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HADI Hawai'i Alzheimer's Disease Initiative

A PROJECT OF THE UH CENTER ON AGING

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Creating Smooth Transitions Across the Continuum of Care For Dementia

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Hawaii Pacific Neuroscience

- SERVING THE PATIENT, THE FAMILY AND THE COMMUNITY WITH INNOVATION, COMPASSION AND EXPERTISE
- KORE LIOW, MD Director
- Intradisciplinary Neuroscience Institute
- Diagnosis and Treatment of Neurologic Diseases
- Nationally Renown Clinical Research Center

Healthy Aging and Memory Center

- ◆ PAT BORMAN, MD Director
- ◆ Diagnostic Evaluation and Treatment of Memory and Cognitive Disorders
- ◆ Geriatrics Consultation and Primary Care
- ◆ Clinical Research Sub-Investigator
- ◆ Clinical Associate Professor University of Hawaii

The Continuum of Care for Those Living with Dementia

- Timely and Accurate Diagnosis with Continuity of Care for Treatment
- Honest Prognosis
- Care at home
- Building a Care Team
Family, Additional Informal Care, Formal Care
Community Resources

The Continuum of Care for Those Living with Dementia

- 💧 Medical Care
Going to the PCP and Specialists
- 💧 Emergency Room Visits
- 💧 Hospitalization
Discharge back to home, or to a Rehabilitation Center
- 💧 Permanent Placement outside of the home
- 💧 End of Life Care

Transitions of Care

- Above all Do No Harm
- Prevent Unnecessary Transfers
- Reduce Readmissions
- Develop a Successful Transition
- Promote Comfort and Safety

The Four Pillars of Transitions

- 💧 Medication Self Management
- 💧 Personal Health Record
- 💧 Scheduled Medical Follow Up with PCP and Specialists
- 💧 Knowing the Red Flags

The Foundations of the Pillars

- 💧 Self-Management - Engagement
- 💧 Self Identification of Goals - Individualized
- 💧 Adult Learning Model - Communication Style

Are the Four Pillars Adequate?

- Caregivers are underutilized in care planning and underprepared for care transitions
- Psychosocial Issues are not identified
- Risk and Resource Assessment is not addressed
- Dementia Stage and Baseline are not communicated
- Goals of Care may not be defined and respected

What is Missing? Defining Dementia

- Dementia must be at the Top of the Problem List
- We need to Define the Stage of Dementia and transmit baseline and current mental status with every transfer and transition
- The primary caregiver and contact information is clear

What is Missing? Who is making the decisions?

- ◆ Decisional Capacity for Medical Affairs
- ◆ Surrogate Decision Maker Name and Contact
- ◆ Authority: Guardianship with court document
DPOA with

What is Missing?

What are the Goals of Care?

- ◆ Goals of care
- ◆ Addressed Early
- ◆ Addressed Yearly
- ◆ Preferred location of Care
 - Acceptable intensity of Care, What is wanted, what is NOT
 - Use of Medically assisted nutrition
 - Interest in Hospice Services when eligible

Can we create a smooth transition?

- Transition of Care Plan is organized, clear, completed and available prior to transfer. The document is a roadmap to coordinate care among the intradisciplinary care team
- It communicates the current medical issues and mental status with stage of dementia and delirium if present
- Included is medication management, symptom relief, patient/caregiver education, recruitment of social and community supports, follow up appointments with PCP and needed specialists
- Decision making capacity, Legal Surrogate decision maker and goals of care are clear with completed POSLT.

Creating Smooth Transitions

1. Principle Diagnosis
2. Problem List with Dementia FAST Score, current mental status and usual baseline at the top
3. Current Medications/Allergies/Adverse Drug reactions with reason for taking, stop dates
4. Treatment provided, Test Results, Pending Results
5. Planned interventions after transfer

Creating Smooth Transitions

6. Clear Identification medical home (PCP), transferring coordinator, Primary Care Giver
7. Decision Maker, Advance Directives and POLST
8. Assessment of strengths, needed resources, potential barriers
9. Emergency Plan Contact person, strategies to prevent unnecessary future transfers