Guidance for Developing an Operational Plan to Address Diagnosis and Care for Patients with Alzheimer's Disease and Related Dementias in Hospital Settings

2018

MHA MASSACHUSETTS Health & Hospital ASSOCIATION

Table of Contents

Introduction p. 2

Considerations for Use p. 4

Organization of Plan p. 5

Recommendations Summary pp. 6 - 10

I. Education and Training of Clinical and Non-Clinical Staff

II. Provide a Dementia and/or Delirium Appropriate Environment

III. Recognition of Dementia and/or Delirium

IV. Management and Treatment

V. Improving Admission, Transfer, and Discharge

VI. Advance Care Planning Information

Expanded Recommendations and Action Steps Resources pp. 11 - 19

Appendix of Resources and Tools pp. 20 - 25

Introduction

In June 2017, the state's Alzheimer's and Related Dementias Acute Care Advisory Committee issued its final report with a stated goal "to identify and communicate the challenges and opportunities for providing optimal care to persons with dementia in acute care settings; to provide options for hospitals to improve the quality of care for the patient and the caregiver/provider experience; and to offer strategies to improve the cost effectiveness of care."

Following the issuance of the state report, the Massachusetts Health & Hospital Association (MHA) convened its own workgroup consisting of clinical and operational experts from its membership, as well as representatives of the Alzheimer's Association.

The MHA Alzheimer's and Related Dementias Workgroup met from December 2017 through the summer of 2018 to develop guidance that would assist hospitals with implementing care and management practices for patients with Alzheimer's and related dementias based on the report from the statewide advisory committee.

Hospitals should be aware that during this time, Massachusetts enacted a new law – Chapter 220 of the Acts of 2018, effective November 7, 2018 – that would require all hospitals licensed by DPH to implement by October 1, 2021, an operational plan for the recognition and management of patients with dementia or delirium in acute care settings. The plan must be kept on file and provided to DPH upon request. In addition, the state is now mandating that physician, physician assistant, registered nurse, and practical nurse license renewal include a one-time completion of a course of training and education on the diagnosis, treatment, and care of patients with cognitive impairments, including, but not limited to, Alzheimer's disease and dementia. This one-time course only applies to the four practitioner categories listed above who serve adult populations. Further, those providers listed above, who were licensed on or before November 7, 2018, have until November 6, 2022, to complete the one-time course.

The goal of this document is to provide guidance for hospitals as to the clinical and operational practices that should be incorporated into a hospital's operational plan to meet the new law, which is based on the statewide advisory committee report. Many hospitals already have existing care plans for patients with Alzheimer's and related dementias; it is encouraged that hospitals meet with appropriate staff to determine if there are additional practices that should be adopted beyond those outlined in this guidance document. This guidance is a work in progress, meaning that when the steps outlined within it are put into practice in a hospital, those steps may need to be adapted.

The MHA Alzheimer's and Other Dementias Workgroup seeks your feedback on how to improve the plan. It is the workgroup's hope that this guidance will improve the planning and delivery of care to patients with dementia and can contribute to a better quality of life for all patients, family, and friends that dementia affects.

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Considerations for Use

It is important to note that this document provides general guidance related to developing clinical and operational practices in the treatment and care of patients with Alzheimer's and other related dementias.

There are several forms of dementia, the most common of which is Alzheimer's disease. However, hospitals also treat patients who suffer from delirium, which is separate and distinct from dementia. Unlike dementia, delirium – which is common in hospitalized patients with dementia – is a temporary condition and may be preventable. This guidance addresses both dementia and delirium in patients in hospital emergency departments and inpatient units.

It is also critical that hospitals consider aligning their operational plan with family caregiver engagement and involvement in identification of dementia and treatment across the continuum. The Massachusetts CARE Act (Caregiver Advise, Record, Enable) requires hospitals to provide patients the opportunity to designate a caregiver. Hospitals should also: share discharge plans and general information about the care and treatment of the patient, provided that the patient consented to such release; demonstrate generally known aftercare tasks to perform at home; show the availability of community resources and long-term care supports (if appropriate); and make clear who to contact at the hospital with questions about the above information. Throughout this guidance, you will see repeated references to the importance of including in the hospital's operational plan the participation of family and caregivers. For background information and hospital requirements related to the CARE Act issued by MHA **please click here**.

As is true for all aspects of care across the continuum, but especially so for those living with Alzheimer's and related dementias, the handoffs from one care setting to another are extraordinarily important.

And perhaps the most important recommendation repeated throughout the following pages is the necessity of screening appropriate patients promptly and thoroughly to determine treatment protocols and appropriate interventions. As stated in the Massachusetts Alzheimer's and Related Dementias Acute Care Advisory Committee Report, the presence of dementia interacts with all other diagnoses and medications that appear in the acute care setting, placing patients with dementia at greater risk for adverse events than other patients. Therefore, special attention is required for the identification and management of dementia in patients experiencing acute illness.

Organization of the Plan

In developing an operational plan, the MHA Alzheimer's and Related Dementias Workgroup recommended the following broad components:

Issue 1. The need to provide a wide swath of staff with culturally sensitive training on dementia and/or delirium.

Issue 2. The importance of providing the optimal environment for the patient as he/she enters into the hospital for care.

Issue 3. The necessity of learning the patient's prior history – which may involve working with family, caregivers, EMS personnel – and the need to employ screening tools to assess a patient.

Issue 4. Management of treatment once the patient is in the care of providers in the hospital.

Issue 5. Transfers to the hospital and discharges to home or another level of care within a healthcare facility.

Issue 6. Advanced care planning.

Recommendations Summary

It is recommended that the general components of a hospital's Operational Plan include the items listed below. Following this summary are additional criteria that include:

- The team members involved;
- Suggested action steps; and
- Resources to assist the care team in carrying out the recommendations.

I. EDUCATION AND TRAINING OF CLINICAL AND NON-CLINICAL STAFF

1. Ensure that, prior to renewal of their license, all physicians, physician assistants, registered nurses, and licensed practical nurses complete a one-time course of training and education on the diagnosis, treatment, and care of patients with cognitive impairments, including, but not limited to, Alzheimer's disease and dementia. This one-time course shall only apply to the four practitioner categories listed above who serve adult populations. Further, those providers listed above, who were licensed on or before November 7, 2018, have until November 6, 2022, to complete the one-time course.
2. It is also recommended that hospitals provide culturally sensitive education on appropriate care and treatment to other clinical and non-clinical staff who may be providing care and treatment to patients with Alzheimer's or related dementia.

II. PROVIDE A DEMENTIA AND/OR DELIRIUM APPROPRIATE ENVIRONMENT

1. Provide quiet and safe areas that are appropriate for the patient and their care (e.g.. location furthest from the exit).

2. Ensure clinical staff are trained on use of such areas, or identify volunteers trained to assist with placement or ensuring quiet areas for patients with dementia and/or delirium.

III. RECOGNITION OF DEMENTIA AND/OR DELIRIUM

Prior History

1. Review medical record to determine prior diagnosis including dementia, which may be documented in the patient's plan of care.
2. Elicit history of cognitive impairment, dementia and/or delirium from the

patient or the caregiver as appropriate.

Screening

1. Identify cognitive impairment to guide treatment protocols and appropriate interventions.
2. Develop and implement standardized approach for screening for possible dementia and/or delirium as a cause for cognitive impairment, among other things a provider would be evaluating.

IV. MANAGEMENT AND TREATMENT

1. Dementia and/or delirium should be identified prominently in the medical record, if known, so the entire care team is aware of the diagnosis.
2. Upon the initial diagnosis of Alzheimer's disease, the physician making such diagnosis should work with the care team to ensure that the diagnosis and resources related to treatment is communicated to a family member, caregiver, or legal personal representative of the patient – provided, however, that the physician has either obtained consent from the patient for the disclosure, or the physician has made a reasonable determination that the patient is incapacitated or unable to consent and that such disclosure is in the patient's best interest.
3. Cognitive status should be integrated into treatment decisions.
4. Establish protocol for pain identification and management for individuals with dementia and/or delirium.
5. Establish protocol to involve family members, caregivers, or the legal personal representative in development and implementation of treatment plan, provided that the patient has consented to such release or the physician determines consent is not possible based on the factors outlined above.
6. Consider developing a standing medical order set for geriatric patients.

V. TRANSITIONS: IMPROVING ADMISSION, TRANSFER, OR DISCHARGE

Arrival to Hospital ED

1. Implement communication from EMS staff to ED staff about known diagnosis of dementia and/or possible delirium, patient preferences, behavior triggers, adaptive devices, etc.
2. Take time to set expectations and reassure family, caregivers, or the legal personal representative (as well as the patient if appropriate); explain what is going to happen and why.

Inpatient Admission (direct or transfer)

3. Prominently identify patient's cognitive status of dementia and/or delirium, if known, in medical record.
4. Include cognitive impairment, dementia and/or delirium diagnosis in handoff communication between ED and inpatient physicians and nurses or between hospital physicians and nurses and those from other healthcare facilities and practices.
5. Implement education about medical treatment plan with the patient, family, caregiver, or the legal personal representative (as allowed by the patient or if determined appropriate by the physician).
6. Provide patient, family, caregiver, or legal personal representative orientation to the inpatient unit.

Discharge to Home, Assisted Living Facility from ED or Inpatient Unit

7. Incorporate dementia and/or delirium into discharge plan. Please note that Medicare requires home health agencies to conduct certain assessments to support the need for skilled services at home and to cover the services that may be required at home. Hospitals are therefore encouraged to work with the home health agency that will be providing services to the patient after discharge to ensure appropriate clinical information is received, or this may prevent many patients from receiving appropriate services at home.
8. Ensure family, caregiver, or the personal legal representative responsible for the patient's care is contacted prior to discharge to review the discharge plan, provided that the patient has consented to such release or the physician determines consent is not possible based on the factors outlined

above.

9. Communicate the dementia and/or delirium screening results or diagnosis with family, caregiver, or the personal legal representative, following disclosure rules outlined above, and also include information on:
    a. Steps to obtain a diagnostic work-up;
    b. Understanding the diagnosis;
    c. Available care planning services, based on patient need; and
    d. Available medical and non-medical options for ongoing treatment, services and supports.
10. Offer family, caregiver, or the personal legal representative as allowed above information on/referral to community based care organizations (e.g. Alzheimer's Association, local elder care services agency, Area Service Access Point (ASAP).
11. Ensure information about cognitive status, specifically the dementia and/or delirium, is shared with the known PCP following discharge.
12. Provide clear identification of any medication changes that could influence cognitive status.

Discharge to Home Institution or New Institution (SNF, LTCH, IRF, etc.) from ED or Inpatient Unit

13. Ensure information about cognitive status and and/or acute change in cognition is communicated in handoff communication between hospital physicians and nurses and home/new institution physicians and nurses.
14. Refer or make recommendations for further assessment. Please note that Medicare and MassHealth require long-term care institutions (specifically nursing homes and Skilled Nursing Facilities (SNF) to obtain and document specific information for patients with Alzheimer's, dementias, or other serious mental illness (SMI) prior to covering the admission. Hospitals are therefore encouraged to work with long-term care facilities prior to discharge to a nursing home or SNF only to ensure handoff of appropriate clinical information, or this may delay the discharge.
15. Ensure clear identification of any medication changes through medication reconciliation process and medication adjustments are made available to receiving facility and/or family, caregiver, or the personal legal

representative, as allowed above.

16. Ensure family, caregiver, or the personal legal representative responsible for the patient's care is contacted prior to discharge to review the discharge plan, as allowed above.

17. Communicate the dementias and/or delirium screening results or diagnosis with family, caregiver, or the personal legal representative, as allowed above, and also include information on:

    a. Steps to obtain a diagnostic work-up;

    b. Understanding the diagnosis;

    c. Available care planning services, based on patient need; and

    d. Available medical and non-medical options for ongoing treatment, services and supports.

VI. ADVANCE CARE PLANNING INFORMATION

1. Ensure that resources for healthcare planning throughout the lifespan are available for patient as well as family, caregiver, or the personal legal representative as appropriate.

Expanded Recommendations and Action Steps

Resources are available to assist you in carrying out the following Recommendations and Action Steps, and you can find many in the **Appendix of Resources and Tools** at the end of this document.

I. Education and Training of Clinical and Non-Clinical Staff	
Recommendation	1. Ensure that, prior to renewal of their license, all physicians, physician assistants, registered nurses, and licensed practical nurses complete a one-time course of training and education on the diagnosis, treatment, and care of patients with cognitive impairments, including, but not limited to, Alzheimer's disease and dementia. This one-time course shall only apply to the four practitioner categories listed above who serve adult populations. Further, those providers listed above, who were licensed on or before November 7, 2018, have until November 6, 2022 to complete the one-time course. 2. It is also recommended that hospitals provide culturally sensitive education on appropriate care and treatment to other clinical and non-clinical staff who may be providing care and treatment to patients with Alzheimer's or related dementia.
Care Team Members	• Clinical and relevant non-clinical staff that care for adult populations • Volunteers and students with patient-facing roles
Suggested Action Steps	Education and training should be: • Provided upon hire, if they have not already taken the one-time training • Part of routine educational trainings on clinical and/or operational practices • Customized to staff role • Available through different modalities to enable training of all relevant staff Education and training should include: • Information on delirium and dementia recognition, diagnosis, prevention, and treatment, including non-pharmacological strategies (as appropriate to clinical role)
Resources	To assist hospitals ensure the four clinical specialties listed above are in compliance with the new Massachusetts law, we strongly encourage staff to review the list of education and training programs available in the Appendix *of Resources and Tools.* While the priority should be to ensure that all four specialties obtain the training prior to their licensure renewal, there are several listed programs for all other clinical and non-clinical staff that would help educate staff to appropriately treat and care for patients.

II. Provide a Dementia and/or Delirium Appropriate Environment	
Recommendation	1. Provide quiet and safe areas (i.e. location furthest from the exit) for the patient and his/her care 2. Ensure clinical staff are trained on proper use of quiet and safe areas, or identify trained volunteers who may be directed to assist with placement or ensuring quiet areas for patients with dementia and/or delirium
Care Team Members	• Facility managers • Clinical staff (physicians, physician assistants, registered nurses, licensed practical nurses, physical therapists, occupational therapists, etc.) • Admissions/Triage
Suggested Action Steps	• Identify quiet areas where a patient can be cared for and accompanied by a caregiver or care attendant. (Note, there may be situations where, based on the determination by clinical staff, that a trained volunteer can be with a patient to provide a presence, diversional activity, conversation, and more to help the patient feel comfortable in a new environment) • Use tools to optimize environment and placement of patients • Review and make adjustments or improvements to the environment, including but not limited to even lighting to ensure predictability of environment; music; sound reduction measures; appropriate signage in patient room, bathroom; white board; safety maintenance via use of walkers, commodes, up and out of bed day/night schedule or bundling care overnight, as able.
Resources	Please see *Appendix of Resources and Tools*
III. Recognition of Dementia and/or Delirium	
Prior History	
Recommendation	1. Review medical record 2. Elicit history of cognitive impairment or prior episodes of delirium from caregivers
Care Team Members	• Patient, family, caregivers, and/or personal legal representatives • EMS • ED admitting and administrative staff • Nursing and other care team staff • MD/DO/NP/PA

	• Transferring facility
Suggested Action Steps	• Use all staff who interact with patients (nursing, physician, EMTs/techs) • Consult with family members, caregivers, or personal legal representatives • Incorporate information about the patient from ED triage assessment, paper reports, and clinician-to-clinician communication with post-acute and community providers
Screening	
Recommendation	1. Identify cognitive impairment to guide treatment protocols and appropriate interventions 2. Develop and implement standardized approach for screening for possible dementia and/or delirium as a cause for cognitive impairment, among other things a provider would be evaluating, using validated instruments.
Care Team Members	• Patient, family members, caregivers, or personal legal representatives • Nursing, physical therapists, occupational therapists • MD/DO/NP/PA
Suggested Action Steps	• Develop institutional guidelines/protocols for screening and diagnosis of delirium and cognitive impairment • Develop institutional protocols to identify individuals at high risk of developing delirium • Speak with caregivers to determine patient's baseline cognitive function and facilitate identification of acute changes in cognitive function
Resources	Please see *Appendix of Resources and Tools*
IV. Management and Treatment	
Recommendation	1. Dementia and/or delirium should be identified prominently in the medical record, if known, so the entire care team is aware of the diagnosis. 2. Upon the initial diagnosis of Alzheimer's disease, the physician making such diagnosis should work with the care team to ensure that the diagnosis and resources related to treatment is communicated to a family member, caregiver, or legal personal representative of the patient – provided, however, that the

	physician has either obtained consent from the patient for the disclosure, or the physician has made a reasonable determination that the patient is incapacitated or unable to consent and that such disclosure is in the patient's best interest. 3. Cognitive status should be integrated into treatment decisions. 4. Establish protocol for pain identification and management for individuals with dementia and/or delirium. 5. Establish protocol to involve family members, caregivers, or the legal personal representative in development and implementation of treatment plan, provided that the patient has consented to such release or the physician determines consent is not possible based on the factors outlined above. 6. Consider developing a standing medical order set for geriatric patients.
Care Team Members	• Case manager or care coordinator • Nursing and other care team staff • Physical therapists, occupational therapists • MD/DO/NP/PA • Pharmacy • Nutritionist
Suggested Action Steps	• Diagnosis of dementia and/or delirium • Implement non-intrusive measures (e.g., bracelet) to enable rapid recognition by hospital staff of individual's cognitive impairment • Minimize ED boarding and length of stay • Avoid unnecessary or inappropriate medications/procedures that may provoke or worsen delirium • Develop geriatric medication order set/risky medication warnings • Focus on non-pharmacologic measures for the prevention and treatment of delirium • Use a PAIN score designed for cognitively impaired person (i.e. PAINAD) • Use teleconferencing capabilities to involve family and caregivers in healthcare team rounding for individuals with cognitive impairment • Develop protocol to provide family or caregivers with daily update on individual's clinical progress and treatment plan
Resources	Please see *Appendix of Resources and Tools*

V. Improving Admission, Transfer, and Discharge	
Arrival to Hospital ED	
Recommendation	1. Implement communication from EMS staff to ED staff about known diagnosis of dementia and/or delirium, patient preferences, behavior triggers, adaptive devices, etc. • Take time to set expectations and reassure family, caregivers, and/or personal legal representatives, as well as the patient if appropriate; and explain what is going to happen and why
Care Team Members	• EMS • Patient, family, caregivers, and/or personal legal representatives • Nursing and other care team staff • MD/DO/NP/PA • Pharmacy • Nutritionist
Suggested Action Steps	• Provide education to EMS on communication with family, caregivers, and/or personal legal representatives regarding patient information and identification, and encouraging family, caregivers, and/or personal legal representatives to accompany patient to ED if possible • Use (warm handoff) clinician-to-clinician communication of information about patient care in person or by telephone between facilities or patient care units
Resources	Please see *Appendix of Resources and Tools*
Inpatient Admission (direct or transfer)	
Recommendation	1. Prominently identify patient's cognitive status of dementia and/or delirium, if known, in medical record 2. Include cognitive impairment, dementia and/or delirium diagnosis in handoff communication between ED and inpatient physicians and nurses, or between hospital and outside facility physicians and nurses 3. Implement patient as well as family, caregivers, and/or personal legal representatives (as allowed) education about medical treatment plan 4. Provide patient as well as family, caregivers, and/or personal legal representatives orientation to the inpatient unit
Care Team Members	• Patient, family, caregivers, and/or personal legal representatives

	• Nursing and other care team staff • Physical therapists, occupational therapists • MD/DO/NP/PA • Case manager and/or care coordinator

Suggested Action Steps	• Use dry erase boards to provide:
	  ○ Individual's preferred name/manner to be addressed
	  ○ Contact information for family, caregivers, and/or personal legal representatives
	  ○ Information on ways to comfort or distract the individual
	• Provide orientation packet for family/caregivers:
	  ○ Fact sheet on signs of dementia and/or delirium
	  ○ Template for "This is Me" – a form that you can use to provide details about a person living with dementia. (See link in *Appendix of Resources and Tools*.)
	• Provide resources for family, caregivers, and/or personal legal representatives (as legally appropriate) on how to support patients in a hospital setting

Discharge to Home, Assisted Living Facility from ED or Inpatient Unit	

Recommendation	1. Incorporate dementia and/or delirium into discharge plan. Please note that Medicare requires home health agencies to obtain a "Face to Face" certification completed by a physician or nurse practitioner that documents how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services. The certification must occur 90 days prior or 30 days following the start of home health care services. Hospitals are therefore encouraged to work with the home health agency that will be providing services to the patient after discharge to ensure appropriate clinical information is received or there is a plan to obtain the "Face to Face", as this may prevent/delay many patients from receiving appropriate services at home.
	2. Ensure family, caregivers, and/or personal legal representatives responsible for the patient's care is contacted prior to discharge to review the discharge plan, as legally appropriate
	3. Communicate the dementia and/or delirium screening results or diagnosis with family, caregivers, and/or personal legal representatives (as legally appropriate) and also include information on:
	  a. Steps to obtain a diagnostic work-up
	  b. Understanding the diagnosis
	  c. Available care planning services based on patient need
	  d. Available medical and non-medical options for ongoing

	treatment, services, and supports 4. Offer family, caregivers, and/or personal legal representatives (as legally appropriate) with information on/referral to community based care organizations (e.g. Alzheimer's Association, local ASAP, such as Elder Care Services) 5. Ensure information about cognitive status, specifically dementia and/or delirium, is shared with the known PCP following discharge 6. Provide clear identification of any medication changes that could influence cognitive status.
Care Team Members	• Patient, family, caregivers, and/or personal legal representatives • Nursing and other care team staff • Physical therapists, occupational therapists • MD/DO/NP/PA • Case manager and/or care coordinator
Suggested Action Steps	• Use community services and resources as indicated, examples include: o Area Service Access Point (ASAP - Elder Service Agencies) o Serving Health Information Needs of Elders (SHINE) o Home Health Agency o Community Senior Center o Hospice Care o Alzheimer's Association • Consider providing a checklist or tools for the family, caregivers, and/or personal legal representatives to use in individualized dementia care planning and follow up, such as medically focused care (e.g. medical appointments, tests) and life care planning (e.g. goals of care discussion with family, caregivers, and/or personal legal representatives, healthcare planning documents) • Coordinate with an available care manager assigned to the patient from a payer, community group, or other organization (e.g., MassHealth community partner, if available). Ensure the payer, community group, or other organization is aware of the discharge to ensure a follow up phone call can occur to ensure that the patient is safe and secure at home • Coordinate the handoff by obtaining clinical information from the treating physician to provide to any home health agency; this ensures necessary clinical information or certifications are obtained to continue skilled services at home. Inform the family, caregivers, and/or personal legal representatives of the need to obtain this information to ensure continuation of services at home.
Resources	Please see *Appendix of Resources and Tools*

Discharge to Home Institution or New Institution (Skilled Nursing Facility, Long-Term Acute Care Hospital, Inpatient Rehab Facility, etc.) from ED or Inpatient Unit	
Recommendation	1. Ensure information about cognitive status and new issues are communicated in handoff communications between hospital physicians and nurses and home/new institution physicians and nurses. Please note that Medicare and MassHealth requires long-term care institutions (specifically nursing homes and Skilled Nursing Facilities (SNF)) to complete a Preadmission Screen and Resident Review (PASRR) processes for individuals having, or suspected of having, serious mental illness (SMI) prior to covering the admission. Hospitals are therefore encouraged to work with long-term care facilities prior to discharge to ensure handoff of appropriate clinical information needed to complete a Level 1 PASRR at the nursing home, or this may delay the discharge from the hospital. 2. Refer or make recommendations for further assessment 3. Ensure clear identification of any medication changes through medication reconciliation; ensure medication adjustments are made available to receiving facility and/or families 4. Ensure family, caregivers, and/or personal legal representatives responsible for the patient's care is contacted prior to discharge to review the discharge plan 5. Communicate the dementia and/or delirium screening results or diagnosis with family, caregivers, and/or personal legal representatives (as legally appropriate) and also include information on: a. Steps to obtain a diagnostic work-up b. Understanding the diagnosis c. Available care planning services based on patient need d. Available medical and non-medical options for ongoing treatment, services, and supports
Care Team Members	• Patient, family, caregivers, and/or personal legal representatives • Nursing and other care team staff • Physical therapists, occupational therapists • MD/DO/NP/PA • Case manager and/or care coordinator
Suggested Action Steps	• Use (warm handoff) clinician-to-clinician communication of information about patient in person or by telephone between hospital patient care unit and facility. As necessary, specifically ensure that the long-term care facility (nursing home and SNF only) have the necessary clinical services needed to complete a Level 1 PASRR form so that the facility does not deny an appropriate

	discharge/transfer to an open bed.
	• Share resources and tools to provide optimal patient care management with staff from receiving facility
	• Share information regarding community services and resources to family, caregivers, and/or personal legal representatives (as legally appropriate) as indicated:
	  ○ Area Service Access Point (ASAP - Elder Service Agencies)
	  ○ Serving Health Information Needs of Elders (SHINE)
	  ○ Community Senior Center
	  ○ Alzheimer's Association
	  ○ LTSS = long term services and supports.

Resources	Please see *Appendix of Resources and Tools*
VI. Advance Care Planning Information	
Recommendation	1. Ensure that resources for healthcare planning throughout the lifespan are available for patient/family/caregivers and provided as indicated
Care Team Members	• Patient, family, caregivers, and/or personal legal representatives • Case manager/care coordinator • Social Worker • Nursing and other care team members • MD/DO/NP/PA
Suggested Action Steps	• Ensure availability of trained consultants to meet with family/caregiver in the ED and/or inpatient unit • Share advance care planning resources as requested by the family, caregivers, and/or personal legal representatives as appropriate. • Create a packet of information that includes list of advance care planning materials, including healthcare proxy, MOLST form, others.
Resources	Please see *Appendix of Resources and Tools*

Appendix of Resources and Tools

Fortunately, there is a wealth of resources available on the topic of Alzheimer's disease and other dementias. Many of these resources, as they relate to the six recommendations detailed in the previous pages, are listed below.

Also included is a list of general resources, including those relating to care for the older adult, resources for delirium, and information for caregivers and for family members.

Please Note: This document is posted at the ***PatientCareLink*** website where you can click on the links detailed below to access the documents.

I. Education and Training of Clinical and Non-Clinical Staff

Training:

- The National Institute on Aging (NIA) provides free clinical practice tools, training materials, and more resources for physicians, nurses, social workers, and other professionals. To learn more, please visit: **www.nia.nih.gov/health/alzheimers-dementia-resources-for-professionals**
- *Dementia and Your Community: A Training for Community Professionals*
    - Alzheimer's Association training for non-clinical staff
    - Available on-site, webinar format pending
- **ConsultGeri – clinical website of The Hartford Institute for Geriatric Nursing**
- ***The General Assessment Try This: ® Series*** – offers assessment tools on a variety of topics relevant to the care of older adults. (The Hartford Institute for Geriatric Nursing)
- Geriatric Emergency Nursing Education Course: **GENE ENA**
- **Hospital Elder Life Program** (HELP).
- ***How to Talk to Families About Advanced Dementia: A Guide for Health Care Professionals***.
- Nurses Improving Care for Healthsystem Elders: **NICHE**
- ACEP, **Geriatric Emergency Department Guidelines**
- National Council of Certified Dementia Practitioners' Alzheimer's Disease and Dementia Training Programs - http://www.alzheimerstraining.org/certification.htm
- Teepa Snow, **Positive Approach to Brain Change**™

    - Online education and training, ex., Positive Approach® to Care certification
    - Online journal

- The Alzheimer's Association offers education and training programs for Primary Care Physicians, clinical and non-clinical staff. Programs are CME or CEU approved. Visit **www.alzmassnh.org/hospital** or call the 24/7 Helpline at (800) 272-3900 and ask about education programs for Massachusetts hospitals and/or healthcare professionals.

Presentations:

- **The Role of Acute Care Staff in Emergency Departments (EDs) and Hospitals for Persons Living with Dementia**, PPT Presentation, HRSA, May 2017.

Resources:

- **Dementia Care: Living with Dementia: Changing the Status Quo 2016**, Dementia Action Alliance

II. Provide a Dementia and/or Delirium Appropriate Environment

Resources:

- **Dementia Friendly Massachusetts**
    - Building Dementia Friendly Communities
    - Memory Cafes
    - Videos

- Age-Friendly Health Systems
    - **The John A. Hartford Foundation**
    - **Institute for Healthcare Improvement**

- **Dementia Friendly Hospital Design** – Research Report 2017
- **How to Make a Sensory Room for People Living with Dementia** – A Guide Book.

III. Recognition of Dementia and/or Delirium

Delirium Measurement Tools:

- **Delirium Measurement Info Cards** – NIDUS

Dementia/Cognitive Impairment Screening Tools:

- **Alzheimer's Association Cognitive Assessment Tools**
- Alzheimer's Pocket Card App www.alzmassnh.org/hospital
- Maslow, K. and Mezey, M. ***Recognition of Dementia in Hospitalized Older Adults;*** *AJN,* January 2008, Vol. 108, No. 1.

IV. Management and Treatment

Tools:

- Beers Criteria for Potentially Inappropriate Medication Use in Older Adults: **Beers List**
- Dementia - *Tips for Caring for Me* tool (provided by Lowell General Hospital, March 14, 2018).
- Boltz, M. et. Al. Evidence-Based Geriatric Nursing Protocols for Best Practice 5th edition (2016).
- **Improving Acute Care for Patients with Dementia,** *Nursing Times*. January 29, 2016. Vol. 112, No. 5
- **American Geriatrics Society Geriatric Emergency Department Guidelines**, January 2014
- **American Geriatrics Society Clinical Practice Guideline for Postoperative Delirium in Older Adults** - GeriatricsCareOnline.org
- **American Geriatrics Society Abstracted Clinical Practice Guideline for Postoperative Delirium in Older Adults** - *Journal of the American Geriatrics Society*, December 2014
- **Delirium Measurement Info Cards** – NIDUS

Resources:

- The Alzheimer's Association **Dementia Care Practice Recommendations** were designed to better qualify care across all care settings.
- **Hospital Elder Life Program** (HELP).
- Sanon, M. et. Al. 2014; **Care and Respect for Elders in Emergencies Program: A Preliminary Report of a Volunteer Approach to Enhance Care in the Emergency Department**; The American Geriatrics Society (AGS),
- The American Geriatrics Society (AGS); **Postoperative Delirium in Older Adults: Best Practice Statement from the American Geriatrics Society**; October 2014.

- Smith, M. and Buckwalter, K.; **Behaviors Associated with Dementia**; *AJN, July* 2005. Vol. 105, No. 7.

V. Improving Admission, Transfer, and Discharge

Arrival to Hospital ED
Tools:

- Beers Criteria for Potentially Inappropriate Medication Use in Older Adults: **Beers List**
- **Geriatric Emergency Department Guidelines**, January 2014; American Geriatrics Society, American College of Emergency Physicians, others

Resources:

- Alzheimer's Association Dementia Care Coordination Program enables hospitals to make a direct referral to the Association, which will provide programs and services at no cost to the family. **Alzheimer's Association, MA/NH Chapter;** 24/7 Helpline (800) 272-3900

Discharge to Home, Assisted Living Facility from ED or Inpatient Unit
Resources:

- Alzheimer's Association Dementia Care Coordination Program enables hospitals to make a direct referral to the Association, which will provide programs and services at no cost to the family. **Alzheimer's Association, MA/NH Chapter;** 24/7 Helpline (800) 272-3900
- ***Dementia Care: Living with Dementia: Changing the Status Quo 2016***, Dementia Action Alliance

Discharge to Home Institution or New Institution (Skilled Nursing Facility, Long Term Acute Care Hospital, Inpatient Rehab Facility, etc.) from ED or Inpatient Unit

Tools:

- A.D.M.I.T. Me Emergency Information Form
- Article on "Enhancing the ADMIT Me Tool for Care Transitions for Individuals With Alzheimer's Disease"

Resources:

- Alzheimer's Association Dementia Care Coordination Program enables hospitals to make a direct referral to the Association who will provide programs and services at no cost to the family. **Alzheimer's Association, MA/NH Chapter;** 24/7 Helpline (800) 272-3900
- ***Dementia Care: Living with Dementia: Changing the Status Quo 2016***, Dementia Action Alliance

- AMDA and the Society for Post-Acute and Long-Term Care Medicine. **Dementia in Care Transitions White Paper**, March 2016

VI. Advance Care Planning Information

Tools:

- Advanced care planning documents, including healthcare proxy at:
  - **Honoring Choices**
  - ***PatientCareLink***: **Healthcare Planning Throughout Your Life**
- **The Conversation Project's Starter kit for people with dementia**
- Massachusetts Medical Orders for Life Sustaining Treatment: **MOLST**
- **National Academy of Elder Law Attorneys, Massachusetts Chapter**

Other General Resources for Patients, Family & Caregivers

Resources for Care of Older Adults

- ***The General Assessment Try This: ® Series*** – offers assessment tools on a variety of topics relevant to the care of older adults. (The Hartford Institute for Geriatric Nursing)

Resources for Alzheimer's & Dementia Care

- ***Talking About Brain Health & Aging: The Basics***; (Updated March 2018)
- **Recommendations from the Alzheimer's and Related Dementias Acute Care Advisory Committee December 2016 - June 2017**
- ***Advanced Dementia: A Guide for Families***
- **Alzheimer's Association 2018 Facts and Figures** - Living Fully with Dementia. White Paper
- **Road Map Action Items: Resources and Examples for Public Health Officials;** Alzheimer's Association; September 2017.
- **Dementia Care: The Quality Chasm, Dementia Initiative;** January 2013
- **American Delirium Society**
- **Recommendations from the Alzheimer's and Related Dementias Acute Care Advisory Committee**, 2017.

Resources for Delirium

- **Flyers/Handouts for Patients & Caregivers**

Information for Caregivers

- ***Dementia Care Specialist Toolkit for Dementia Care Management***, Alzheimer's Greater Los Angeles
- **Family Caregiver Alliance, National Center on Caregiving**.

Person and Patient Resources

- **Person Centered Support Plan for People with Dementia; South West** Dementia Partnership.

Websites/Organizations with Resources

- **Alzheimer's Association, MA/NH Chapter**
- **American Delirium Society**
- **Dementia Friendly Massachusetts**
- **Honoring Choices website**
- **Hospital Elder Life Program** (HELP).
- **National Academy of Elder Law Attorneys, Massachusetts Chapter**
- ***PatientCareLink* website**
- The Conversation Project's **Your Conversation Starter Kit**

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