Improving Outcomes for an Aging Population: Alzheimer's Treatment in Long Term Care

Algorithm for Improved Outcomes in Alzheimer's Treatment

STAGE A: Baseline Assessment

Retrospectively identify 20 residents

- **10 charts** should be from **residents with Alzheimer's disease (AD)**. The **other 10 charts** should come from **residents who do not have AD** (it is acceptable for these other 10 residents to have a dementia diagnosis or other cognitive or memory impairment as long as there is no documented diagnosis of AD).

Review and analyze how patients were evaluated and treated for specific disease-related symptoms (see quality measures included in Stage B)

Set goals for quality improvement

STAGE B: Intervention & Action Plan

Educate and train Long-Term Care clinicians on best practices outlined below, based on areas of need/low performance in Stage A

Quality Measure I:
Percentage of residents with Alzheimer's disease or dementia for whom an assessment of cognition was performed and the results reviewed at least within a 12 month period

- Detailed patient history
- Neurologic exam
- Physical exam/review of systems
- Validated, symptom-specific assessment scales or patient questionnaires (ie, cognitive screen/assessment)

Quality Measure II:
Percentage of residents with Alzheimer's disease or dementia receiving pharmacotherapy for their cognitive impairment

- Symptom-specific pharmacologic treatments—was medication initiated when a cognitive impairment/dementia was noted? If so, did symptoms improve or worsen with the addition of medication?

Quality Measure III:
Percentage of residents with Alzheimer's disease or dementia requiring physical restraints

- Interventions required to control behavior. Were these interventions pharmacological or nonpharmacological?
- If restraints were used, which type(s) were used?

Quality Measure IV:
Percentage of residents with Alzheimer's disease or dementia with a documented medication review

- Frequency of medication review (ie, daily, weekly, monthly)

Quality Measure V:
Percentage of residents with Alzheimer's disease or dementia receiving a quality of life (QoL) assessment

- Types of forms used to assess QoL (ie, SF-36, resident and staff observation checklist)

Quality Measure VI:
Percentage of residents with Alzheimer's disease or dementia with a care plan that addressed existing mental health concerns

- Psychiatric conditions such as depression, mania, and schizophrenia can cause behavioral symptoms similar to those in AD. A management plan that helps mitigate the behavioral symptoms offers residents better care.

STAGE C: Reassessment

Allow 12 weeks for action plan to take effect

Retrospectively identify 20 residents

- **10 charts** should be from **residents with Alzheimer's disease (AD)**. The **other 10 charts** should come from **residents who do not have AD** (it is acceptable for these other 10 residents to have a dementia diagnosis or other cognitive or memory impairment as long as there is no documented diagnosis of AD).

Review and analyze how patients were evaluated and treated for specific disease-related symptoms

Reset goals for quality improvement, and repeat intervention & action plan, as needed

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Instructions for Implementation

This toolkit was created based on a completed quality improvement (QI) CME/CE activity, and accordingly is designed based on the following model of performance or quality improvement:

- Stage A: Learning from current practice performance assessment
- Stage B: Learning from the application of QI to patient care
- Stage C: Learning from the evaluation of the QI effort

Instructions for Stage A:

- Review a minimum of 20 patient charts (or another number determined to be appropriate) from residents most recently admitted, and complete the Data Collection Form, one form per chart
    - **10 charts** should come from **residents with Alzheimer's disease (AD)**. The **other 10 charts** should come from **residents who do not have AD** (it is acceptable for these other 10 residents to have a dementia diagnosis or other cognitive or memory impairment as long as there is no documented diagnosis of AD).
- Calculate and analyze how residents were managed based on the provided Quality Measures and Calculation Instructions
- Set goals for quality improvement

Instructions for Stage B:

- Educate long-term care facility clinicians on best practices; PowerPoint slides used for clinical in-service meetings are available within this Toolkit, and/or you can use other sources to customize the education as needed
- Develop and implement action plans for improvement (as determined to be relevant and appropriate). An action plan template is provided for reference.

Instructions for Stage C:

- Allow several weeks for the action plan(s) to take effect—the amount of time needed will depend on several factors, including the specific actions taken and number of Alzheimer's/dementia residents at facility
- Identify 20 **new** patients (or another number determined to be appropriate) admitted to the long-term care facility since completion of Stage B, and complete the same Data Collection Form, one form per chart
    - **10 charts** should be from **residents with Alzheimer's disease (AD)**. The **other 10 charts** should come from **residents who do not have AD** (it is acceptable for these other 10 residents to have a dementia diagnosis or other cognitive or memory impairment as long as there is no documented diagnosis of AD).
- Calculate and analyze how residents were managed based on the provided Quality Measures and Calculation Instructions, and compare to performance in Stage A
- If desired, set new quality goals again and repeat Stages B and C to reach desired outcome