Case Management of Dementia Residents—

A Tool to Optimize Outcomes and Quality of Life

Anne Ellett, NP, MSN

As the population in the United States ages—the first baby boomers celebrated their 60th birthday in 2006—the social and economic implications are likely to be profound for society in general and the senior housing industry in particular.

The changes have been coming for some time. Today's nursing facilities look much different than they did 10 or 20 years ago. The acuity of residents has increased significantly, and subacute care, rehab, and special units (such as those for Alzheimer's disease) are becoming mainstays of the industry. At the same time, assisted living is seeing more residents with chronic illnesses such as dementia that require varying levels of medical care; and many experts agree that providing good care for residents with dementia is the future for the AL industry.

If ALFs are to effectively care for the growing number of demented residents they are seeing, they need case management tools that not only ensure excellent care but also optimize outcomes and maximize quality of life.

ALFs and Dementia

Recent studies show that over 50% of residents living in assisted living may have some form of dementia or cognitive impairment.[1] Looking ahead, the increase in Alzheimer's disease (AD) and other dementias will soar as the 85-plus population grows; as there is an almost 50% risk of developing some form of

Case Example

Myra is a 78-year-old woman who lives with her 85-year-old husband, Stan, in a two-room suite in an assisted living residence. Myra and Stan moved in three months ago at their son's urging. Due to Stan's decreasing vision, he was no longer able to drive; and they both needed assistance. However, they reported no history of significant problems with ADLs. When the couple moved into the ALF, staff noted that Myra often was absent for meals in the dining room and didn't participate in most social gatherings. At times, her clothing appeared mismatched, and she occasionally would come to the dining room with her dress on over her nightgown.

The ALF's nurse consultant began to use case management with Myra because she was concerned that the elderly woman may have dementia. The nurse made a recommendation for a physician visit to assess for possible dementia. The physician diagnosed a vascular dementia, and the nurse completed the FAST to begin her case management of Myra. Myra's FAST score was Stage 5, showing decreased organization abilities, inability to perform complex tasks, and needing 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 the AL environment. Stan had been providing a lot of the support to help maintain Myra's ADLs, and the staff was able to offer him more assistance in getting Myra groomed and to the dining room for meals. Many aspects of Myra's 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 couple's 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 residence.

dementia for people 85 and older. Figure 1 shows the projection for the prevalence of AD in this country.

Providing adequate care for dementia residents living in assisted living settings can be a challenge for the staff. The needs of dementia residents for supervision, engagement, and clinical oversight may be greater than for other cognitively intact residents, yet residents with dementia often are unable to adequately communicate their needs to staff.

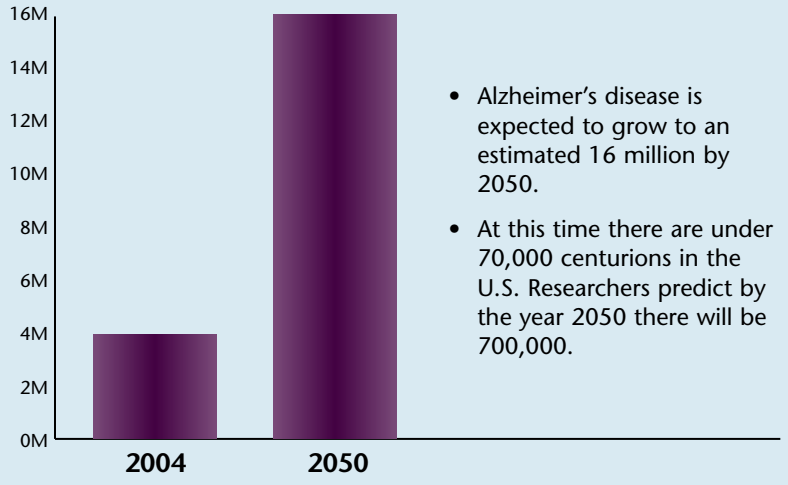
As health care providers and consumers become more sophisticated and demanding regarding their expectations for residential care for demented individuals, ALFs will be expected to develop effective programs to manage residents with dementia, while delivering a good quality of life experience. In an effort to set standards of care for people with dementia, the Alzheimer's Association (AA) already has published initial dementia care guidelines.[2] This tool addresses the issues globally and focuses on the specific areas of social engagement, food and fluid consumption, and pain management.

Study Fuels Guidelines

The Alzheimer's Association based its guidelines on the results of a study examining the quality of care for dementia residents in long term care facilities. This 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.[3]

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 and can help optimize positive health outcomes and quality of life for demented residents. Case management of these residents also can benefit ALFs when they use it as a risk management tool.

Figure 1. Number of Alzheimer's Disease Cases



Sources: *USA Today; New York Times Magazine*

Regular assessment and intervention of dementia residents avoids crisis management.

Why is case management so important for ALF residents? 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 it improves the quality of the resident's experience in the AL environment.

Case management also allows AL staff to recognize the number of residents with dementia in the facility; and it can help focus staff training on important topics such as communication with dementia residents, behavior management, special program development, and so on. Another recognized need for case management of dementia residents is to help plan the successful transition of a demented person when they move into an assisted living environment from a higher level of care.[4]

An example of a case management tool for dementia residents is included in Table 1, with a case example of how it can benefit dementia residents' experience in assisted living.

As part of the case management, many areas of dementia residents' well-being is tracked and monitored. The stage and progression of the dementia is tracked through the resident's Functional Assessment Staging (FAST) scale score.[5] The FAST scale (Table 2), a commonly accepted scoring tool, follows the progression of dementia from mild memory impairment on through moderate to severe dementia. A FAST score of seven or greater is required for a person with dementia to receive Medicare-certified hospice services.

There are several other areas that need to be tracked as part of dementia case management, including:

- **Weight changes**. Both increases and decreases can be significant. 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. 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 good. Tracking the frequency of infections, as well as the medical follow-up for each infection, helps staff monitor that adequate medical care is being delivered in a timely way. Frequent infections may signal increasing frailty of the resident.
- **Falls and injuries**. Falls may be the first sign of an acute infection or they may signal gait changes due to other health problems or medication side effects.
- **MD/ER visits**. How often has the resident been seen by his or her primary care provider or required an emergency room visit? By tracking the dates of medical care, staff can be proactive in facilitating regular care and help to avoid medical crises.
- **Pain assessment**. Pain may be unrecognized in dementia residents, especially as their dementia progresses. Staff who know the residents well can assess for verbal and non-verbal indications of pain.
- **Medication changes**. Tracking the number and types of medications can help avoid over medication, duplication of medications, and medication side effects.
- **Activities of Daily Living (ADLs)**. Rapid declines in ambulation, hygiene, feeding, and toileting may signal an acute problem such as infection or pain, another problem such as a stroke, or medication side effects.

Table 1.
Dementia Case Management Tool

Monthly Wellness Assessment

	Jan, ____	Feb, ___	Mar, ____	Apr, ____
Resident Name: BD: Move-in date:				
FAST Score				
Weight: (5 lb change needs Care Plan)				
Infections/type: Follow-up care:				
Falls/injuries: Follow-up care:				
M.D. visits/ ER visits Reason/Follow-up				
Pain Assessment:				
Medication Changes:				
ADL changes: Ambulation Hygiene/bathing Feeding/nutrition Toileting				
Social Engagement:				
Behavior Changes: Follow-up care:				
Other				

Table 2.
Functional Assessment Staging (FAST) Scale

Resident's Name:_____ Admit Date:_____

Stage	Function	Date Admit	Date	Date	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. 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: A. Improperly putting on clothes without assistance or cueing (eg, may put street clothes on over night clothes, or put shoes on wrong feet, or have difficulty buttoning clothing). B. Unable to bathe properly (eg, difficulty adjusting bath water temperature) occasionally or more frequently over the past weeks. 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. D. Urinary incontinence occasionally or more frequently over the past weeks. E. Fecal incontinence occasionally or more frequently over the past weeks.				
7	Required for Hospice Certification: 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. 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). C. Ambulatory ability is lost (cannot walk without personal assistance). D. Cannot sit up without assistance (eg, the individual will fall over if there are not lateral rests on the chair). E. Loss of ability to smile. F. Loss of ability to hold up head independently.				

- **Social engagement**. How often is the resident engaged in social activities? If the resident is not participating in offered activities, the staff can be alerted to develop programs appropriate for the resident's interests and abilities.
- **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 can also result in difficult behaviors. Assessment of the potential cause is necessary before any medication for the behavior is offered.

(continued on page 13)

care plan meetings on a monthly, rather than a quarterly, basis.
- The family is provided with information about care management agencies available to assist them in decision-making and appropriate placement to meet the changing needs of their loved one.

There are several conditions that trigger circumstances where an assisted living environment may no longer be appropriate for the resident. One example is when the resident becomes bedridden (except in cases of hospice). Sometimes the resident is no longer able to participate in transfers or the transfers become complicated. Once a mechanical lift is required, clearly the patient requires additional assistance that cannot be delivered at the usual assisted living facility level of care. If the resident requires a restraint, then he or she is not appropriate for this setting. Half-rails on the bed may be acceptable for care if they are being used for mobility and self-transfers within the bed; however, as with the resident in skilled nursing facilities, they must be able to demonstrate their use unaided or else they will increase injuries to the resident. The perceived need for side rails for patient safety is another indicator that the resident's function may be declining. If the resident becomes a danger to himself or others that cannot be explained by concurrent medical illness, such as an infectious process, we also address this issue with the family. If the resident requires therapy at any level that cannot be provided by a home health agency, such as physical therapy, occupational therapy, and simple wound care, that also triggers a response. In addition, if the resident requires intravenous therapy or other skilled nursing services that are not provided by a home health agency, that would be included. If the resident consistently refuses medication or the resident's medical power of attorney (MPOA) refuses to allow the use of medication to assist in behavior management when such medication is deemed appropriate by the medical provider (eg, physician, nurse practitioner, physician assistant, and/or consultant, such as a psychiatrist), we initiate the actions noted above. If the resident begins to refuse care on a consistent basis and we feel that this may be a danger to the resident or a sign of significant decline, we also initiate these meetings.

Because of the disease process of dementia, there are times that that a resident's rate of decline does not allow for this transition process to go to the monthly care plan meetings. Certainly, when that occurs, the family and medical provider are notified immediately and appropriate actions initiated.

If the resident begins to refuse care on a consistent basis and we feel that this may be a danger to the resident or a sign of significant decline, we initiate care plan meetings.

As the field of assisted living continues to develop over time, it is of utmost importance to begin to develop policies and procedures that are consistent with both patients' rights and their medical safety within the facility. We believe that by initiating the protocol described in this article, we have been able to deal proactively with difficult patients and issues within our facility. ALC

Scott M. Bolhack, MD, CMS, of the Catalina Health Care Center located in Tucson, AZ.

Case Management of Dementia Residents in Assisted Living

(continued from page 10)

Keeping Residents from Disappearing

Dementia residents, by nature of their condition, often "disappear into the wallpaper." They can be loud, disruptive, and demanding. But demented residents also can be quiet, undemanding, and unassuming. Either way, these residents may not have received a thorough medical assessment and the correct diagnosis of dementia. Through good case management, assisted living 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 to be able to successfully integrate many of these dementia residents into your environment while successfully meeting their needs. The case management approach for dementia residents in assisted living environments helps ensure that their health and social needs are met. It also allows the staff to be proactive, improve communication with involved family members, and help to avoid crises that may require the resident to move from their assisted living home. ALC

Anne Ellett, NP, MSN, is Health Services Vice President of Silverado Senior Living.

References

1. 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.

2. Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes. Alzheimer's Association, 2005.

3. Alzheimer's Association Press release: Residents with Alzheimer's May Receive Inadequate Care in Nursing Homes and Assisted Living. Retrieved from www.alz.org/Media/newsreleases/2003/112403 .

4. Lobsen N, Stackpole I, Discharge Planning and Managing Early Alzheimer's Disease. *Assisted Living Consult* 2005; Vol 1, No. 5, 8-12.

5. Functional Assessment Staging Scale, developed by Barry Reisberg, M.D., 1984.