Veterans Health Administration (VHA) Innovative Dementia Models of Care: Patient-Centered Alternatives to Institutional Extended Care

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Background

The Veterans Health Administration (VHA) is committed to transforming itself into a 21st-century health care organization that embodies patient-centered care. The vision of the VHA Office of Geriatrics and Extended Care (GEC) is to empower Veterans and the Nation to rise above the challenges of aging, disability, or serious illness. The GEC mission is to honor Veterans' preferences for health, independence, and well-being in the face of aging, disability, or illness by advancing expertise, programs, and partnerships.

GEC has three strategic priorities, the **ABCs of GEC**: **(1) Access.** Optimize the health, independence, and well-being of Veterans by ensuring access to Geriatrics, Palliative Care, and long term services and supports (LTSS) in facilities, home and community-based settings; (2) **Balance.** Honor Veterans' preferences by increasing the delivery of long term services and supports (LTSS) in home and community-based settings, thereby reducing preventable hospital and nursing home stays and emergency department visits; and (3) **Coordination.** Improve care quality and enhance the experiences of Veterans facing the challenges of aging, disability or serious illness by supporting optimal care coordination and management**,** especially when home care is needed or during transitions between care settings.

Veterans Health Administration (VHA) Innovative Dementia Models of Care: Patient-Centered Alternatives to Institutional Extended Care

Innovative Models of Dementia Care

Beginning in Fiscal Year (FY) 2010, GEC launched a range of far-reaching initiatives to enhance VHA capabilities relevant to these strategic priorities, with support from the VA Office of Strategic Integration. A total of 167 innovative, patient-centered, non-institutional care programs were implemented in four phases from FY2010 through FY2014 during the special funding provided by VA. These programs were defined as clinical demonstration programs rather than research projects.

Twenty two of these programs (13% of the total) involved implementation of models of care that focused on key elements of dementia care such as care coordination, care management, or caregiver support. In addition to the 22 dementia models of care, 23 other model type programs indicated that dementia care was a strong component, although not the primary focus. These other 23 programs consisted of the following model types: 9 geriatric primary care, 2 geriatric consult, 5 transitional care, 2 case management, 2 staff educational programs, a delirium toolbox program and 2 mobile Adult Day Health Care (ADHC) programs.

Expected Outcomes

The programs that addressed Veterans with dementia and their caregivers were developed and implemented with multiple anticipated outcomes. Some of those most commonly planned outcomes included:

- Decreased risk for institutionalization
- Decreased utilization of hospital services
- Increased use of community services
- Increased caregiver scores for satisfaction
- Increased support and education to caregivers
- Decreased caregiver stress
- Increased phone contact leading to fewer clinic visits
- Increased referrals from Patient-Aligned Care Teams (PACT)

Veterans Health Administration (VHA) Innovative Dementia Models of Care: Patient-Centered Alternatives to Institutional Extended Care

Specific Accomplishments of Dementia Care Programs

During the time that dementia-related programs were receiving special funding, more than 6,500 unique Veterans with dementia and 5,000 caregivers were served. This number does not include those served after programs were adopted and sustained by host VA medical facilities. The programs with dementia as a primary or secondary focus were successful in numerous areas that directly and indirectly benefitted Veterans with dementia and their caregivers, through activities such as:

- Building capacity for better support services in the community for caregivers
- Conducting educational conferences
- Conducting video phone visits
- Creating a Caregiver Handbook with list of resources available
- Developing and implementing a new "Safehome" program to individualize monitoring technologies for Veterans with dementia
- Establishing a dementia case registry established in one pilot to identify and track status of Veterans with dementia
- Establishing a memory disorder clinic with phone support and dedicated phone line for caregiver support
- Following up after hospital discharge by call back to Veterans with dementia
- Founding Mobile Adult Day Health Care in rural New York and Pennsylvania
- Increasing support to Home-Based Primary Care (HBPC) patients with dementia
- Improving assessment and documentation of family status
- Improving home evaluations including the need for support services and integration of available community resources
- Making referrals to Adult Day Health Care and Respite services
- Providing case management services
- Providing patient-centered care and bringing the Veteran and caregiver together as part of the care team
- Supporting caregivers in their homes
- Supporting Patient Aligned Care Team (PACT) in the care of the Veteran with dementia
- Training clinical providers who conduct support interventions
- Utilizing in home telehealth technology

Veterans Health Administration (VHA) Innovative Dementia Models of Care: Patient-Centered Alternatives to Institutional Extended Care

Challenges

Challenges encountered by awardees attempting to launch programs for Veterans and their caregivers with dementia were reported in three primary areas: 1) the need to define roles and interface with the Patient-Aligned Care Teams (PACT) where most Veterans with dementia are managed in outpatient settings, 2) the need to demonstrate value for sustainability, which required identification of costs and benefits, and 3) the lack of recognition of dementia, which results in an under-counting of Veterans and caregivers that need services.

Sustainability

Overall, awardees reported that in order to market their programs to local VA Medical Center leadership in an effort to have their programs adopted for continuation by the local facility, they needed to make the case that the new program:

- Provides improved patient-centered care
- Uses resources efficiently
- Supports PACT in the care of complex patients with dementia
- Sustains the VA caregiver mission

Evaluation of Dementia Programs by the Center for Organization, Leadership & Management Research (COLMR)

Background

VHA funding permitted an independent evaluation of ten of the twelve dementia care programs that were developed in the first phase of the initiative (FY2010). The final report received at the end of January 2014 aggregated data from phone interviews conducted with sites' points of contacts in July 2013.

Veterans Health Administration (VHA) Innovative Dementia Models of Care: Patient-Centered Alternatives to Institutional Extended Care

A. Keys to Successful Implementation of Dementia Programs

A major theme that resonated among the dementia programs was the need to establish strong collaborations within many levels of the organizations. They recommended that future programs should involve medical center leadership early on in implementation because as one point of contact stated, "it is critical to have the administration be supportive of the complex patients using more resources." Additionally, collaboration with providers and departments can facilitate enrollment, so future programs should be prepared to educate providers on a regular basis by going to clinics and departments while nurturing partnerships with geriatricians and other dementia experts within the medical center.

The most commonly cited barrier for dementia programs was '*Resource allocation'* (40% of programs), followed by '*Human Resources and staffing'* (30%). One site commented, "In the first year, it takes time to train providers and get the team in place."

The ability to utilize existing staff for the program can alleviate the burden of having to undertake the hiring process. Furthermore, sites recommended that future programs should set realistic goals, particularly in the first year of implementation since it takes time to set up the proper resources, to get staff on board, and to enroll patients.

B. Replicable Dementia Programs

Although all ten of the dementia sites were successful in implementation, meeting or exceeding goals, and securing sustainability, nine dementia programs were considered to have the best potential for wider dissemination.

- **Adult Day Health Care Outreach Program, Canandaigua, NY (V02, 528A5-2):** A team of three (social worker, recreational therapist, nursing assistant) created mobile Adult Day Health Care (ADHC) centers at three community sites and offer services at each site 1-2 days/week. A medical home model was implemented with health maintenance activities, caregiver support, nutritional counseling, and education under the direction of the program director and staff from the medical center. A monthly Geriatric Evaluation and Management clinic was made available as needed. This program has the potential to be widely disseminated because it has had a great deal of recognition thus far. Some factors to bear in mind before replicating this program elsewhere are to have the appropriate mix of staff and to build relationships with Veterans.

- **Telephone Case Management for Dementia, Syracuse, NY (V02, 528A7):** A full-time nurse case manager and half-time clinical social worker staff the program with support from the site-based geriatrician and existing Tele-health

program. Participants are voluntarily enrolled from the population of new and existing patients at the Memory Disorder Clinic. Families are contacted at least quarterly for updates, education, and support for both medical and psychosocial needs. Families may also place interim calls as needed. Program adoption could be likely because telephone case management services are provided to Veterans in group calls. The program relies on having partnerships with geriatricians and dementia experts.

- **Dementia Competencies at Home, Coatesville, PA (V04, 542):** The Dementia Competencies at Home (DCAH) program provides a structured, outpatient-based, in-home education program for caregivers (CG) of Veterans with dementia related disorders. The program was implemented to improve the Veteran's continuum of care, by maximizing functional competencies and the caregiver's ability to cope with situations in a more therapeutic manner. Counseling is provided in the Veteran's home and was designed to help the CG to develop compensatory strategies to better manage the areas of functional difficulty impacted by the cognitive deficit. This program has the potential to be widely disseminated because it is simple to implement.

- **In-Home Care Coordination and Intensive Caregiver Support for Veterans with Dementia. Pittsburgh, PA (V04, 646-2):** The program focuses on intensive in-home support for caregivers of Veterans with dementia or cognitive impairment. The primary goals of this clinical demonstration were to reduce caregiver burden and stress, provide caregiver education and resource identification, and improve overall quality of life for caregivers and Veterans. This clinical demonstration project utilizes a multidisciplinary team approach involving a psychologist, social worker, and a registered nurse to provide intensive caregiver support for this population. Team members utilize telehealth technology, home visits, phone interventions, and monthly caregiver telephone support group participation to monitor and provide interventions for caregivers. For success with the program, leadership buy-in and provider education are important.

- **Evidence Based Protocol to Minimize Institutionalization of Cognitively and Behaviorally Impaired Geriatric Veterans, Durham, NC (V06, 558-2):** The Geriatric Resources for Assessment and Care of Elders (GRACE) model consists of an initial evaluation for a comprehensive needs assessment that occurs in the home with the nurse practitioner and psychiatric social worker. The home team meets with the larger group (pharmacist, geriatrician, geriatric psychiatrist) to develop individualized care plans. Subsequent visits occur in the primary care clinic, with additional home visits after Emergency Department visits or hospitalizations. This program has not only secured a permanent role at the

Durham VA Medical Center but also has plans to increase staffing and to expand services in more rural areas. The team has presented posters and papers to disseminate the model and is consulting with other VAMCs as they aim to replicate the Durham program.

- **Supportive Homecare Alternatives for Demented Elders (SHADE) in Urban and Rural Alabama, Birmingham, AL (V07, 521):** The Supportive Homecare Alternatives for Demented Elders (SHADE) program provides patient-centered supportive care at home to Veterans with dementia with the goal of avoiding need for institutional care. The foci were to minimize the symptom burden for the affected Veterans and to provide both support and education for the caregivers. A telehealth module was developed for caregiver education and support. The roll-out comprised of two phases. First, the program enrolled patients in the urban area of Birmingham in cooperation with the existing home-based primary care (HBPC) service. The second phase expanded into the rural areas at the community-based outpatient clinic (CBOC) in Guntersville with dementia-specific care and to offer HBPC. Although this program has the potential to be disseminated widely because it is unique and low-cost, it is specific in its focus.

- **SafeHome: A Suite of Technologies to Support Extended Home Care of Veterans with Dementia, Tampa, FL (V08, 673-6):** The SafeHome program uses technologies to prevent dangerous consequences for Veterans with Dementia (VWD) during unattended times. The goals of the program were three-fold: utilize results of a current project evaluation of technologies to identify those most appropriate to supporting home care of Veterans; develop assessment tools to identify Veterans most in need of technologies to prevent or delay institutionalization; develop models to implement technologies in the home environment and evaluate for effectiveness. The Tampa SafeHome program has published an article, and the site has plans to expand the program to rural areas and to link it to telehealth. Furthermore, the site is consulting with other VAMCs to disseminate the model.

- **Enhanced Care for Veterans with Dementing Illness, Cleveland, OH (V10, 541-4):** The core team, consisting of a clinical nurse specialist and a social worker, works with patients' primary care providers and the HBPC team to identify gaps in care. Goals are five-fold: (1) identify the high priority patients; (2) implement Tele-health; (3) develop caregiver support groups and a helpline; (4) implement the facility's existing Dementia Care Handbook; and (5) provide educational programs for the medical providers caring for patients with dementia. The program's Caregiver Toolkit and Dementia e-Consult Visit have been shared with the VA Healthcare System of Ohio (Veterans Integrated Service Network VISN 10) and have the potential to be shared more widely.

Veterans Health Administration (VHA) Innovative Dementia Models of Care: Patient-Centered Alternatives to Institutional Extended Care

- **Bridging the Gap: Care Management Targeting Veterans with Cognitive Impairment at Times of Transition, Ann Arbor, MI (V11, 506-2):** This intervention targets older Veterans with cognitive impairment at discharge from acute care hospitalization with two modes of care: case management and transitional care. There are three prongs of care: Callback Program, Transitional Care Clinic and ongoing Dementia Case Management. This program utilizes an interdisciplinary team approach, with the advanced practice nurse taking the lead on care coordination. The primary aims are to assist the Veterans with cognitive impairment to live at home as long as feasible and to decrease both preventable admissions and sub-acute placements. While this program has the potential to be disseminated widely, this pilot project was based out of a Geriatric Research, Education, and Clinical Center, thus they did not have to face as many hiring challenges as other sites that did not have as many existing resources.

The following outcome analysis takes into account end of year reports completed by all 22 Dementia programs in addition to the above independent evaluation

Lessons Learned

- Human Resources (HR) is the greatest cause of delay in implementation and sustainment of programs beyond initial funding. The hiring process and onboarding of personnel is a lengthy process. Loss of personnel assigned to a program can result in the program not being sustained.

- Facility leadership support is crucial to sustainment. Leadership can support the provision of necessary resources for the program and can facilitate collaboration with providers and other services.

- Effective communication with leadership, providers and other services is essential to program success. It is especially important to share positive outcomes with leadership.

Veterans Health Administration (VHA) Innovative Dementia Models of Care: Patient-Centered Alternatives to Institutional Extended Care

Preliminary Outcome Analysis*

- Programs reported reduced medication problems in 55% to 88% of patients served. Identification of potentially inappropriate medications for patients was measured by the number of medication adjustments recommended by the pharmacy assessment. Criteria for defining inappropriate medications were based on literature (e.g. Beers et al., 2002) as well as patient presentation indicating potential risk factors (e.g. increased fall risk due to medication side effects).

- Satisfaction with services was reported as good or excellent in all programs that measured it.

- Reduction of perceived caregiving burden, as measured by reductions of scores on the Zarit Caregiving Burden Inventory.

- Nursing home placement was below the expected target for the population involved in the programs.

- Increased safety and care supports and resources, measured by durable medical equipment, nutritional supplements, and home-care referrals provided to patients and families. These include home health services, emergency alert systems, home safety equipment, ambulation assistance equipment, nutritional supplements, Meals on Wheels and other items.

The VHA Geriatrics and Extended Care Data Analysis Center (GEC DAC) is currently conducting an outcome analysis of T21 NILTC Dementia model types.

Veterans Health Administration (VHA) Innovative Dementia Models of Care: Patient-Centered Alternatives to Institutional Extended Care

Conclusion

All of these programs offer patient-centered approaches to dementia care. Below is a list of characteristics that are evident in successful programs. A multi-faceted approach incorporating the elements noted below might be the best approach for dementia care:

- Caregiver support is an essential component of dementia programs. The support of Veterans' caregivers, who are recognized by providers as partners in a Veteran's care, has a direct impact on the management of chronic illnesses and the quality and effectiveness of a treatment plan. Support of a long-term caregiver is directly beneficial to permitting an aging Veteran with dementia to remain in the home longer, decreasing/delaying institutionalization and in turn, potentially reducing overall costs to VA while supporting quality of life for the Veteran and family. It is important to provide regular contact with the caregiver. It repeats important messages, including the message that the caregiver is not alone and that he/she has support. A multiple-media approach should be considered, as a caregiver might be more comfortable with a specific medium.

- Inclusion of other family members in education about dementia can help to support the primary caregiver. In addition to educating other family members so that they have a better understanding of the disease and what the caregiver is experiencing, family members can be guided to ways in which they can assist the caregiver. For instance, a distant relative might be able to provide assistance by looking into community support services that are available where the Veteran and caregiver live.

- In-home support services may include a safety assessment to determine the need for and the proper use of safe home technology.

- Maintaining functional mobility is important. Focusing on gait and balance to promote safe locomotion for individuals with dementia is an important aspect of dementia programs.

- Communication should include regular interaction with the primary care teams. This includes referrals from primary care for dementia care and also education

and training of team members through direct contact and multimedia such as video conferencing technology for underserved/rural areas.

- Education of staff and caregivers is a necessary component of dementia programs. A multiple media approach may be used so that education can be provided by telephone, web based media, written handbooks, toolkits and telehealth technology.

- Rural care needs to be considered. One promising program for providing support to caregivers of rural Veterans with dementia is mobile ADHC. This brings ADHC to rural areas through partnership with Veterans Service Organizations (VSO) for the use of space. Since the space is donated, this program is extremely cost efficient. It is a winning combination of providing meaningful activities for the Veteran, support for the caregiver, positive involvement of VHA with the VSOs, and direct observation and communication with Veterans and caregivers. The care team is mobile, allowing for care to be provided at more than one site during the week.

For More Information

For more information on any of the innovative programs described in this report, please contact Ms. Karen Massey, RN, Chief of Strategic and Transformational Initiatives VACO GEC at Karen.massey@va.gov.

Veterans Health Administration (VHA) Innovative Dementia Models of Care: Patient-Centered Alternatives to Institutional Extended Care

Appendix A: History of Funding Dementia Clinical Demonstration Projects

- **Phase I (Fiscal Years 2010-2012).** 59 Phase I programs were initiated in the 2nd quarter of FY2010. 55 were able to implement and received an additional 2 years of T21 funding (FY2011 and FY2012). 12 of the 55 Phase I programs (22%) were dementia model types. In addition to the 12 Phase I Dementia model types, the Phase I mobile ADHC, 2 geriatric primary care, 2 transitional care and 1 case management model type had a strong dementia component.

- **Phase II (Fiscal Years 2012-2013).** 25 Phase II programs were initiated at the start of FY2012. 23 were able to implement and received a second year of T21 funding (FY2013). There were no Phase II dementia model types although a geriatric primary care program, a case management program and a transitional care program all indicated a strong dementia component.

- **Phase III (Fiscal Years 2013-2014).** 69 Phase III programs were initiated at the start of FY2013 and all were able to implement. Some transitioned to early facility sustainment. 55 received a second year of funding in FY2014. 6 of the 69 Phase III programs (9%) were dementia model types. In addition the following programs indicated strong dementia components: 5 geriatric primary care, 2 geriatric consult, 2 transitional care, 2 staff education and a delirium toolbox program.

- **Phase IV (Fiscal Year 2014).** 20 Phase IV programs were initiated at the start of FY2014. 3 of the 20 Phase IV programs (15%) were dementia model types. In addition to the 3 Phase IV Dementia model types, the Phase IV mobile ADHC model type had a strong dementia component (this was an expansion of the Phase I mobile ADHC program to a new location) as did a Phase IV geriatric primary care program.

Veterans Health Administration (VHA) Innovative Dementia Models of Care: Patient-Centered Alternatives to Institutional Extended Care

Appendix B: Full list of funded T21 NILTC Dementia and Dementia Related Programs

See table on following page.

Veterans Health Administration (VHA) Innovative Dementia Models of Care: Patient-Centered Alternatives to Institutional Extended Care

Phase	VISN	Program	Location	Brief Description	CG	In-Home	MH	Outpt	PACT	Phone	Rural	Telehealth	Sustained Y/N
I	01	VISN 1&3	VISN 1 & 3	Use of an empirically based tool to reduce caregiver stress & depression while maintaining the Veteran in the home	1								Y
I	02	528A7-1	Syracuse, NY	Telephone Case Management Team (RN, SW) offers education and support/services to Veterans with dementia and their caregivers	1			1		1	1		Y
I	04	542	Coatesville, PA	Structured, outpatient-based, in-home education program for caregivers of Veterans with dementia-related disorders	1	1	1	1	1			1	Y
I	04	646-2	Pittsburgh, PA	Multidisciplinary coordination of existing programs (HBPC, ADHC, telehealth, support groups) for rural caregivers of Veterans with dementia	1						1	1	Y
I	05	512	Baltimore, MD	VISN-wide expansion of services of dementia-focused GEM				1		1			N
I	06	558-2	Durham, NC	Caring for Older Adults and Caregivers at Home (COACH): Home-based Dementia care program that provides caregiver support and education to improve dementia care, alleviate caregiver burden, and delay nursing home placement in collaboration with PACT.	1	1		1	1	1	1		Y
I	07	521	Birmingham, AL	Patient-centered supportive dementia care at home through telehealth support of caregiver needs	1							1	Y
I	08	673-6	Tampa, FL	SAFE HOME: Support extended care placement at home for Veterans with dementia through safety monitoring technologies.									Y
I	10	541-4	Cleveland, OH	Dementia Care Coordination will offer patient centered care thru leveraged telehealth, care pathway, and geriatrics expertise.				1				1	Y
I	11	506-2	Ann Arbor, MI	Case management directed to optimizing care transitions for Veterans with dementia	1			1					Y
I	15	589A4	Columbia, MO	"Next Step" clinic (a "one-stop" outpatient GEM) program with interdisciplinary dementia focus and collaborative care with PACT.	1		1	1	1		1		Y
I	19	660	Salt Lake City, UT	SCORE: Supporting Caregivers of Rural Elders Electronically. Rural dementia caregiver support--expansion of a successful pilot employing telehealth to provide personalized care management	1					1	1	1	Y
III	05	G512-2	Baltimore, MD	Enhance case management services provided to Veterans with dementia and their caregivers; develop a toolkit for gait/balance and behavioral problem management.	1			1		1			Y
III	06	637	Asheville, NC	Partnering in Care - Support for caregivers in the homes of Veterans with dementia or cognitive impairment. (Dementia Caregiver Support Program)	1	1		1	1	1			Y
III	08	573-5	Gainseville, FL	Web Support for Caregivers of Elderly Veterans with Dementia	1	1		1		1			Y
III	08	673-13	Tampa, FL	Safe Locomotion in Dementia Lab (SLID Lab) - Development of a caregiver toolkit for safe locomotion that can be disseminated by HBPC and other VHA staff.	1								Y
III	08	G573-1	Gainseville, FL	In-home and outpatient support services for caregivers of Veterans with dementia using the REACH VA intervention (for Veterans enrolled in GAP, HBPC, and GeriPACT).	1	1		1	1		1		Y
III	23	636A6-1	Des Moines, IA	Frail & Elderly Patient Centered Care Team (F&EPCCT) provides interdisciplinary care to Veterans in the right place at the right time (in a Geriatric Problem-Focused Clinic, via telehealth, and/or via house calls). This model addresses the Veteran as a unique individual with physical, emotional, spiritual, and mental needs.		1		1		1	1	1	Y
III	23	G618-1	Minneapolis, MN	Provide PACTs with patient/care-provider dyads to address needs of Veterans with dementia and their families referred from PACTs to the GRECC Memory Loss Clinic for evaluation.	1			1	1	1			Y
IV	07	G508-3	Atlanta, GA	Tele-Implementation of the VA Savvy Caregiver (CG) Program for CGs of Veterans with Dementia - Standardized, evidence-based multi-session program provides informal CGs with training and tools be more effective and less distressed. Designed to strengthen CG/Clinician partnerships by providing training for ATL VA GeriPACT providers in a "train the trainer" format.	1				1				N
IV	11	G506-5	Ann Arbor, MI	Caregiver dyad Tai Chi for cognitively impaired outpatient Veterans	1			1	1	1			Y
IV	17	G671-2	San Antonio, TX	Geriatrics Behavioral Health Clinic: Augmentation to the Existing GeriPACT and Memory Clinic with Caregiver education and support	1			1	1				Y
				Program Component Totals	18	6	2	15	9	10	7	6	

Key to Components: CG - Strong caregiver component; **In-Home** - at least some care is provided in the home setting; **MH** - mental health component; **Outpt** - outpatient care component; **PACT** - the program interacts with Primary Aligned Care Team(s); **Phone** - there is phone call workload as defined by VHA phone call stop codes; **Rural** - the program provides care to at least some rural Veterans; **Teleheath** - telehealth technology is utilized; **Sustained Y/N** - Y means the program is sustained/N means the program has not been sustained by the facility