Ensuring Better Transitions for Patients With Dementia

By James Lett II, MD, CMD

A s clinicians know, dementia is not a specific disease but a syndrome comprising multiple etiologies, which regularly overlap. Perhaps the most insidious, destructive—and to the clinician, frustrating—form of dementia is of the “ambulance acquired” variety.

Known to all LTC clinicians, this syndrome refers to that patient who arrives at your facility seemingly fine and is discharged fine but, according to the transfer paperwork, left the sending facility “alert and oriented x3,” “WNL,” or, more commonly, mentally status is left unaddressed. LTC colleagues have often postulated there is a tunnel in the universe through which ambulances pass on their trip to the skilled nursing facility, where urinary catheters, pressure wounds, and dementia materialize. Does being ignorant of dementia diagnosis and treatment of cognitive impairment. Alzheimer’s disease and related dementia materialize. Nearly half of patients with Alzheimer’s disease and related dementia have clinical import? Dementia, as a primary disabling condition or a comorbidity, has a profound impact on transitions of care, medical costs, morbidity, and mortality. Being ignorant of its presence is costly at best, and disastrous at worst. Its import is magnified by its abundance in our facilities. Nearly half (48%) of nursing home residents have Alzheimer’s disease and related dementia and 68% in 2009 had some degree of cognitive impairment.

Far-Reaching Impact

Further specifics of the impact of dementia on clinical outcomes include:

▶ Dementia patients are hospitalized two to three times as often as people the same age who do not have the disease.
▶ There is a significant association for hospitalization in Medicare beneficiaries with dementia, across chronic disease comorbidities and disease pairings.
▶ Those with dementia have an increased number of comorbidities and more serious comorbidities.
▶ Health care costs for people with dementia are more than 80% higher than those for people with heart disease or cancer. One study showed patients with heart disease had an average total cost of $175,136 over the last 5 years of their lives, whereas those with cancer incurred $173,183. The costs for patients with dementia was $287,038.
▶ One in five nursing home residents with advanced dementia harbors strains of drug-resistant bacteria.
▶ Hospitalizations of Medicare beneficiaries with a dementia diagnosis were two to three times as often as people at your facility cognitively impaired, but, upon being transitioned to the typical ED, hospital admission may become the easy path to triaging complicated patients out of the department to open up the bed. In the competitive world of ED waiting times, “…time pressure limits the time ED health care providers spend with patients and may result in poor quality of care for complex (nursing home) residents who have multiple medical conditions, multiple medications, dementia, delirium, functional impairments, and behavioral symptoms.” (Ouslander JG, et al. Is this really an emergency? Reducing potentially preventable emergency department visits among nursing home residents. J Am Med Dir Assoc 2015;16:354–7).
▶ Nothing disrupts the ED flow like the time-consuming attempt to assess a cognitively impaired patient when accompanying information is inadequate for history or to ascertain whether the altered mental status is chronic or acute.
▶ Many may believe that for an ill elder with acute problems superimposed on dementia, there is no downside to being in the hospital, given the difficulty in obtaining an appropriate history and the array of diagnostic tools close at hand. Yet, there is evidence that hospital-acquired disabilities decrease quality of life for patients with dementia and their family caregivers and increase societal costs. Additionally, elders in the hospital may experience negative events such as urinary catheter infections and decubitus ulcers. Medication management issues continue to be an additional source of adverse events. A plurality of nursing home residents with advanced dementia receive medications of questionable benefit, and incur substantial associated costs, including hospitalizations.

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What Clinicians Can Do

A likely source of increased costs in patients with dementia is the higher incidence of transitions with the resultant hospitalizations, duplicative testing, adverse drug events, delirium, and other eventualities due in part to deficient handoffs. Unnecessary transitions also negatively influence costs and quality of care. How can the clinician improve transitions for patients with dementia?
▶ Seek, stage, document and regularly update the progress of dementia in the residents of your facility/facilities.
▶ Transmit mental status information consistently as part of the core data set when a patient is transitioned from one site of care to another. Such transmission should include at a minimum:
  ▶ Mental status abnormality, present or absent
  ▶ Features of cognition, including normal or abnormal alertness, orientation, attention, and/or thinking (psychosis)
  ▶ Etiology of any present mental status abnormality or change, if known
  ▶ Time course of a mental status abnormality or change, if present, including onset, expected duration, and permanence
▶ Determine specific advance directives on all residents, update them periodically (at least annually and as significant change of clinical status) and establish a readily available, consistent site in the clinical record for their permanent storage.
▶ Contact the destination sites of care for dementia patients promptly after transfer from the facility to ensure the patient arrived and adequate clinical data was received, and answer further questions on the patient’s status.
▶ Intense medication management is essential for all patients but especially for those with dementia. A focus on antipsychotics, antibiotics, anti-diabetic drugs, psychoactive medications, and anticoagulants will serve all patients well, but especially those with cognitive impairment.
▶ The clinician should educate him/herself on medically ineffective interventions in patients with dementia, especially issues around feeding tubes. That information should be shared with the patients and family when interventions are considered.
▶ Recognition of the increasing clinical impact of dementia has encouraged AMDA and its Transitions of Care Committee (TOCC) to create support information and tools. Initial efforts include:
  ▶ The AMDA Universal Transfer Form (UTF) will be updated this year to include mental status information that should be included in transfers.
  ▶ An AMDA TOCC White Paper on the impact of dementia on care transitions will be submitted in March.
  ▶ An AMDA TOCC resolution to establish the elements of mental status information that should be transferred with all patients will be submitted to the AMDA House of Delegates in March.
  ▶ “The Dementia Factor in Care Transitions,” will be presented by the AMDA TOCC as a half-day symposium dedicated to reducing rehospitalization rates in dementia patients at the AMDA annual meeting on Thursday, March 17, 2016.

Please join us on Thursday, March 17 to discuss this important and timely subject in depth at the AMDA annual meeting.

A past AMDA president, Dr. Lett chaired the AMDA workgroup that created the clinical practice guideline “Care Transitions in the Long-Term Care Continuum,” and currently is chairman of the AMDA Transitions of Care Committee. For more information and references, please view this article on the Caring for the Ages website under “Columns.”