cognitive impairment can be a complicating factor

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Care Transitions: Hospital to SNF *(cont.)*

- Cognitive impairment increases risk during transition:
  - Falls
  - Elopement
  - Behavioral symptoms impacting others
- SNF's responsibility to manage risk and prevent incidents
  - Injury to resident/others
  - Quality Measure triggers (Falls with Injury, Antipsychotics)
  - Rehospitalization

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Cognitive Impairment and Hospital Transfers

- PointRight analysis of 30-day rehospitalization and long-stay hospitalization rates
  - CY 2015-2017
  - N = 1,649,140 from over 3,000 SNFs
- Cognitive Impairment Definition - one or more of:
  - BIMS < 13
  - CPS < 2
  - I4200 Alzheimer's
  - I4800 Non-Alzheimer's Dementia

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PointRight Analysis: Cognitive Impairment and 30-Day Rehospitalization (CY 2015-2017)

	Patient Assessments (#/%)	Observed Rehospitalization Rate
Total Study Population	1,649,140	15.1%
Moderate – High Cognitive Impairment	640,677 (39%)	17.5%
No – Low Cognitive Impairment	1,008,463 (61%)	13.5%

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Why the Difference?

- Difference of 4% in rehospitalization rates is statistically significant
- The only differentiating variables are cognitive assessment and diagnosis of dementia
  - What complicates the hand-off from the hospital to the SNF?

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Why the Difference? *(cont.)*

- Complex care needs of patients with impaired cognition and other comorbidities
- Differences in care planning goals and priorities between hospitals and SNFs
- Lack of communication of patient's cognitive status during care transition

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In a Perfect World…

- Time to prepare the resident
  - Show pictures, where SNF is located, if there will be a roommate
    - Repeat/reinforce information multiple times as needed
- Time to prepare the SNF
  - Get social history from family/caregivers
  - Have appropriate items/equipment in place before admission
  - Have clinical staff available for baseline cognitive assessment

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In the Real World…

- SNF Nurses report issues with transition from hospital that complicate care planning for cognitive impairment
  - Lack of communication about dementia related behavioral symptoms
    - Perceived as intentional omission by hospital staff
  - Lack of control over admission decisions
    - Time pressure, driven to fill bed, limited clinical knowledge of marketing/admissions liaison
  - Lack of caregiver engagement
    - Hinders SNF's ability to obtain social history

Gilmore-Bykovskyi et al. (2016)

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Hospitals and SNFs: Different Priorities

- Hospital – focus on acute illness, limit length of stay
  - Limited cognitive assessment (acute delirium vs. baseline dementia)
  - PRN Medication for behaviors/agitation
- SNF – focus on rehabilitation or LTC
  - Develop care plans tailored for cognitively impaired residents
  - Regulations against chemical restraints
  - Reducing antipsychotic use

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Another Interesting Finding…

- Among PAC patients who were rehospitalized within 30 days, 7% (118,825) had no cognitive assessment, either on discharge MDS or the one prior to it
  - Cognitive assessment items are active on discharge MDS
- If cases with no cognitive assessment are included in the analysis, overall rehospitalization rate increases to 17.8%
- Missing a vital component of a comprehensive baseline assessment and care plan

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F655: Baseline Care Plan

- Reform of the Requirements of Participation - Phase 2
  - Person-Centered Care to support resident choice
  - Applicable to both short term rehab and long term care
- Baseline care plan required within 48 hours of admission
- Minimum healthcare information needed to care for the resident
  - Requires interdisciplinary input/communication
- To be shared in writing with resident/responsible party

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Does Your Admission Assessment Measure Up?

- Physical, cognitive, psychosocial, medical needs
  - Include cognitive/behavioral issues that put safety at risk
  - Resident preferences/habits
- Consider interaction of physical issues with cognition
  - Pain, mobility limitations, infection
  - New/changed medications from hospital
- Admission orders, initial goals
  - Includes therapy, dietary, social service

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Communication with Hospital: Care Planning Goals

- Considerations:
  - Course of hospital stay/prior history
  - Patient/family expectations
  - Primary care physician involvement
- Rehabilitation
  - Orthopedic, cardiac, strengthening, balance
- Long Term Care
  - Significant dementia or other degenerative disease (e.g. Parkinson's)
  - Limited/no options for safe discharge to community

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Rehab or Long Term Care?

- Residents with cognitive impairment can still benefit from skilled therapy, but goals depend on the individual
  - Discharge to home/community with support and services
  - Improve/maintain level of function for long-term NF stay
- Priorities: Safety, managing chronic disease, maintaining participation in ADLs to extent possible
- Goals can be achieved, but may take longer and require ongoing reinforcement

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Dementia Care and Survey

- Dementia Care Critical Element Pathway
  - Comprehensively assess physical, mental, and psychosocial needs of residents with dementia
    - Identify risks and/or to determine underlying causes
  - Develop a care plan with measurable goals and interventions to address the care and treatment for residents with dementia
    - Individualized and person-centered
  - Newly admitted residents
    - Baseline care plan addresses dementia/behavioral care needs

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What About Long-Stay Residents?

- Long-stay residents: More than 100 days in the SNF/NF
- Rate of cognitive impairment in LS population: 79%
  - SS rate of cognitive impairment: 39%
- Does cognitive impairment also play a role in long-stay hospitalization?

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PointRight Analysis: Cognitive Impairment and Long-Stay Hospitalization (CY 2015-2017)

	Patient Assessments (#/%)	Observed Hospitalization Rate
Total Study Population	1,807,908	9.3%
Moderate – High Cognitive Impairment	1,385,049 (77%)	8.5%
No – Low Cognitive Impairment	422,859 (23%)	12.2%

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Why the Difference? (Again)

- Cognitively intact patients without significant co-morbidities more likely to be discharged to community
  - Long term residents – more likely to have chronic/degenerative disease or conditions
- LS Residents with cognitive impairment well known to facility
  - UTIs/pneumonia/other infections more likely to be treated in-house
  - End stage residents – hospice/palliative care/DNH orders

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We Have Been Making Progress

- National Partnership to Improve Dementia Care in Nursing Homes
  - Launched in 2012
  - Goal to improve person-centered care for residents with dementia
  - Reduce unnecessary use of antipsychotics
- Results so far:
  - Goal met: Reduction in LS antipsychotic use by 30% (end of 2016)
  - New goal: Focusing on those facilities with limited reduction rates
    - 15% reduction by end of 2019

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Person-Centered Dementia Care

- "The National Partnership emphasizes non-pharmacological, person-centered, evidence-based practice approaches for residents, such as stronger family involvement; consistent staff assignments; increased exercise or time outdoors; monitoring and managing acute and chronic pain; and planning individualized, meaningful activities."
  - Nursing Home Quality Initiatives Questions and Answers
    - August 29, 2017

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Clinical Practice Guidelines

- Alzheimer's Association 2018 Dementia Care Practice Recommendations
  - Person-Centered Care Planning
  - Detection and Diagnosis
  - Medical Management
  - Information, Education, and Support
  - Behavioral and Psychological Symptoms of Dementia
  - ADL Support
  - Staffing
  - Supportive and Therapeutic Environment
  - Transitions in Care

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Alzheimer's Assoc. Recommendations for Transitions in Care

- Prepare and educate persons with dementia and family caregivers about common transitions in care
- Ensure complete and timely communication of information between, across and within settings
- Evaluate preferences/goals of persons with dementia along the continuum of transitions in care
- Create strong inter-professional collaborative team environments to assist with transitions
- Initiate/use evidence-based models to avoid, delay, or plan transitions in care

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AMDA Clinical Practice Guidelines

- Guidelines for medical care processes of recognition, assessment, treatment, and monitoring
  - Dementia
  - Transitions of Care
  - Acute Change in Condition
  - Delirium
- Standardize key care processes using evidence-based resources

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The Drive to Integrate

- Medicare is pushing providers towards value and cost savings (ACOs, Bundles, Value-Based Purchasing)
- Service delivery models that advance best practices and care coordination
  - Can facilitate communication and coordination further upstream
  - Consider entire episode of care from hospital through PAC
- Regardless of the payment model (or payer), the need for collaboration between provider settings is not going away

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Coordination and Communication

- Effective communication between SNF and hospital requires a process that is agreed upon and adhered to
  - For each referral
  - Regular meetings (monthly/quarterly) for discussion of issues/opportunities
- Specify what information is needed before transfer
- Educate on SNF's capabilities
  - Cognitive impairment can be managed with proper planning and resources

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Internal Education

- Caring for cognitively impaired residents as a core competency for all staff
  - Recognition of signs/symptoms
  - Behavioral management
  - Working around communication deficits
- Admissions/Marketing
  - What to look for in the hospital documentation
  - What questions to ask

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Family Involvement

- Work with family to set realistic goals and expectations
  - Educate on dementia/disease progression, interaction with co-morbidities
- Educate on SNF's capabilities to treat in-house
- Engage in care plan whenever possible
- Keep open, proactive communication
  - Manage expectations and prevent surprises

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References

- Alzheimer's Association 2018 Dementia Care Practice Recommendations
  - https://www.alz.org/dementia-care-practice-recommendations/
- AMDA Clinical Practice Guidelines
  - https://paltc.org/product-type/cpgs-clinical-practice-guidelines
- Gilmore-Bykovskyi, A. L., Roberts, T. J., King, B. J., Kennelty, K. A., & Kind, A. J. (2016). Transitions From Hospitals to Skilled Nursing Facilities for Persons With Dementia: A Challenging Convergence of Patient and System-Level Needs. *The Gerontologist*. doi:10.1093/geront/gnw085

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Thank You!

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