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PROGRAM INSTRUCTION

PI-11-01
Ref: IM-11-01

TO: ASAP Executive Directors
ASAP Program Managers
ASAP Nurse Managers

FROM: Ann L. Hartstein

DATE: February 24, 2011

RE: Standards for Home Care Program Consumers with Alzheimer's disease or a related disorder (ADRD Standards)

Purpose:

The purpose of this Program Instruction (PI) is to communicate standards for Home Care Program consumers with ADRD.

Background:

In the fall of 2008, Elder Affairs convened a work group to review all aspects of the Home Care Program for the purpose of identifying areas in need of development to better serve consumers with ADRD. The work group was comprised of experts in the field, stakeholders, and ASAP representatives, including Executive Directors, Program Managers, and ASAP RNs. In March of 2009, the group concluded its work and produced a set of standards for implementation in the Home Care Program that addressed assessments, care planning, care coordination, and training and qualifications of ASAP and provider staff.

Since that time, the ADRD Standards in draft form have been circulated for comment to the ASAPs a number of times. This process has improved the standards and ensured that each element has been considered from multiple perspectives such as cost, training requirements, system barriers, and consumer choice. As a result, the standards have been modified and clarified without fundamentally altering the work group product or reducing the prospect of significant positive impact on the quality of care for Home Care Program consumers with ADRD and their families.

Required Actions:

Required actions are detailed in the attached Elder Affairs ADRD Standards document.

Effective Date:

February 24, 2011

Contact:

If you have any questions, please contact Joe Quirk, Director of Home and Community Programs, at joe.quirk@state.ma.us.

Elder Affairs ADRD Standards

Assessments

1. All home care consumers (HC/ECOP/Choices/VD-HCBS) are assessed for cognitive impairment within the first six months of enrollment using the Mini-Cog.
    a. The Mini-Cog replaces the dementia indicators.
    b. Consumers with a diagnosis related to a cognitive impairment (e.g., Alzheimer's, vascular dementia) should not be screened.
    c. Consumers with a Mini-Cog result that indicates impairment should not be screened again.

2. All consumers with a cognitive impairment are screened appropriately for depression.

3. All consumers with a cognitive impairment are assessed for safety/risk issues.
    a. Elder Affairs will issue a standard tool.

4. The assessment(s) generates a problem list to be addressed in the care plan.

5. Results are documented appropriately in the Senior Information Management System (SIMS).

Informal Caregivers

1. Informal caregivers are assessed.

2. Care plans for consumers consider services that provide respite to informal caregivers. Guideline: Respite is available on a regular schedule in blocks of four or more hours.

3. As appropriate, consumers with a cognitive impairment and/or their caregivers are provided with a copy of the Alzheimer's Association's *Family Care Guide*. Caregivers of persons in mid- to late stage are provided with a copy of the Alzheimer's Association's *Later Stage Alzheimer's Disease: A Caregiver's Guide*.
    a. Elder Affairs will work with the Alzheimer's Association to make the guides available.

4. Caregivers are provided with information about additional resources for caregivers, including information about the Alzheimer's Association, the Family Caregiver Support Program, and local caregiver support groups.

Primary Care Coordination

1. Consumers with an assessment result that indicates a cognitive impairment are referred to their PCP for follow up. With the consumer's consent, the ASAP provides the PCP with the results of the screening and other information.

2. With the consumer's consent, the consumer's plan of care is sent to the PCP.

3. The ASAP ensures that the utilization of primary care is assessed and appropriate interventions are made in accordance with PI-93-70 and its successors.

4. The ASAP discusses with the consumer/caregiver his/her perception of the adequacy of the health care provider's time, clarity, and respect in discussing the consumer's care. As indicated, consumers and families are provided with information about primary care and its utilization, such as *A Guide for Older People: Talking with Your Doctor* (National Institute on Aging).
    a. The guide is available in PDF version (English and Spanish) via the following link: http://www.nia.nih.gov/HealthInformation/Publications/TalkingWithYourDoctor/ Print copies may also be ordered at this site.

5. The ASAP RN assesses the consumer/caregiver understanding of prescribed medications (use, dosage, side effects, and efficacy). With the consumer's consent, the ASAP RN reports problems to the consumer's PCP. This requirement is optional if the ASAP RN is not already involved in the consumer's care (i.e., if the consumer does not receive personal care and/or is not enrolled in ECOP or the Waiver).

6. The ASAP RN assesses the treatment and management of co-morbid conditions and, with the consumer's consent, reports problems to the consumer's PCP. This requirement is optional if the ASAP RN is not already involved in the consumer's care (i.e., if the consumer does not receive personal care and/or is not enrolled in ECOP or the Waiver).

7. Other requirements for primary care coordination are followed.

a. See PI-93-70 and its successors.

Care Planning

1. The care plan incorporates the preferences and values of the consumer and is developed in conjunction with the consumer and caregiver.

2. The care plan addresses all problems identified in the assessment process, including the risk assessment.

3. The care plan includes services/activities intended to support current functional ability, not just to supplement functional deficits, including, as appropriate, meaningful social interaction, failure-free activities, and physical exercise, as appropriate and as accepted by the consumer/caregiver.

4. The care plan development process considers all available services, especially those Home Care Program services targeted to assist persons with ADRD:
   a. Alzheimer's Day Care
      - For early stage, Supportive Day Program may be appropriate; otherwise, preference should be given to an Adult Day Health center that meets the guidelines for Alzheimer's Day Programs.
   b. Habilitation Therapy (Alzheimer's/Dementia Coaching)
      - Plan of care (POC) includes specific recommendations to address non-cognitive symptoms.
      - POC includes strategies for reality orientation, as appropriate.
      - POC includes recommendations for environmental modifications to reduce agitation and anxiety, promote continence, or address other problems identified.
      - Recommendations are coordinated with other providers (OT, Supportive Home Care Aide, ADH, etc.)
   c. Occupational Therapy
      - OT evaluation includes comprehensive home safety assessment (including loose rugs, electric cords, door locks, cooking, smoking, storage of household cleaners, etc.)
      - For persons with ADRD, reactivating occupational rehabilitation (memory training, manual/creative activities, improving sensorimotor functions, and self-management therapy) is more efficient in improving cognitive

performance, psychosocial functioning, emotional balance, and subjective well-being than functional rehabilitation (functional occupational therapy, physiotherapy, and speech therapy).

- POC includes recommendations for a predictable routine of daily activities.
- OT coordinates recommendations with those of Habilitation Therapist.
- Fall risk is assessed and addressed.

d. Supportive Home Care Aide

- The standard personal care service is not recommended for persons with a cognitive impairment.

e. Wanderer Locator Service/Caregiver Jewelry

f. Wandering Response System

Provider Qualifications

1. At least one RN at each agency that provides Supportive Home Care Aide must participate in the Train the Trainer program for direct care workers.

2. SHCAs are specially trained to work with persons with ADRD through the Train the Trainer program.

3. All direct care staff (homemakers, personal care workers, home health aides, companions) receive basic training in ADRD developed by the Alzheimer's Association.

4. Service requirements for supervision and support of direct care workers are followed.

ASAP Training and Care Coordination

1. Key ASAP interdisciplinary staff that includes at least one ASAP RN must participate in the Elder Affairs approved ADRD training.

2. In-service training for ASAP care managers and RNs includes at least one training on ADRD every 12 months.

3. All care plans for consumers who are at risk due to a cognitive impairment are reviewed by an interdisciplinary team that includes an ASAP staff member trained by the Alzheimer's Association. If the care plan includes personal care, the personal care plan must be developed or reviewed by an ASAP RN who has received the required training.

Personal Care Plan (for SHCA)

1. Care plan orientation for the SHCA includes a review of the consumer's physical health, physical functioning, behavioral status, sensory capabilities, communication abilities, assessed risks, and personal background and/or cultural preferences as necessary.

2. The personal care plan reflects the predictable schedule for daily activities as recommended by the OT/Habilitation Therapist.

3. The personal care plan encourages independence in ADLs through graded assistance and positive reinforcement.

4. As indicated, the personal care plan incorporates scheduled toileting (every two hours) and prompted voiding to reduce episodes of urinary incontinence.

5. The personal care plan incorporates task simplification.

6. The personal care plan incorporates behavior management strategies.

7. The personal care plan includes goals for food and fluid consumption.

8. For extended hour care, the personal care plan incorporates recommendations for activities and physical exercise, as appropriate.