Advancing Veteran-Centric Care for Veterans, Families, and Caregivers

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Partners in Dementia Care (PDC): Implementing and Evaluating Coordinated VA and Alzheimer’s Association Services

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Dementia Diagnosis is Increasing in Veterans

- 500,000 total current Veterans.
- 300,000 Veteran current enrollees.
- The number of Veterans with dementia will peak in 2018.
Dementia Characteristics

• Impairs cognition -- primarily memory – but also language, insight, judgment, ability to plan.

• Affects ability to care for self, including managing own medical care.

• Triggers behavioral and psychological problems.

• Creates strain on caregivers.
Impact on Caregiver

• Negatively affects family caregivers because of:
  – Intensity of needed care
  – Stresses and strain of care giving
  – Changes in the relationship with the person with dementia
  – Lengthy and progressive course of the disease

• Results in:
  – Caregiver stress and strain
  – Depression
  – Poor medical health
Gaps in Dementia Care

- Diagnosis often missed
- Ongoing comprehensive care lacking after diagnosis
- Impact of dementia on medical care overlooked
- Caregivers rarely receive needed attention
- Need for comprehensive care for Veterans and their caregivers
Partners in Dementia Care

- Four year research & demonstration study.
- Controlled trial - Five sites (Houston, Oklahoma City, Boston, Providence and Beaumont).
- Tests effectiveness of a Telephone-based Care Coordination Intervention that provides:
  - Health-related information/education
  - Linkages to services and other resources
  - Emotional support
  - Mobilize family and friends
- Focuses on U.S. Veterans with dementia and their family caregivers.
Who participates in PDC?

• Intervention Providers
  – Dementia Care Coordinators in VA medical centers
  – Care Consultants in Alzheimer’s Association chapters

• Sites
  – Houston (Intervention site)
  – Boston (Intervention site)
  – Oklahoma City (Education only Comparison site)
  – Providence (Education only Comparison site)
  – Beaumont (Education only Comparison site)

• Sample
  – U.S. Veterans age ≥ 60 with diagnosed dementia
  – Family caregivers (mainly spouses)
What is the goal of PDC?

Test effectiveness of PDC Care Coordination Intervention.

• To improve the quality of care.
• To improve primary health care.
• To improve information and support for Veterans & families.
• To improve the continuity of care by linking:
  – Primary health care
  – Specialty health care
  – Community health and social services
  – Information and support services
What prior studies led to PDC?

Cleveland Alzheimer’s Managed Care Demonstration
- Cleveland Alzheimer’s Association
- Kaiser Permanente of Ohio
- Tested efficacy of Care Consultation
- Recognized by Agency on Aging as Evidence Based Intervention

Chronic Care Networks for Alzheimer’s Disease Initiative
- Partnered health care organizations and Alzheimer’s Association chapters
- 10 communities across the U.S. (VA in Upstate NY)
- Tested feasibility of dementia identification and diagnostic tools for primary care
- Tested feasibility of partnerships

http://www.alz.org/professionals_and_researchers_coordinated_care.asp
Expected outcomes of the PDC Care Coordination Intervention?

- Reduce health care service use by Veterans with dementia:
  - Hospital admissions
  - Emergency department visits
  - Nursing home days
  - Specialty physician visits
- Reduce cost of Veterans’ health care services.
- Improve psychosocial well-being of Veterans & caregivers:
  - Decrease depression
  - Improve perceived adequacy/satisfaction with care
  - Reduce caregiver-related strain
  - Improve informal social support
What are the design features of PDC research?

- Recruit new and previously diagnosed community-dwelling Veterans.
- Comparison sites receive primary care training and comparison patients/caregivers receive educational materials.
- Intervention sites receive same as comparison intervention + Care coordination.
- Three structured telephone research interviews six months apart – Veteran and caregiver followed for 12 months.
  - Measures: health and functioning, care-related strains, satisfaction & adequacy of care, formal and informal support
What are the features of PDC’s Care Coordination Intervention?

- Partnerships between VA medical centers and Alzheimer’s Association Chapters
- Capitalizes on complementary skills of partner organizations

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<thead>
<tr>
<th>VA Medical Center</th>
<th>Alzheimer’s Assoc. Chapter</th>
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<tr>
<td>• Patient-focused</td>
<td>• Family-focused</td>
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<td>• Health &amp; medical services</td>
<td>• Consumer advocacy</td>
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<tr>
<td>• Diagnostic assessment</td>
<td>• Information &amp; support</td>
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<tr>
<td>• Primary care and disease management</td>
<td>• Volunteers &amp; professionals</td>
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<td>• Messages of help &amp; hope</td>
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What are the key features of PDC’s Care Coordination Intervention?

• A key staff member in each partner organization:
  – Dementia Care Coordinator (VA DCC)
  – Care Consultant (Alz. Chapter CC)

• Two key staff members share coordinating responsibilities.

• Work as a team with one care plan.

• Predominantly, a telephone-based intervention.

• Uses a standardized set of protocols for PDC implementation.
What domains does intervention address for Veterans/caregivers?

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<tr>
<th>Patient Domains</th>
<th>Patient &amp; Caregiver Domains</th>
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<tr>
<td>Cognitive Symptoms</td>
<td>Health Information</td>
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<td>Behavioral symptoms</td>
<td>Communicating with Providers</td>
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<td>Co-existing medical conditions</td>
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<td>ADL and IADL dependencies</td>
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<td>Sensory Issues</td>
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<td>Social Isolation</td>
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<td>Informal Support</td>
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<td>Formal Support Services</td>
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<td>Sleep</td>
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What are the components of PDC’s Care Coordination Intervention?

• For each Veteran-caregiver dyad:
  – **Triggers:** Shortcuts for determining the need for assessment
    • 19 patient and 11 caregiver domains
  – **Assessment:** Structured questions to identify & evaluate potential problems
    • 19 patient and 11 caregiver domains
  – **Implementation & Development of Care Plan:**
    • Goals: Intervention objectives that address problem areas through education, emotional support and/or referral linkages.
    • Action Steps: Concrete, manageable tasks to address problems.
    • Individualized Action Plan: Outlines intervention tasks for Veteran and caregiver.
  – **On-Going Monitoring of Care Plan**
A Veteran’s and Caregiver’s Experiences

- Hubert McCarty, Veteran
- Wanda Shedd, Caregiver
Initial Findings

• Recruited 504 Veterans and caregivers
• Average age of Veteran study participant is 81
• 70% of caregivers are wives
• Veterans in PDC have wide variability in dementia severity
• On average, Veterans had more than five medical problems
• Veterans have considerable difficulty with instrumental activities of daily living (eg., managing finances and medical care), and much less difficulty with personal care tasks (eg., bathing and dressing)
Initial Caregiver Findings

- 50% of caregivers have clinical depression
- Caregiver strain relatively low, but there was social isolation and emotional strain occurred in more than 15% of caregivers
- Nearly 50% of caregivers felt unmet needs for:
  - Understanding memory problems
  - Gaining service access
  - Understanding VA benefits
Next Steps

• Does PDC reduce costs and service use?
• Does PDC improve psychosocial well-being of Veterans & caregivers?

Answers in Fall 2010!

• If results are positive, plans are in place to roll out in VHA by 2012