# Case Management of Dementia Residents: Optimizing Outcomes and Quality of Life

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As the US population ages (the first baby boomers turned 60 in 2006), the social and economic implications are likely to be profound for society in general and, in particular, the senior health care industry.

The group of individuals 85 and older is now the fastest growing segment of the US population. The proportion of elderly people aged 80 years or older is projected to increase by 300% between now and the year 2040.[1] Figure 1 highlights the projected growth of our older citizens to the year 2050.

The provision of good care for residents with dementia is the future for the assisted living (AL) industry. Recent studies show that over 50% of residents living in assisted living facilities (ALFs) may have some form of dementia or cognitive impairment.[2] Looking ahead, the increase in Alzheimer's disease and other types of dementia will soar as the 85+ population increases, as the risk of developing some form of dementia for people 85 and older is almost 50%. Figure 2 shows the projected increase in Alzheimer's disease cases to the year 2050.

### Case Example: Myra S.

Myra S. is a 78-year-old woman who lives with her 85-year-old husband Stan in a 2-room suite in an ALF. Myra and Stan moved in 3 months ago at their son's urging. Due to Stan's decreasing vision, he was no longer able to drive and needed assistance, but there was no history of significant problems with activities of daily living (ADLs). Upon moving to the facility, the staff noted that Myra was often absent from meals in the dining room and didn't participate in most social gatherings. Her clothing appeared mismatched at times, coming to the dining room with her dress on over her nightgown.

The AL nurse consultant began to do case management on Myra, concerned that she may have dementia. The nurse recommended that a physician visit to assess for possible dementia. The physician diagnosed a vascular dementia and the nurse completed the Functional Assessment Staging Scale (FAST). Myra's FAST score was Stage 5, showing decreased organization abilities, inability to perform complex tasks, and the need for assistance in choosing appropriate clothing.

By identifying the stage of Myra's dementia, the staff was better able to meet Myra's and Stan's needs in their AL environment. Stan had been providing a lot of the support to help maintain Myra's ADLs. With the recognition of her dementia, the staff was able to offer Stan more assistance in getting Myra groomed and to the dining room for meals. Many aspects of her health and socialization were monitored, and staff was better prepared to engage her in social activities. Stan had more time to develop friendships and participate in areas of his own interest. The son was involved in a care plan meeting and appreciated the proactive approach and the regular case management of his mother to help ensure her quality of experience in the AL environment.

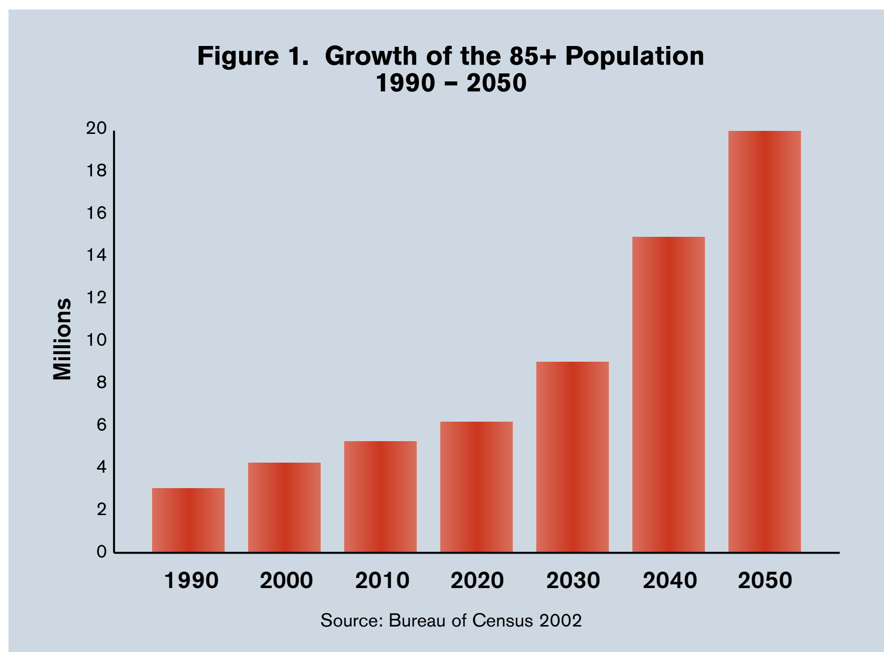
Providing adequate care for dementia residents living in AL

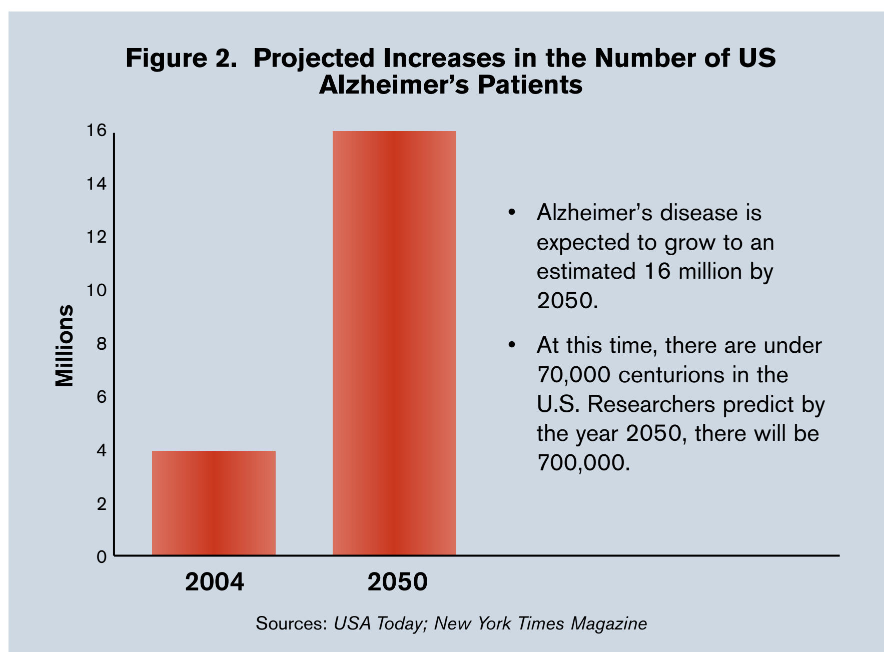
settings can be a challenge. The needs of dementia residents for supervision, engagement, and clinical oversight may be greater than for cognitively intact residents and residents with dementia often are unable to adequately communicate their needs.

As health care providers and consumers become more sophisticated in their expectations of residential care for elderly individuals with dementia, AL will need to develop effective programs for the management of residents with dementia, while delivering a good quality of life experience. In an effort to set standards of care for people with dementia, the Alzheimer's Association has already published initial dementia care guidelines.[3] These guidelines address the areas of social engagement, food and fluid consumption, and pain management.

The Alzheimer's Association guidelines are based on the results of a study that evaluated the quality of care for dementia residents in long-term care facilities.[4] The study found that over 50% of residents with dementia had low food and fluid intake during meals, 40% of residents with recognized pain received no pain medication, and unrecognized depression was common.[4]

A system of case management of dementia residents, which includes regular intervals of assessment, is an excellent method for AL communities to meet the Alzheimer's Association's guidelines, as well as optimize positive health outcomes and quality of life for their dementia residents. Case management of dementia residents can also benefit ALFs as a tool for risk management.




Effectively caring for this population of residents can be very labor intensive and complex. A monthly case management program for dementia residents monitors both clinical and social outcomes. An organized approach of regular assessment and intervention of dementia residents avoids crisis management and improves the quality of the resident's experience in the AL environment.

Case management also allows the staff to recognize the number of residents in their facility that have dementia. This can help focus staff training on important topics, such as communication with dementia residents, behavior management, special program

development, etc. Another recognized need for case management of dementia residents is to help plan the successful transition of a person with dementia when they move into an AL environment from a higher level of care.[5]

An example of a case management tool for dementia residents is shown in Table 1, with a case example of how such a tool can benefit dementia residents' experience in ALFs. As part of the case management, many areas of dementia residents' well-being is tracked and monitored:

- *The stage and progression of the dementia:* These parameters are tracked through the resident's FAST (Functional Assessment Staging Scale) score.[6] The FAST scale (Table 2) is a commonly accepted scoring tool to follow the progression of dementia. The FAST scale follows the progression of dementia from mild memory impairment through moderate to severe dementia. A FAST score of Stage 7 or greater is required for a person with dementia to receive Medicare-certified hospice services.
- *Weight changes:* Both increases and decreases can be significant. A weight decrease may signal a decline in appetite due to pain, infection, dental problems, medication side effects, depression, food preferences, or an inability to manage the complexities of silverware and table etiquette. A weight increase may signal the success of the ALF's dining program or, conversely, an exacerbation of a chronic condition, such as heart failure with fluid retention.
- *Infections:* Residents with dementia may not be able to articulate to staff when they do not feel well. Tracking the frequency of infections, as well as the medical follow-up for each infection, helps staff ensure that adequate medical care is being delivered in a timely manner. Frequent infections may signal increasing frailty of the resident.
- *Falls and injuries:* Falls may be the first sign of an acute infection. They also may signal gait changes due to other health problems or medication side effects.
- *MD/ER visits:* How often is the resident seen by their primary care provider, or have emergency room visits been a necessity? By tracking the dates of medical care, staff can be proactive in facilitating regular care, helping to avoid medical crises.
- *Pain assessment:* Pain often may be unrecognized in dementia residents, especially as their dementia progresses. Staff, who know the residents well, can assess for verbal and nonverbal indications of pain.
- *Medication changes:* Tracking the number and types of medications a resident receives can help avoid overmedication, duplication of medications, and medication side effects.
- *ADLs:* Rapid declines in ambulation, hygiene, feeding, and toileting may signal an acute problem, such an infection, pain, stroke, or medication side effects.
- *Social engagement:* How often does the resident engage in social activities? If the resident is not participating in offered activities, the staff can develop programs appropriate for the resident's interests and abilities.

**Table 1. Dementia Case Management Tool**

**Monthly Wellness Assessment**

| | Jan | Feb | Mar | Apr |
|---|---|---|---|---|
| Resident name:<br>BD:<br>Move-in date: | | | | |
| FAST Score | | | | |
| Weight:<br>(5 lb change needs care plan) | | | | |
| Infections/type:<br>Follow-up care: | | | | |
| Falls/injuries:<br>Follow-up care: | | | | |
| MD visits/<br>ER visits<br>Reason/follow-up | | | | |
| Pain assessment: | | | | |
| Medication changes: | | | | |
| ADL changes:<br>Ambulation<br>Hygiene/bathing<br>Feeding/nutrition<br>Toileting | | | | |
| Social engagement: | | | | |
| Behavior changes:<br>Follow-up care: | | | | |
| Other | | | | |

**Table 2.**
**Functional Assessment Staging (FAST) Scale**

Resident's Name:_______________________ Admit Date:____________

| Stage | Function | Date Admit | Date |
|---|---|---|---|
| | *Choose Stage 1 thru 7 which best describes the resident's abilities.* | | |
| 1 | No difficulty either subjectively or objectively. | | |
| 2 | Complains of forgetting location of objects.<br>Subjective work difficulties. | | |
| 3 | Decreased job functioning evident to co-workers. Difficulty in traveling to new locations. Decreased organization capacity. | | |
| 4 | Decreased ability to perform complex tasks, eg, planning dinner for guests, handling personal finances (such as forgetting to pay bills), difficulty marketing, etc. | | |
| 5 | Required assistance in choosing proper clothing to wear for the day, season, or occasion (eg, patient may wear the same clothing repeatedly, unless supervised). | | |
| 6 | Decreased functional abilities:<br>A. Improperly putting on clothes without assistance or cueing (eg, may put street clothes on overnight clothes, put shoes on wrong feet, or have difficulty buttoning clothing).<br>B. Unable to bathe properly (eg, difficulty adjusting bath water temperature) occasionally or more frequently over the past weeks.<br>C. Inability to handle mechanics of toileting (eg, forgets to flush the toilet, does not wipe properly, or properly dispose of toilet tissue) occasionally or more frequently over the past weeks.<br>D. Urinary incontinence occasionally or more frequently over the past weeks.<br>E. Fecal incontinence occasionally or more frequently over the past weeks. | | |
| 7 | Required for Hospice Certification:<br>A. Ability to speak is limited to approximately a half dozen different intelligible words or fewer in an average day or in the course of an intensive interview.<br>B. Speech availability is limited to the use of a single intelligible word in an average day or in the course of an intensive interview (the person may repeat the word over and over).<br>C. Ambulatory ability is lost (cannot walk without assistance).<br>D. Cannot sit up without assistance (eg, the individual will fall over if there are not lateral rests on the chair).<br>E. Loss of ability to smile.<br>F. Loss of ability to hold up head independently. | | |

- *Behavior changes:* Sudden behavior changes are often the result of an acute problem, such as infection or pain. Anxiety, confusion, fear, and other emotional issues also may result in difficult behaviors. Assessment of the potential cause of the behavior is necessary before any medication for the behavior is offered.

Dementia residents, by nature of their condition, often "disappear into the wall paper." They may be that quiet, kind, elderly lady who never bothers anyone and is often seen sitting alone. In contrast, a dementia resident may be a loud resident who everyone avoids because he interrupts and repeats himself. Either of these residents may not have received a thorough medical assessment and the correct diagnosis of dementia. Through good case management, AL staff may help facilitate these residents getting the correct medical diagnosis and care. Proper diagnosis and medical care can help stabilize the resident's condition and allow him or her to enjoy a better quality of life.

The challenge for ALFs is being able to successfully integrate many of these dementia residents into their environment, while successfully meeting their needs. The case management approach for dementia residents in AL environments helps ensure that their health and social needs are met. The case management tool allows the staff to be proactive, improving communication with involved family members and helping to avoid crises that may require the resident to move from the AL environment. *MPM*

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## References

1. Wan H, Sengupta M, Velkoff VA, DeBarros KA. *65+ in the United States: 2005.* Washington, DC: US Census Bureau. Current Population Report, P23-209. US Government Printing Office, 2005.

2. Hawes C, Phillips CD, Rose M. *High Service or High Privacy Assisted Living Facilities, Their Residents and Staff: Results from a National Survey.* National Center for Assisted Living, November 2000. Available

## Take-Away Message

- The number of ALFs is growing and will soon surpass SNFs in number of residents. With over half of the residents in ALFs having some level of dementia, dementia care is a growing issue.
- There is a significant need for appropriate care management, with over 50% of residents with dementia having problems with food intake and pain management.
- Successful care management involves not only case managers, but physicians, pharmacists, therapists, and dietitians–in short all health care providers.

### ROI

- There is an opportunity for physicians and other health care providers to play key roles in the care management of LTC residents with dementia.
- A successful care management team can improve outcomes for residents and facilities, providing rewards for all team members.


at: http://aspe.hhs.gov/daltcp/reports/hshp.htm. Accessed March 25, 2006.

3. Alzheimer's Association. *Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes*. Chicago, IL: Alzheimer's Association, 2005. Available at: http://www.alz.org/Downloads/DementiaCarePracticeRecommendations.pdf. Accessed March 25, 2006.

4. Alzheimer's Association Press release: Residents with Alzheimer's May Receive Inadequate Care in Nursing Homes and Assisted Living. Available at: www.alz.org/Media/newsreleases/2003/112403. Accessed March 25, 2006.

5. Lobsen N, Stackpole I. Discharge planning and managing early Alzheimer's disease. *Assisted Living Consult*. 2005;1: 8-12.

6. Functional Assessment Staging Scale, developed by Barry Reisberg, MD, 1984.


## Where is Medicare Part D Headed Now?

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result in improved medication use, others may represent inappropriate barriers to medication access. Unfortunately, PDPs are silo'ed in being responsible only for direct medication costs. As a result, their goal is to reduce drug utilization—not to improve overall care—which will drive them to implement barriers to access even appropriate medications.

The federal government, including CMS, has the ability to dictate formulary recommendations. As a result, some products have a forced inclusion on a Medicare Part D formulary, while others are excluded. Thus, under the Medicare Modernization Act, the federal government has developed a list of medications that are excluded from coverage under Medicare Part D (Table 4), while at the same time mandating that plans cover substantially all medications in 6 drug classes (Table 5). The ultimate result of federal government involvement, either through legislation or CMS regulations, is more or less access to certain drugs for Medicare beneficiaries. This shift from prescribers having unobstructed authority in deciding what drug is dispensed will continue, moving rapidly to the groups that control the dollars and rules.

## Take-Away Message

- There are 3 groups that can still enroll in Medicare Part D beyond the May 15, 2006 deadline (dual eligibles, beneficiaries eligible for the low-income subsidy program, and Hurricane Katrina victims).
- The channels controlling how medication is dispensed will move away from physicians to PDPs and the federal government.
- Legislative and regulatory changes are likely to have implications in how practices operate.

### ROI

- Ensuring that medications physicians want for their patients are dispensed in an efficient and effective manner requires:
  - understanding the enrollment process;
  - knowing the scope of coverage plus the appeals and prior authorization process, if needed; and
  - keeping informed of legislative and regulatory changes to Medicare Part D.

### So Where Is Medicare Part D Headed?

Unfortunately, the answer is not one that will be based on a sound clinical basis or a sensible health policy. Instead, it will be determined by Washington politics and is very much dependent on the results of the next few elections. Much debate has centered on removal of the noninterference clause, which prohibits the federal government from negotiating prices with pharmaceutical companies. Whatever direction Medicare Part D takes, clearly it will represent a change for all stakeholders involved in the care of seniors. MPM


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