



## Bridging the Gap: Improving Transitions in Care for People with Dementia

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- Funding:
  - ✓ National Hartford Centers of Gerontological Nursing Excellence
  - ✓ National Institute on Aging

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## Goals

- Identify health-system problems and outcomes associated with poor quality transitional care
- Understand why people with dementia are at increased risk for experiencing poor quality transitional care outcomes
- Identify components of effective transitions from hospital-to-home with dementia
- Solutions for improving transitions between hospitals and nursing facilities for people with dementia

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## What is Transitional Care?

- 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 in the same location

\* Coleman, JAGS, 2003

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## Outcomes of Poor Quality Transitional Care

- Medication Errors
- Care delays
- Inappropriate care delivery
- Increased use of emergency and ambulatory services
- Increased care costs
- Increased staff work strain and burden
- Patient/caregiver dissatisfaction and stress
- Re-hospitalization

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## High Quality Transitional Care is Important for All Patients

- Anyone can have issues in the post-hospital setting, sometimes very serious

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## Certain Factors Increase Risk of Rehospitalization

- Prior Hospitalization
- Patient Disease, Comorbidities
  - ✓ CHF
  - ✓ Pneumonia
  - ✓ MI
  - ✓ COPD, Vascular or Orthopedic Procedures...
- Patient Cognition
- Social Situation
- Discharge Setting

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## Certain Factors Increase Risk of Rehospitalization

- Prior Hospitalization
  - Patient Disease, Comorbidities
    - ✓ CHF
    - ✓ Pneumonia
    - ✓ MI
    - ✓ Psychoses
  - Patient Cognition
  - Social Situation
  - Discharge Setting
- OFTEN NOT RECOGNIZED**

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## 30 Day Rehospitalizations: A Major Health System Problem

- Affect 1 in 5 hospitalized Medicare patients
- Account for over \$17.4 billion annually
- Major target in health reform

\* Jencks et al. NEJM. 2009. 360: 1418-28.

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## Dementia Patients Experience with the Care Continuum

- Majority of dementia care provided by informal caregivers in community
- Majority of patients with dementia will utilize nursing facility services at some point
- Transitions across care continuum are not necessarily linear
  - ✓ About 21% of people with dementia experience frequent transitions across hospital, home (with or without home care), and into and out of skilled nursing facilities
  - ✓ Majority die in their homes

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## Nursing Facilities Play A Critical Role

- 5 million discharges to nursing homes annually
- 1 in 4 is rehospitalized within 30 days
- Costs >\$4 billion each year
- In Wisconsin, rehospitalizations from nursing homes account for \$30 million annually

\* Mor et al. Health Affairs. 2010;29(1):57-6

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## Dementia and Hospital-to-Nursing Facility Transitions

- Nearly half of Nursing Facility residents have some form of dementia
- Dementia increases re-hospitalization risk by 40%\*

\*Callahan et al., JAGS, 2012. 60(5): 813-820.

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## Major Points

- Health system fragmentation contributes to poor quality care transitions
- Evidence-based transitional care programs decrease re-hospitalization but are not appropriate for nursing facility patients or people with dementia
- Effective clinician-to-clinician communication lies at the core of safe transitions, especially for dementia patients

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## The Problem: Health System Fragmentation

Hospital

Primary Care

Nursing Home

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## Contributors to Health System Fragmentation

- Organization of the health system into distinct, independent institutions ("silos")
- Lack of formal relationships/information systems between care settings
- Communication between settings is often poor
- Nursing facility patients move frequently between care settings
- Transitional care given little emphasis in traditional clinical training programs

\* Coleman, JAGS. 2003;51: 549-555; Ma et. Al. J Am Geriatr Soc 2002; 49(4):S35.

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## Dementia Patients Struggle to Overcome Health System Fragmentation

- Little patient/caregiver empowerment in hospital
- Often can not advocate for themselves
- May not have family/caregiver to advocate for the patient during the transition
- Completely reliant on the system to "get it right"

\* Coleman, JAGS, 2003;51: 549-555.

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## Major Points

- Health system fragmentation
- Education-based transitional care services decrease rehospitalizations in those going home, but are largely inappropriate for patients discharged to nursing facilities
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## Transitional Care Programs Combat System Fragmentation



- Post-hospital home visits to teach patients about their care and conditions
- Decrease rehospitalizations by 30%

....But they are not appropriate for most nursing facility patients or people with dementia

\* Naylor, JAMA, 1996; Coleman, Archives, 2005.

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## VA Coordinated-Transitional Care Program (C-TraC)

- Phone-based program
- Specially-trained RN nurse case manager
- Protocolized encounters
- Teachings based on theory of Spaced Retrieval\*
  - ✓ Method of learning information by practicing recalling that information over increasingly longer periods of time
  - ✓ Applicable in early stages of dementia
- Caregivers involved, activated at each step

\* Bourgeois, et al, J Comm Disord, 2003; Camp et al, Appl Cog Psych, 1996.

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## C-TraC Goals

1. Educate and empower the veteran/caregiver in **medication management**
2. Ensure the veteran/caregiver has **medical follow-up**
3. Educate the veteran/caregiver regarding **red flags**
4. Ensure the veteran/caregiver knows **whom to contact** if questions arise

\* Kind, Health Affairs, 2012; Gilmore-Bykovskiy et al. 2014

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## Protocol: In-Hospital Visit

- NCM meets with eligible veteran during their hospital stay for a brief educational intervention
  - Introduction
  - Medical follow-up
  - Red Flags
  - Contact information
- Contact reinforced by a brightly colored ½ page handout documenting 3 red flags, date/time of next NCM call, date of next f/u appointment and contact information for NCM and triage nurse

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## Protocol: Telephone Follow-up

- Initial call is 48-72 hours after discharge with caregiver/veteran to reinforce
  - ✓ Medication management
  - ✓ Medical follow-up
  - ✓ 3 Red flags
  - ✓ NCM contact information
- Medication discrepancies or red flags prompt additional action
- Average 36 min per call
- Coordination with PCP

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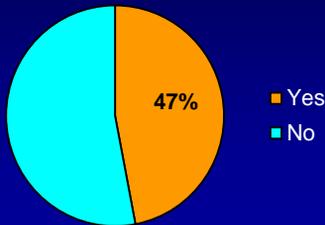
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## Percent of Veterans with Medication Discrepancy Detected at 48-72h by C-TraC

Medication Discrepancy?



\* Kind, Health Affairs, 2012.

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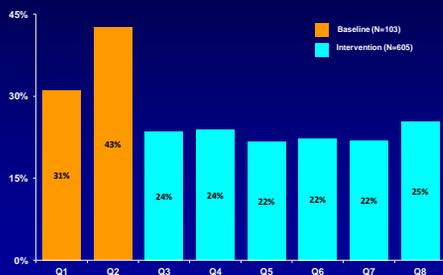
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## 30-Day Rehospitalization Rates for Veterans in VA C-TraC Program During Baseline and Intervention Periods, Overall



Q = 3-month period (i.e., quarter)  
Average rehospitalization rates for baseline (34%) and intervention (23%), P-value = 0.013

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## Estimated Cost Avoidance

- Total up-front program cost = \$250/veteran enrolled
- Gross direct cost avoidance of \$966,167 over 18 months
- After accounting for all programmatic costs, net cost avoidance of \$1,225/veteran enrolled

\* Kind, *Health Affairs*, 2012.

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## Major Points

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## Hospital Discharge Summary

- Primary post-hospital communication tool
- Can dictate patient's care for up to 30 days
- Care plans for nursing home patients are copied directly from the discharge summary
  - ✓ Medications
  - ✓ Diet
  - ✓ Activity
- Accreditation groups set minimal standards which most transitional care experts feel are inadequate
- Discharge summaries are often inadequate, slow to arrive at next setting of care

\* Kripalani, *JAMA*, 2007; Dimant, *JAMDA*, 2003

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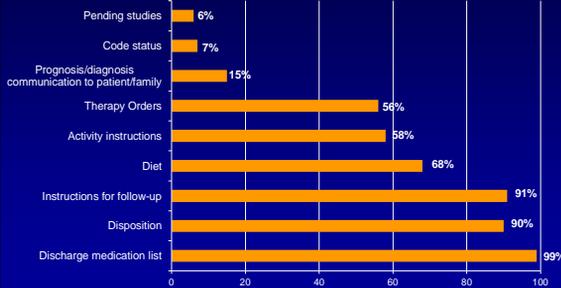
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## Inclusion of Care Plans in Hospital Discharge Summaries



\*Kind et al, JGIM, 2011

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## Nursing Facility Nurses Want Better Quality Discharge Communication

- Focus groups of nursing facility nurses:
  - ✓ How do they transition care of hospitalized patients?
  - ✓ What are the primary challenges they face?
- Nursing facility nurses could not identify a single example of a 'good quality' care transition from the hospital to the nursing home

\* King, AGS Abstract, 2012.

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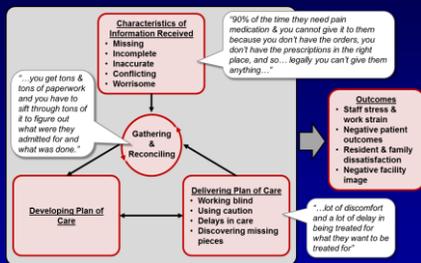
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## Nursing Facility Nurses Need Better Quality Discharge Communication



\* King, AGS Abstract, 2012.

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## Information: Missing/Incomplete

- Necessary information that is omitted from discharge paperwork
  - ✓ No wound care instructions
  - ✓ Medication orders missing important details
  - ✓ No signed prescription for opioids
  - ✓ No plans for medical follow-up
- "... there was nothing about the femur fractures... we had no idea ... if she was weight bearing or not weight bearing.. [or] what we were supposed to be doing with them."

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## Information: Conflicting

- Discrepancies among written discharge documents
  - ✓ Multiple medication lists and order sets which vary in content
- "... we have three discharge summaries with all these different medication lists... it is just like, how are we safely supposed to take care of this patient?"

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## Information: Inaccurate

- Mismatch between the hospital's report of the patient's condition and the SNF nurse's assessment on patient presentation
  - ✓ Mismatch between reported/observed cognitive status
  - ✓ Activity orders reflect a different level of assistance than needed by resident
  - ✓ Resident presents as physiologically unstable
- "... a lot of the times we find when the person actually comes here they are a completely different picture than what we got in the pre-admission assessment."

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## Consequences: Patient and Family

- Care delays, Inappropriate care
  - ✓ Pain medications delayed
  - ✓ Necessary equipment unavailable
  - ✓ Providing care without orders– wound care
- Patient safety compromised
- Increased rehospitalization risk
- Dissatisfaction with care during transition
  - "... we didn't know what her mobility [was].. And we didn't know if she was weight bearing... so we left her in bed for probably a week."

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## Consequences: SNF Staff

- Increased work stress, frustration/inadequacy
- Guilt associated with patient harm
- Additional work effort
  - ✓ Delivering care 'blindly' while awaiting additional orders/clarifications
  - ✓ Unsuccessful attempts to clarify orders with multiple providers
- "I had to talk to like 3 people just to find out who the doctor was... Well then I called that office.. He wasn't in. Nobody at the office could help me. It was like a week before we got some good information...."

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## Consequences: Facility

- Additional costs in staff time, wasted resources
- Decreased work satisfaction contributes to high turnover rates
- Patient/family dissatisfaction with care, perpetuating a negative facility image
  - "... It sends a terrible message to the patient and their family that we are ill prepared or that we are not capable of handling the acuity."

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## The Gap for Dementia Patients

- Discharge communication in hospital-to-nursing facility transitions tends to be poor quality
- Transitional Care Programs improve the quality of transitions, but people with dementia are excluded from most of these interventions
- Transitional care needs of dementia patients not well understood

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## Goals

- Identify health-system problems and outcomes associated with poor quality transitional care
- Understand why people with dementia discharged to nursing facilities are at increased risk for experiencing poor transitional care outcomes
- Identify components of effective hospital-to-nursing facility transitions
- Discuss challenges and potential solutions for improving transitions between hospitals and nursing facilities for people with dementia

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## Challenges for Dementia Patients

- Individual/group interviews with nurses (N=33) employed at 8 SNFs in Wisconsin
- Goal: To identify factors that impact transitional care quality for people with dementia

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### Transitions for Persons with Dementia: Difficult, Resource-Intensive and Dominated by Behavioral Symptoms

- Successful transitions for persons with dementia required **more time, more information and more resources**
- Behavioral symptoms dominated the transition process for persons with dementia
- Behavioral symptoms were not consistently or accurately communicated, which put patients and the facility at risk for negative outcomes
  - ✓ *"The more challenging the resident is...the more discrepancy we hear... it's a big safety issue and the biggest struggle... we've learned the hard way-we just can't, like we did in the hospital we just call a doctor and get the Haldol...regulations are so different here...it's chaotic for us, the people, this is their home-it upsets them too"*

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### Facilitating High Quality Transitions for Persons with Dementia

- "Easing the Transition"
  - ✓ Engaged caregivers during transition
  - ✓ High quality discharge communication
  - ✓ Access to knowledgeable informants to establish personal/social history prior to admission
  - ✓ Additional time as social information is not readily available
    - "What makes it better (is) a lot of interaction with the family...personal history is extremely helpful. We never get that ahead of time."*
    - "...thing that helps with the transitions is that they come and set the room up ahead of time- and have the pictures hung- have the room set up - so that it looks like- their room."*

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### Patients with Dementia Were Rarely Engaged or Prepared for the Transition Process

- Lack of engagement of the person with dementia worsens the quality of the transition
  - ✓ *"Oftentimes they'll just tell them 'we're going for a ride' from the hospital... and unfortunately lie or fib to make the transition... cause the person with dementia...there is a lot of paraphrasing like that.... So unfortunately that (makes) some difficult transitions...the repeated questions, 'can I go home now', 'when's my family coming'...trying to escape cause they probably thought they were going home"*

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## Hospital Provider Perspectives

- Focus groups with 51 hospital providers
  - ✓ 11 MDs, 26 RNs, 5 discharge planners, 8 HUCs, 1 CNA

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## Challenges

- Sense of pressure to discharge
- Emphasis on acute care needs and placement criteria but little follow-through communication
  - ✓ *"... I don't think the social issues are really addressed... we always care for people with dementia as well as you know we should but I feel like there is a big push to like get them out of there and get them moving and do what we need to do. Its really systematic when they go to the nursing facility. I think sometimes a lot of the social aspects get pushed to the wayside."*
  - ✓ *"...Nothing with, over a 24 hour period, they got to be completely chemical and mechanical free."*

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## Challenges

- Difficulty identifying caregiving support
  - ✓ *"...with people with dementia I really try to encourage to have somebody there. I am usually talking with the family members to see if somebody can be there...but sometimes it seems like those people are kind of you know, I don't know if the family isn't close or a spouse is at a nursing facility as well. So they can't be involved."*

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## Communication Barriers

- Inconsistent hand-offs to the nursing facility
- Hesitancy to share information
  - ✓ *"That's the challenge I've found is that when they call back, they're looking for information that I know is in there. Not to be rude to the person that's calling, but to say, the information is in the packet so that I don't have to duplicate work, could you please look a little further before I, you know, I'll be happy to answer your questions, but could you please look a little further before I repeat everything that I spent two hours on preparing to send this patient to you."*

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## Discharge Summary Communication of Dementia-Related Care Needs

- Dementia Diagnosis/Cognitive Status
  - ✓ Dementia Diagnosis
  - ✓ Cognitive Status/Delirium/Onset and Features
- Dementia-Related Care Needs
  - ✓ Behavioral Symptoms
  - ✓ Antipsychotic Medications
  - ✓ Direct, 1:1 Supervision
  - ✓ Fall-risk precautions
  - ✓ ACE/Geriatric Psychiatry Consultation
  - ✓ HCPOA/Activation Status and Contact Information
  - ✓ Family Involvement/Contact Information

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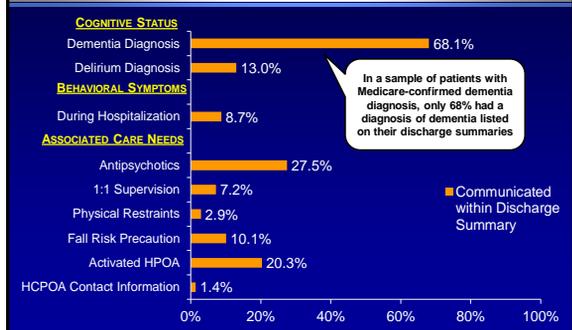
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## Discharge Communication for Dementia Patients




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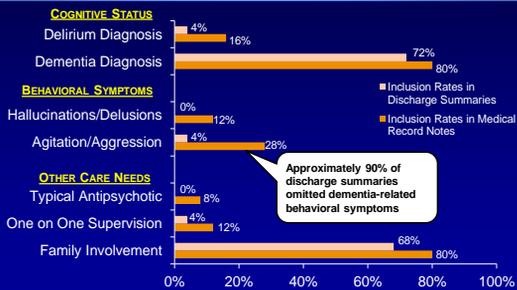
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## Omissions in Discharge Communication for Dementia Patients




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## Major Points

- Discharge communication during hospital-to-nursing facility transitions in general is poor in quality
- Preliminary research findings strongly suggest under-communication of behavioral symptoms for dementia patients and communication barriers between staff in hospitals and nursing facilities
- Lack of detailed information about dementia-related care needs may limit the Nursing Facility's capacity to implement adequate care plans and respond to changes in conditions, potentially increasing rehospitalization risk

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## Emerging Interventions



### VA Care-cOordination and eMpowerment of PAtients in System-to-System Transitions (COMPASS) Protocol:

COMPASS Team

Amy JH Kind, MD, PhD  
 Laury Jensen, BSN, RN-BC  
 Marilyn Bazinski, BSN, RN-BC  
 Michele Pawlowsky, RN, BSN

Jacque Porter, BS  
 Alice Huang  
 Korey Kennelty, PharmD, PhD  
 Rachel Rolland, RN, PhD  
 Melissa Hovanes, RN, BSN

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## COMPASS Goals

1. Improve system-to-system communications
  - ✓ COMPASS nurse schedules medication review with SNF 4-24h post-transfer
  - ✓ Direct phone line to COMPASS nurse available to SNF at any time during business hours for questions
  - ✓ Confirmation of key information transfer (opioids, etc.)
2. Empower patients/caregivers in system-to-system transitions
  - ✓ Coach patients/caregivers regarding what to expect in SNF, what condition-related red flags to watch for and how to respond

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## COMPASS Enrollment

- Launch at William S. Middleton Veterans Hospital in April 2013
- 231 enrolled veterans over first 12 months
- No patient refusals
- Discharged to 78 Unique SNFs

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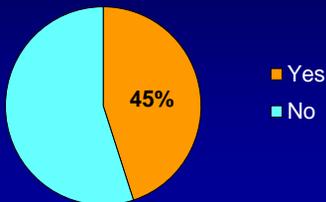
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## Percent of Veterans with Medication Discrepancy Detected at 4-24h by COMPASS

Medication Discrepancy?



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## Medication Discrepancies

### Top 5 Medication Discrepancy Categories

1. Analgesics
2. Endocrine agents (i.e., insulin)
3. GI medications
4. Psychiatric medications
5. Anticoagulants

Range 0 – 15 medication discrepancies per patient

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## Other Outcomes

- Strong stories of clear impact
  - ✓ Post-hospital arrangements for serial paracentesis
  - ✓ Patient behavioral distress post-discharge → urgent VA psychiatry management → no rehospitalization
  - ✓ Family rapport building/support → palliative care/hospice
  - ✓ Activated/coached local community members to medically support socially isolated veteran(s) post-discharge
  - ✓ Opioid prescription tracking, security

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## What You Can Do Now to Improve Transitions for Dementia Patients

- Warm hand-offs for all hospital-to-nursing facility transitions
- Encourage accountability for every patient hand-off
- Family activation/engagement
- Involve the persons with dementia in the transition whenever possible
- Transparency regarding behavioral care needs

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## Acknowledgements



### Collaborators

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