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policybrief

JANUARY 2017

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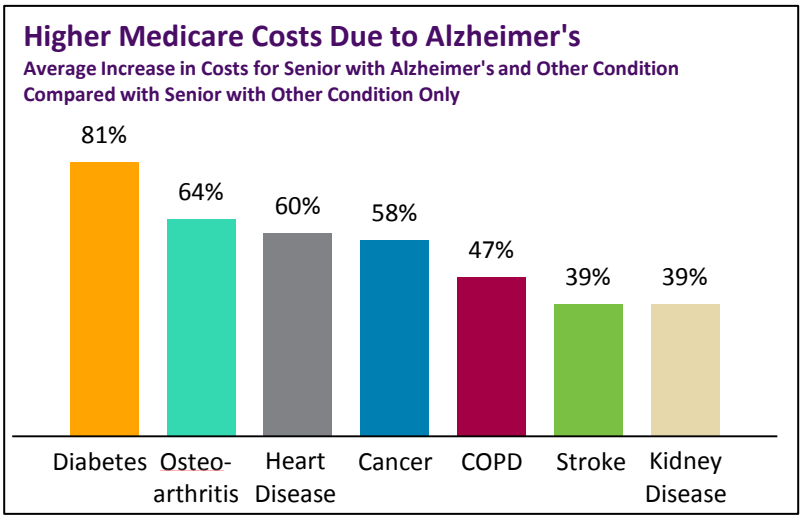
Reducing Potentially Preventable Hospitalizations for People Living with Alzheimer's and Other Dementias

Preventable hospitalizations are hospitalizations for health problems that could have been avoided or treated with adequate primary care or disease management in outpatient settings. Among people living with Alzheimer's and other dementias, 25.3 percent experience a preventable hospitalization,[1] and such preventable hospitalizations cost Medicare nearly $2.6 billion in 2013.[2] Recognizing the higher costs and poorer health outcomes of unnecessary hospitalizations, *Healthy People 2020*, the nation's 10-year public health agenda, includes an objective to "reduce the proportion of preventable hospitalizations in persons with diagnosed Alzheimer's disease and other dementias."[1]

There are a limited number of studies on direct interventions to reduce hospitalizations for people living with Alzheimer's and other dementias.[3] However, one area with the potential to mitigate adverse health events that can lead to unnecessary hospitalizations is improvements in primary care services and disease management for community-dwelling individuals living with Alzheimer's and other dementias.

Reasons for preventable hospitalizations among people with dementia

Alzheimer's, the most common cause of dementia, is typically associated with symptoms such as confusion and memory loss, impaired judgment, and trouble understanding spatial relationships. Some individuals may also experience behavioral symptoms such as depression, aggression, and wandering. These disabling symptoms can make it difficult for affected individuals to manage their own health care or recognize the onset of deteriorating health, putting them at risk for self-neglect and injury.



These symptoms can also complicate the management of other chronic conditions, making comorbidity one of the strongest risk factors for hospitalizations among community-dwelling people living with Alzheimer's and other dementias.[4,5] At least 85 percent of people with Alzheimer's and other dementias have one or more other chronic conditions, and compared to those without dementia, people with dementia are more than 5.5 times as likely to have six or more comorbid conditions.[6] Thus, hospitalizations for people living with Alzheimer's and other dementias are often due to complications resulting from cognitive impairment and not for the cognitive impairment itself. The most common reasons for hospitalizations among people living with Alzheimer's and other dementias are syncope and falls, ischemic heart disease, gastrointestinal disease, pneumonia, and delirium.[5,7] Hospitalizations for people with Alzheimer's and other dementias are also associated with adverse health events such as delirium, falls,

pressure ulcers, untreated pain, and functional decline[7,8] – as well as a higher risk of death.[9] Such adverse health events can hinder or delay recovery after a hospitalization, create new care challenges, or intensify the existing burden of care.

Compared to cognitively normal individuals, people with Alzheimer's and other dementias have higher frequency of hospitalizations and higher health care costs. Adults age 65 and older living with Alzheimer's and other dementias have over twice as many hospital stays as other older adults.[10] From 2000 to 2008, 40 percent of all annual hospitalizations were by individuals age 85 and older living with dementia; in 2050, this population is projected to have as many as 7 million hospitalizations.[11] Average Medicare payments for beneficiaries with Alzheimer's and other dementias are nearly three times higher compared to beneficiaries without dementia.[10] One study found seniors with dementia who had a preventable hospitalization related to long-term complications with diabetes cost Medicare on average $18,338 more than seniors with dementia who did not have a similar preventable hospitalization; the difference was even larger among seniors who had dementia and preventable hospitalizations related to heart failure, which cost Medicare on average 121 percent more than seniors who had dementia but did not have a similar preventable hospitalization.[4]

Unnecessary hospitalizations may be avoided with adequate symptom management and ambulatory care in outpatient settings,[4,5,7] but proactive care management requires training on how to recognize and deal with issues of cognitive impairment before health crises arise. Many primary care providers do not recognize the signs of cognitive impairment[12,13] or feel they lack the time or education[14] to properly assess for it. This can lead to missed or delayed diagnoses[14] or hinder disclosure of a dementia diagnosis.

Also, caregivers of people with Alzheimer's and other dementias are frequently overwhelmed by the burden of caregiving and the challenges associated with behavioral symptoms.[15,16] In stressful situations, caregivers are typically the ones who decide when a person with dementia needs to go to the hospital or when a crisis can be managed at home. Despite the number of effective non-pharmacological interventions available to assist with the management of Alzheimer's symptoms, they are not widely available or known to families affected by Alzheimer's and other dementias or health care staff.[15,16,17]

Readmissions: Another Opportunity

Readmissions – unplanned inpatient hospital stays that occur within a short period after an initial hospitalization – have been the subject of increased attention under the Affordable Care Act. Currently, hospitals may receive penalties for readmissions associated with certain health conditions believed to be manageable with adequate discharge and post-acute care. Because people with Alzheimer's and other dementias are more likely to have co-occurring chronic conditions and greater Medicare spending than other beneficiaries, reducing readmissions among this population may be another opportunity to improve care and lower costs.

Recent research indicates dementia is associated with increased risk for rehospitalization. A 2014 study found Medicare beneficiaries with a dementia diagnosis were nearly 20 percent more likely to have a readmission within 30 days than beneficiaries without dementia.[18] One reason may be patient and caregiver preparedness after discharge. Cognitive impairment has been associated with a higher risk of rehospitalization for individuals who were discharged to home rather than to a facility.[19]

Although not specific to individuals with cognitive impairment, evaluations of evidence-based care transition programs demonstrate the opportunity to reduce readmissions for vulnerable older adults through strong continuity of care across clinical and community-based settings.[20] But more research is needed on the interplay between dementia and readmissions, particularly by identifying new and refining existing strategies to mitigate unnecessary recurring hospital stays. Doing so will help to improve health outcomes and reduce costs.

What Can Be Done?

Evidence indicates employing collaborative care models – managing a patient's overall health with integrated, coordinated care – in primary care settings with patient and caregiver engagement is an effective way to improve quality of life and health outcomes for people affected by Alzheimer's disease and other dementias.[21,22] The American Public Health Association (APHA) supports care coordination as a strategy to improve care and outcomes, including for seriously ill and vulnerable populations.[23,24]

To reduce preventable hospitalizations among people living with Alzheimer's and other dementias, the following public policies can strengthen the management of chronic conditions, promote effective dementia care, and help meet the needs of caregivers.

- *Integrate best practices and models of care*. Several best practices and care models have recently been published, including a 12-step program for improving dementia care across health systems with focused strategies to help reduce potentially avoidable acute care;[25] a synthesis of 15 common best practices of dementia care, some of which address vascular risk factors and managing comorbidities in the context of dementia;[26] and the DICE model (Describe, Investigate, Create and Evaluate) as guidance on how to deal with the neuropsychiatric symptoms of dementia.[16] In addition, several states have outlined actions in their state Alzheimer's disease plans to integrate dementia care into routine ambulatory care. For example, Maine is expanding use of the patient-centered medical home model to integrate and coordinate dementia care within primary care practices,[27] and Vermont is integrating quality improvement activities for dementia with other chronic disease initiatives such as the Vermont Blueprint for Health.[28]

- *Develop guidelines specifically for the care of individuals with Alzheimer's and other dementias.* Overall, efforts to integrate best practices and models of care would be aided by the development of guidelines that define unnecessary and preventable transitions between settings, including preventable hospitalizations, specifically for individuals with Alzheimer's and other dementias.[29] And to further minimize risk of readmissions, discharge guidelines should be developed, including identifying a post-discharge arrangement, establishing follow-up appointments before discharge, providing discharge instructions, and working with individuals and their caregivers on medication management.[29]

- *Target cognitively impaired individuals who live alone, particularly in falls prevention efforts.* Among individuals with dementia who live in the community, 25 percent live alone.[10] And, according to data from the 2015 Behavioral Risk Factor Surveillance System (BRFSS) in 34 states and the District of Columbia, nearly one-third of those experiencing subjective cognitive decline – which is associated with a higher risk of developing dementia – live alone.[30] These individuals are more vulnerable to malnutrition, wandering, having medical conditions go untreated, and falling – a major cause of serious injury, emergency room visits, and hospital admissions. In fact, syncope/fall/trauma is the number one reason that individuals with Alzheimer's and other dementias are hospitalized.[5] To avoid such preventable hospitalizations, state falls prevention plans should recognize the unique needs of those with dementia, especially those who live alone, and target specific efforts to ensure needed services are provided.

- *Educate providers about dementia and its impact on comorbidities*. When physicians are aware of the presence of cognitive impairment, they can adapt care plans for all medical conditions to support patient – and caregiver – adherence to attain the best health outcomes possible. Health care providers should be educated about the warning signs of Alzheimer's disease, validated cognitive assessment tools, and the value of documenting comorbidities (including dementia) in a patient's medical record.

- *Improve tracking and surveillance of hospitalizations.* States should equip public health officials with the capacity for early event detection through the creation of a near real-time database on hospitalizations and emergency department visits. One example is the North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NC DETECT).[31]

- *Link individuals to resources*. Better health systems and community supports for individuals with Alzheimer's and other dementias can improve the management of the disease. Those with dementia should receive care planning that includes information on and referral to community resources and evidence-based programs. Beginning January 1, 2017, Medicare will reimburse providers for care planning services for individuals with cognitive impairment; this includes referral to community resources. Such information could include the

Alzheimer's Association's free 24/7 Helpline (800.272.3900), contact information for the regional Aging and Disability Resource Center (ADRC), and information on falls prevention programs. In addition, public health agencies, state aging and disability agencies, and health systems could partner to promote and deliver evidence-based programs that support people with cognitive impairment such as the Chronic Disease Self-Management Program (CDSMP),[32] falls prevention, and physical activity programs.

- *Adopt multicomponent interventions to support caregivers*. The health system often relies on family caregivers of people with Alzheimer's and other dementias to manage issues before they escalate into greater health problems, including unnecessary hospitalizations. To help caregivers continue in their role, states should adopt multicomponent interventions that combine counseling, education, and support over time to reduce the burden of caregiving while improving the quality of care for people with Alzheimer's and other dementias. Programs such as the North Dakota Dementia Care Services Program[33] (based on the New York University caregiver intervention[34]) reduced both inpatient admissions and emergency department visits while empowering caregivers to achieve their care goals and improve their ability to provide care.

- *Fund research*. More research on innovative approaches to reduce preventable hospitalizations for people with cognitive impairment or dementia, including readmissions, is needed. The Centers for Medicare and Medicaid Services should begin by collecting data on how many people participating in the readmissions reduction programs have dementia as a comorbid condition. This would help to identify the scope of the problem and help target potential approaches to be studied. Additional research is also needed on caregiver-focused interventions aimed at reducing preventable hospitalizations among those with dementia. For example, family caregivers could be given guidance on risk factors for hospitalizations among people with Alzheimer's and other dementias and how to manage them.[3] This may include counseling, education or care consultations.

Conclusion

Preventable hospitalizations for community-dwelling individuals living with Alzheimer's and other dementias are a significant burden that leads to higher health care costs and poor health outcomes. Promoting strategies and resources to enhance care delivery and coordination, implementing interventions to reduce common causes of hospitalizations (such as falls), and expanding targeted caregiver interventions can be effective ways to prevent and manage adverse health events that lead to unnecessary and preventable hospitalizations.

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