

Impact of the care coordination program “Partners in Dementia Care” on veterans’ hospital admissions and emergency department visits

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Abstract

Introduction: “Partners in Dementia Care” (PDC) tested a care-coordination program based on partnerships between Veterans Affairs (VA) medical centers and Alzheimer’s Association chapters. The hypothesis posited PDC would reduce the likelihood and number of veterans’ hospital admissions and emergency department (ED) visits, particularly for those with more cognitive impairment or behavioral symptoms.

Methods: The sample included 328 veterans with dementia and their primary family or friend caregivers from five matched sites (two randomly selected treatment sites). Data came from VA records; supplemented by caregiver research interviews. Regression analyses using the likelihood and number of hospital and ED visits as outcomes tested for overall treatment-comparison group differences and statistical interactions with cognitive impairment and behavioral symptoms.

Results: Consistent with the hypothesis, three significant interactions showed treatment-group veterans, with more cognitive impairment and behavioral symptoms, had fewer hospital admissions and ED visits than comparison-group veterans. There were no differences in the likelihood of hospital or ED use.

Discussion: PDC, a low-cost program for veterans and caregivers, was effective in reducing the number, but not the likelihood, of hospital admissions and ED visits. Reductions in service use were greater when caregivers reported more difficulties with veterans’ symptoms, which in the absence of PDC would place veterans at risk of being high-volume, high-cost service users.

Clinical Trial Registration: ClinicalTrials.gov: NCT00291161.

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Keywords:

Care-coordination; Support for veterans and caregivers; Hospital and ED use; Partnering VA medical centers and community agencies; Veteran outcomes; Telephone and computer support

1. Introduction

More than 300,000 veterans with diagnosed dementia receive care from the Department of Veterans Affairs (VA), the largest healthcare system in the US [1]. “Partners in Dementia Care” (PDC) was one program being tested as a

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possible component of the VA's system of support services for veterans with dementia and their informal caregivers [2,3]. PDC was designed to coordinate healthcare and community services, which is a goal of the National Plan to Address Alzheimer's Disease [4] and other state and federal initiatives [5]. Care coordination was facilitated by a formal partnership between a healthcare organization (e.g., VA) and community service organization (e.g., Alzheimer's Association Chapters). This partnership addresses a number of limitations of dementia care by promoting: holistic, less fragmented care for medical, and nonmedical needs of individuals with dementia and their caregivers [6]; increased attention to informal caregivers as the lynchpin of long-term care [7]; greater access to information and educational resources [8]; and improved management of coexisting medical conditions [9]. PDC was a version of the evidence-based program, "BRI (Benjamin Rose Institute) Care Consultation," which was developed through a series of studies led by the Benjamin Rose Institute on Aging [10].

Previously published results showed PDC improved psychosocial outcomes for both veterans and their caregivers, including depression, strain, and unmet needs [11,12]. The hypothesis tested in this analysis posited PDC will reduce the likelihood of veterans having any hospital admission or emergency department (ED) visit during the 1-year study period, and will decrease the number of hospital admissions and ED visits. Differences in the likelihood and number of admissions and visits were tested by comparing veterans in PDC with a matched comparison group that received usual care (UC).

Examining the number of admissions and visits is related to the growing interest in readmissions and return ED visits, which can be avoided with quality postdischarge transitional care [13]. Reducing readmissions and return visits is at the core of attempts to lower healthcare costs, including financial penalties in reimbursement for hospitals with high risk-standardized readmission rates [13,14].

Hospital and ED use by individuals with dementia account for a sizeable portion of the higher costs for dementia care than for other chronic conditions [15]. Individuals with dementia have hospitalization rates 1.5 to 3 times higher than persons with other chronic conditions [15–18]. Excess utilization often results from complications in coexisting conditions caused by dementia; care management problems; lack of care alternatives during crises; unmet need for home and community services; insufficient family support; and lack of care coordination [15,18–20]. Individuals with dementia also have more preventable hospitalizations and ED visits [15,21], many of which are due to poor postdischarge and transitional care [17].

Hospital and ED use have unintended negative consequences for individuals with dementia, such as increased delirium, aggression, falls, incontinence, confusion, functional decline, and the use of feeding tubes and urinary catheters [22–26]. Moreover, family members often identify a hospital admission as a turning point, after which preadmission levels of functioning are never regained

[27,28], and the likelihood of nursing home placement increases [29].

The Stress Process Model [30,31] guided this research, with hospital admissions and ED visits conceptualized as "well-being outcomes" that are determined by: (1) primary stressors, (2) support resources, and (3) background and context characteristics. "Primary stressors" are perceived difficulties with symptoms; symptoms perceived as causing more difficulties have more negative effects on outcomes. Cognitive and behavioral symptoms of dementia represented primary stressors. "Support resources" are coping mechanisms that can have direct benefits, regardless of the severity of primary stressors; or conditional benefits that are only realized when primary stressors are appraised causing more difficulties [32,33]. In this research, PDC was conceived as a support resource hypothesized to provide direct and/or conditional reductions in hospital and ED service use. "Background and context" are demographic and social characteristics. For this analysis, these were restricted to characteristics that significantly differed at baseline between PDC-UC groups, despite the matching sites on key organizational characteristics. Background and context also included baseline functional status as an indicator of veterans' general health. Functional status reflected the cumulative effects of all veterans' chronic health conditions, which in this sample averaged over five.

2. Method

2.1. Design

Five study sites included: Boston, MA; Houston, TX; Providence, RI; Oklahoma City, OK; and Beaumont, TX. Northeast and southwest sites were in the same Veterans Integrated Service Networks that provided a common overarching administrative structure. Additionally, matched VA medical centers were similar in: size; inpatient, and outpatient services; academic affiliations; research missions; and medical residency programs. Matched Alzheimer's Association Chapters were similar in size and programs. The study was approved by the Institutional Review Boards of the Providence VA Medical Center, VA Boston Healthcare System, University of Oklahoma Health Sciences Center, and Baylor College of Medicine, and is registered at [ClinicalTrials.gov](https://clinicaltrials.gov) (NCT00291161).

One of the matched sites from each region was randomly selected to deliver PDC; the other provided UC. Boston was the randomly selected PDC site in the Northeast; Providence was its matched UC site. Houston was the randomly selected PDC site in the Southwest; Oklahoma City and Beaumont were matched UC sites. Matching, rather than within-site randomization, was used to allow PDC implementation throughout partnering organizations, without concerns about diffusion to UC veterans.

The study included veterans and the unpaid primary family or friend caregiver, who provided the most assistance

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