Dementia Action Collaborative
Washington State

CARE TRANSITIONS:
Hospital to Home for People Living with Dementia

People living with dementia have more hospitalizations, including potentially avoidable hospitalizations, than people without dementia. This tool shares action steps and programs for hospital staff that can help reduce potentially avoidable hospitalizations for people with memory loss and/or dementia.

EASY WINS
Actions that any staff can take

- Identify and flag cognitive decline or dementia upon intake by using a screening tool such as the 3Ds
- Consider obtaining family caregiver names upon check-in to assist with historical knowledge
- Engage with family caregiver during discharge planning and ensure needs upon discharge are understood and can be met
- Connect with your local Area Agency on Aging (AAA) for community-based services and referral resources
- Share resources with family caregiver upon discharge

See specific resources for staff and to share with family caregivers on the last page.

LONG-TERM CONSIDERATIONS

Consider implementing an evidence-based re-admission reduction program, ones that included Persons Living with Dementia (PLWD) are included in the table below. Care Transitions programs being implemented in hospitals are sometimes done internally and sometimes in partnership with community organizations. Criteria to consider for a successful program include:

- Method of identification of PLWD at or around admission
- Incorporating evidence-based practices for accommodating physical and behavioral needs for PLWD
- Hospital staff education (ongoing)
- Family caregiver education and support during stay, discharge planning
- Identify services to continue to support PLWD after discharge
- Engage multidisciplinary team

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MENU OF EVIDENCE-BASED CARE TRANSITIONS PROGRAMS

Name	Description	Notes	Greatest Outcomes
Top 5	Multi-disciplinary team of 4 champions are trained and provided materials to implement the TOP 5 clinician-family caregiver communication tool for PLWD and their care partners.	This was well rated by care partners and clinicians. It is a simple, low-risk and low-cost intervention.	• 74% of clinicians say Top 5 reduced agitation and distress • 61% reported less use of physical or chemical restraint after implementing Top 5 • 89% say Top 5 makes it easier to relate to family caregivers • 71% report less complaints from family caregivers after implementing Top 5
Transitions of Care Model (TCM)	TCM includes identifying and training "resource nurses" to complete screening, reporting and documenting cognitive deficits and providing specific care and coaching for other nurses throughout the entire stay. TCM program includes at least one physician follow-up, telephone outreach and 7 days/ week availability. TCM extends for approximately 2 months post-discharge.	Fewest readmissions among several programs, average time to readmission was 83 days. This does require multiple FTE nurses to administer.	• 83 days average time to readmission vs. 19-22 for hospital-only interventions • 9% rehospitalization or death within 30 days vs. 26% in control group
Dementia Care Transitions Overlay	Dementia Care Transitions Overlay distributes tools (Care Transitions Notebook) and protocols (1 in-home visit and 3 phone calls within 30 days post discharge) to dementia care partners to overlay other programs.	ER and hospitalization rates within 30 days of hospital discharge (based on self-report) were lower than historical reports. This program was successfully studied and implemented in a culturally diverse population.	• 15% ER visit rate within 30 days • 5% rehospitalization rate within 30 days • 35-38% reduction in readmission rate
Bridge Model	The Bridge Model uses a person-centered, social work-led model to work with PLWD. The SW uses evidence-based transition models to provide education and supportive services to PLWD and their care partners. This model uses collaboration and partnership with many supportive community-based organizations.	There are several ways that the bridge model can be implemented. The model implemented by Nevada Senior Services reduced same-diagnosis readmissions to 0 for 30 days post-discharge.	• 0% 30-day readmission rate for same diagnosis • 4% 30-day readmission rate for different diagnosis

RESOURCES FOR STAFF

CLINICAL RESOURCES AND TOOLS

- Cognitive decline identification tools and algorithms are found in Clinical Provider Practice Tool
- Dementia Care Plan and Clinical Tool Beyond Diagnosis provides resources for clinicians and care partners for a variety of situations Dementia Care Plan and Clinical Tool Beyond Diagnosis.pdf (wa.gov)
- Consider using pain assessment tools for patients with cognitive impairment
- 3Ds: Delirium-Dementia-Depression is a pocket-sized screening tool; training and resources are available at no cost
- BREE Collaborative Alzheimer's Disease and Other Dementias Report and Recommendations
- Geriatric-Injury Documentation Tool (Geri-IDT) | USC Center for Elder Justice
- Alzheimer's Association Dementia Care Practice recommendations Dementia Care Practice Recommendations | Alzheimer's Association
- Community Living Connections are local, trusted resources operated by Washington State's Area Agencies on Aging.

AGE FRIENDLY AND DEMENTIA FRIENDLY GUIDANCE

- Consider reviewing and implementing the practical steps of Dementia Friendly Hospitals
- Consider reviewing and implementing actions towards becoming an Age-Friendly Hospital

RESOURCES TO SHARE WITH FAMILY AND CARE PARTNERS

- Tip Sheets for Family and Care Partners
- Dementia Road Map: A Guide for Family and Care Partners
  - To order up to 5 copies for personal use, send your name and mailing address to dementiaroadmap@dshs.wa.gov
  - To order 6 or more copies, review these instructions or visit MarketDirect Storefront (myprintdesk.net)
- Dementia Road Map - A Guide for Family and Care Partners Spanish version
  - To order the Spanish language version, go to inquirywa@alz.org
- Care-Transitions-Notebook-English.pdf (alzheimersla.org)
- Local Area Agency on Aging go by a variety of names, become familiar with Community Living Connections are local, trusted resources operated by Washington State's Area Agencies on Aging.
- Connect with local services and support through the Alzheimer's Association's Washington State Chapter. Included are caregiver education programs, support groups and consultation with masters-level staff for decision making and local support. For more information, please visit alzwa.org or call the Association's 24/7 helpline at 1-800-272-3900 (accommodates 200 languages), All Association services are free.

Dementia Action Collaborative Washington State

This toolkit is produced by the Dementia Action Collaborative (DAC), a statewide collaboration of public and private partners committed to implementing the Washington State Plan to Address Alzheimer's Disease and Other Dementias. The menu includes information provided to the DAC through focus group interviews with hospital-based staff; thank you to all who provided insights.