



State Plan for Alzheimer's and Related Disorders Working Group

LTC Sub-Group

9:00 – 10:00 pm

Wednesday, February 20, 2013

Elmhurst Extended Care

50 Maude Street

Providence, RI 02908

1. **Home Care** – Understanding the Challenges of Providing Home Care Services for those with Dementia
 - a. Last month we looked at adult day, assisted living and nursing home care for those with dementia.
 - b. Home care patients are not typically accessing adult day services so they're home one-on-one with a caregiver or they have not yet been identified as someone with a need for services. Physicians are not creating any form of outreach for early stage Alzheimer's.
 - c. What we need to do as a state is improve strong primary care physician outreach – prepare them (geri-psych, neurologists, etc.) to understand the disease process. Once they see signs they need to be able to look at them holistically. They need to take a deeper dive; how do you get your meals? How do you get to the grocery store? How are you managing?
 - i. From home care perspective; dementia isn't always qualifying event for Medicare because patient doesn't always have a skilled need. So it's because of another co-morbidity that they're qualifying for home care (which often coincides with needing the hospice level).
 - d. From primary care perspective, there is little in between someone who can remain at home and seeing someone at home who compels you to want to call DEA because they're concerned the person isn't safe on their own (not taking medicine, etc.).
 - i. DEA will send a caseworker to assess the situation, work with the family and try to make interventions that will make the person more safe. This is the only recourse unless there is an illness and they can call visiting nurses. There should be a case manager to help improve the situation. Case managers (anchor medical has case managers who work in the physician offices).
 - e. The palliative and skilled care piece are filling in when there is a case manager.

- f. There needs to be coordination between the physician office, home care, the case manager and the family –if there’s not a case manager there’s nothing along these lines.
 - g. Medication management, or if there’s a medication change, constitutes a skilled need. It can “skill” for a few weeks and then other needs may arise to support the skilled need – weight loss, swallowing, etc. Regardless of this approach, the system is not meeting the need, however, it does get someone into the home to help articulate the need for home care services.
 - h. Home care does not have the tools it needs to take any “next steps.” Often, this leads to a referral out to the Alliance or DEA because of neglect. There is nothing else they can do.
 - i. What are case workers able to do and what are they doing?
 - ii. If they’re not getting anywhere, they just keep returning each week and not making progress.
 - iii. How can we think through what the issue is that presents someone with a diagnosis or group of behaviors preventing them from being eligible?
 - iv. If you’ve had some skilled services and have identified needs like not taking shower or they’re forgetting that becomes a need. Early onset, however, wont present sufficient need to qualify for home care.
 - v. A need to watch someone over night may qualify if the caregiver needs to sleep and the person with Alzheimer’s needs to be watched.
 - vi. Elements of nutrition and medication, skin issues, balance, etc. may also qualify the person, but a person doesn’t need a guardian just because they need assistance with care.
 - i. From hospital side, those who are on the cusp of failure (fall, medication issues) often show a UTI, other things, nutrition, etc. This is a gap in resources and funding. Can we proactively address that and preempt those visits to the ER that end up in a nursing home stay? We need to build a proactive system to keep the person at home and prevent acute incidents. There are some organizations, Anne Mulhall’s Moving Minds and Eden at Home (Eden Alternative branch that trains people/volunteer groups to support people who are living at home caring for someone with dementia).
 - j. Church groups are another great place to start.
2. **Urgent Care Centers** – Blackstone valley, Midland Medical, Cranston in garden city, etc. – are another concern. Patients don’t have a primary care physician, but are managing their care through the urgent care center and the center doesn’t dissuade them from that. They aren’t pushing them to the primary care setting. They pull you right back in.
 3. **Physician Offices** are an area we can work to improve continuity with home care once there’s been an admission.
 4. There is no reason not to do a check in. CNA/home health aide can check in with person twice a week, but the home care agency only gets the COC Form if they call the hospital to let them know they’re the provider.

5. There's a need for more objective medical evidence (medical provider does cognitive level, medical, etc.) is crap and it would help with the process. The needs in the home when they leave the nursing home and go to the community – the physical environment and not waiting until the person is in the home (“flip the switch”). The nurse (AL) filling out level of care will say the person needs help getting a shower but there is a lot more to that that must be included.
6. The meeting was adjourned at 10:30 am.