New Hampshire State Commission on Aging
Monday, March 18, 2023, 10 am to noon
NH Hospital Association, 125 Airport Road, Concord, NH

Attendance:
Present in person - Members: Susan Ruka, Chair; Wendi Aultman, DHHS; Susan Buxton, Long Term Care Ombudsman; Richard Lavers, Dept. of Employment Security; Tracy McGraw, Dept. of Labor; Shelley Winters, Dept. of Transportation; Suzanne Demers, Belknap/Merrimack; Carissa Elphick, Belknap; Margaret Franckhauser, Belknap; Doug McNutt, Merrimack. **Staff:** Rebecca Sky, Executive Director, Karen Knowles, Director of Special Projects. **Guests**: April Torreiro from At Home Hearing; Steve Maloney; Peter Burke, St. Joseph Hospital.

Online – Members (with reasons for remote access in parenthesis): Brandy Cassada, Dept of Safety (last minute conflict) Polly Campion, Grafton (unable to drive due to injury); Laurie Duff, Strafford (caregiving for injured family member); Roxie Severance, Clerk, Coos (caregiving - family medical appointment); Beth Quarm Todgham, Hillsborough (out of state); Joanne Ward, Rockingham (car trouble). **Guests:** Laura Davie, UNH; Kim Murphy; Cheryl O'Malley; April Steffensmeier; Christian Seasholtz, of Chris Pappas Office; Shawn Jones, NHDMA; Madeline Ullrich, NH Care Collaborative; Jennifer Rabalais, UNH.

Guest Speakers: Kerry Dennis, volunteer with Alzheimer's Association; Kris Hering, Foundation for Healthy Communities; Susan Antkowiak, Alzheimer's Association.

Members Absent – Representative James MacKay; Representative Charles McMahon; Senator Bill Gannon; Sunny Mulligan Shea, NH Attorney General; Jack Ruderman, NH Housing Finance Authority; Beverly Bjorklund, Sullivan; Daniel Marcek, Hillsborough; David Ross, Hillsborough; Rep. Lucy McVitty Weber, Cheshire.

I. Welcome-Susan Ruka

Susan Ruka, Chair called the meeting to order, and February Meeting Minutes were approved.

II. Continuing the Discussion -Alzheimer's Disease & Related Dementias.

PURPOSE: To learn what's working and what is missing regarding support for individuals and their families in NH. Both to inform future COA recommendations to Gov. and State Legislature and be able to better support the upcoming ADRD public awareness campaign.

Personal Experience with Dementia - **Kerry Dennis,** Auburn, NH

Kerry Dennis from Auburn, NH, a volunteer with the Alzheimer's Association shared her journey with Alzheimer's Disease. Still in an early stage, she shared her challenges working with her primary care physician to get a diagnosis. Many of the barriers mentioned at the previous Commission meeting were affirmed as inhibiting diagnosis in Kerry's instance – primarily a lack of provider education. Kerry also suggested that the initial diagnostic screening is not sensitive enough to facilitate early diagnosis. This resulted in feelings of distress and stress, consternation, and frustration. Diagnosis only came after a referral to a Boston specialist by her employer close to two years after seeking a diagnosis from her primary care provider. Emotions at point of diagnosis ranged from relief from finally confirming what

was happening, to sadness and loneliness, and fear of living without purpose and future loss of dignity. Connecting to the Alzheimer's Association accessing their resources and participating in one of their peer support groups made a significant positive difference since diagnosis. Kerry advocated that early-stage diagnosis needs to become the norm. It creates the opportunity for setting and communicating goals for one's own care and quality of life over the course of the disease with family and future care partners. Kerry ended by talking about all the things she loves in her life that she is still able to enjoy even with this diagnosis.

Continuum of Care Continued: Acute Care – Hospital Dementia Operational Plans - **Kris Hering**, Vice President of Vice President, Quality Improvement at Foundation for Healthy Communities

Kris spoke to the requirement in statute for hospitals to complete and implement an operational plan for the recognition and management of patients with dementia or delirium in acute-care settings by January 2023. In early 2022, hospitals collaborated in a learning community reviewing resources, studying best practices, conducting gap analysis, hearing from experts, to help each other develop plans and trouble-shoot implementation. There we many "aha moments", such as realizing the impact of delirium and the imperative of preventive measures. So valued by hospitals, the learning community continues to convene past its intended end date. One significant challenge for hospitals is supporting patients who lack family or a designated care partner at home. A Commission member asked how hospitals are communicating the complexity of post hospital care of patients with dementia or delirium with a patient's primary care physician. Kris attested to hospital acknowledgement of the value of care coordinators in primary care practices in the care management for this patient population. Without that person, communication to primary care providers is more challenging. Another member asked about staff training on dementia. Kris replied that the plans do address hospitals providing annual training to staff. Kris expressed uncertainty as to whether or not hospitals track staff participation in training or assess impact of training. A final question was asked about how hospitals are held accountable to planning and implementation. The response was that accountability falls to the Bureau of Health Care Facility Licensing within the NH Department of Health and Human Services. People with concerns can raise issues to the Bureau.

Public comment was made that it can be time consuming for leaders of organizations who are required to provide training on dementia and dementia care to weed through all the information out there to ensure their staff are getting a relevant and accurate training. The commenter expressed a desire for the state would provide free updated annual trainings to meet this requirement.

How the Landscape is Changing - Opportunities on the Horizon - **Susan Antkowiak**, Vice President, Programs & Services, Alzheimer's Association, MA/NH Chapter.

Susan spoke about Alzheimer's research and innovation and resulting changes on the horizon. Susan covered what we know about prevention and the emotional, social, and medical benefits of early diagnosis. Susan gave her presentation with slides, but as research is always progressing and out of concern of the slides becoming quickly outdated, the slides are embargoed and will not be part of the meeting minutes.

Speaking to research on various biomarkers, Susan suggested we could be optimistic that a blood draw could be used for diagnosis within the next five years. As access to PET scans is limited, especially in rural areas, this could significantly open the door for early diagnosis. The Alzheimer's Association is

involved in developing clinical guidelines towards their use, but it could take time to get into common practice. Early diagnosis will have increased value as we move into an era of treating not just symptoms, but the biology of the disease interrupting its progression. There are currently over 140 unique therapies being tested in clinical trials at this time.

III. COA Updates: Older Adult Volunteer Awards Program (OAVA) and Tracking of Bills in Legislature

Beth Quarm Todgham shared that nominations for people to be honored through the Older Adult Volunteer Awards program were going well. Still, the deadline was extended by a week at this meeting for two counties where no nominations have been made, Cheshire and Sullivan Counties. The Committee reviewing nominations will meet April 9th. A date will be forthcoming from the Governor's Office for the award presentations. We have asked for it to be the afternoon of our May Commission meeting. Commission members we asked to please make every effort to attend to celebrate those being honored and lift up the value of this program (and older adults in our communities!)

Polly and Rebecca updated members on bills working their way through the legislature. Sue Buxton made an impassioned call for Commission members to connect with their legislators about HB 1098 relative to ballots delivered to elder care facilities. The bill content itself is not necessarily harmful, but the testimony provided by bills sponsors and other public entities in support of bill was ageist and heavily biased against people living in long term care facilities right to vote.

IV. Public Input

No public input.

V. Adjournment

Presentation Slides:

Acute Care- Hospital Dementia Operational Plans

PRESENTED BY:
Kris Hering
VP Quality Improvement,
Foundation for Healthy Communities

Where it all began- SB 119

CHAPTER 194
SB 119 - FINAL VERSION

03/07/2019 0738s
06/06/2019 2407EBA

19-0873
01/04

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Nineteen

AN ACT directing hospitals to develop an operational plan for the care of patients with dementia.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 194:1 New Section; Health Facilities Licensure; Hospital Dementia Operational Plan. Amend
2 RSA
3 151 by inserting after section 2-h the following new section:
4 151:2-i Hospital Dementia Operational Plan Required.
5 I. Every facility licensed as a hospital under RSA 151:2, I(a) shall, not later than January 1,
6 2023, complete and implement an operational plan for the recognition and management of patients
7 with dementia or delirium in acute-care settings. The plan shall address the following
8 recommendations:
9 (a) Recognition of dementia and/or delirium.
10 (b) Cognitive assessment.
11 (c) Management and treatment in all relevant departments.
12 (d) Development of a dementia-friendly environment.
13 (e) Transfer or discharge procedures.
14 (f) An annual hospital self-assessment.
15 (g) Education and training of clinical and non-clinical staff.
16 II. Hospitals shall keep the plan on file and make the plan available to the department of
17 health and human services, bureau of health facilities administration upon request.

194:2 Effective Date. This act shall take effect January 1, 2020.

Implementation Strategy

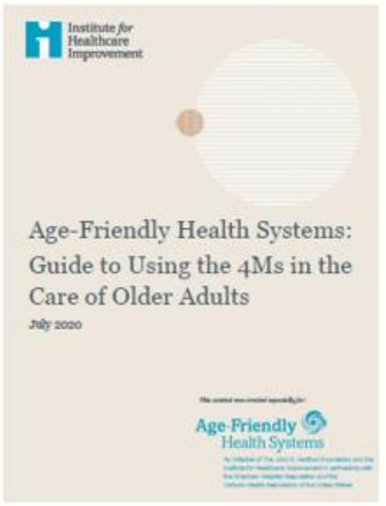
December 2021 & January 2022 FHC administered *Dementia Survey* to ascertain hospital readiness.

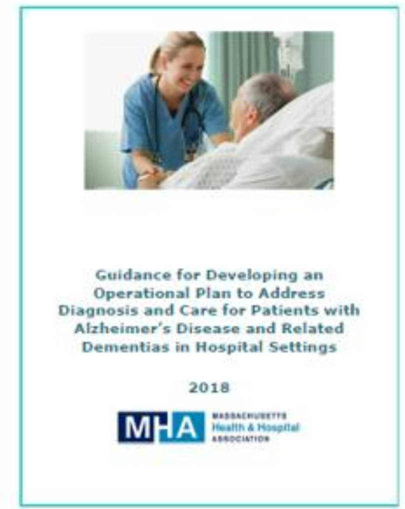
February 2022 survey results published, and areas of need identified.

May- December 2022 Learning Community met monthly to address each requirement and to create best practice gap analysis.

All NH hospitals prepared with plans for January 1, 2023!

Where to start





Crucial elements of success

- Hospitals already had many pieces of the required elements in place and were willing to share.
- Resources/toolkits can be overwhelming: group made recommendations for screening & assessment tools, education & training programs, etc.
- Involvement of the Alzheimer's Association throughout the process was key.

'Aha' moment

Understanding the impact of delirium on long-term health:

- 1/3 of patients over 65 who experience delirium never clear
  - Cascading effect on health
  - Risk of death over the next year doubles

- Vanderbilt University over 800 ICU patients enrolled
- Repeatable Battery for the Assessment of Neuropsychological Status
- During a 12 month follow up:
  - 1/3 of patients of all age groups had scores comparable to a traumatic brain injury
  - 1/4 of patients had scores similar to Alzheimer's disease

Diwell, R.A., **BMC Geriatrics**, (2018); Pandharipande, P.P., **The New England Journal of Medicine**, (2013).

Example: Development of a dementia-friendly environment

Best Practice	Delirium	Dementia	TBI
Shades Up/Lights On	x	x	
Correct Vision and Hearing	x	x	x
Face and Mouth care BID	x	x	x
Ambulate as tolerated	x	x	x
Attentive Activites	x	x	Yes, if recommended by provider and OT team.
Toileting Schedule	x	x	x
Minimize Tubes and Lines	x	x	x
Avoid/Minimize Restraints	x	x	x
De-escalation Techniques PRN	x	x	x
Create a Familiar Environment	x	x	x
Safe Sleep Practices	x	x	x
Thorough Workup of All Underlying Causes	x Yes, there should be an urgent, thorough workup of all underlying causes in this patient population.	x Yes, if there is sudden, new, or agitated behavior. If so, assume delirium and perform an urgent workup.	x Yes, if there is sudden, new, or agitated behavior. If so, there should be a thorough workup of agitation to ensure there are not cofounding factors.
Treat Underlying Pain	x	x	x
Re-orient as needed	x Yes, with a caveat: Not advised in agitated delirium. Do not argue. Instead, if a patient is agitated, provide a neutral statement and use distraction techniques and movement as part of the de-escalation process.	x Yes, with a caveat: Not advised in dementia with agitation. Do not argue. Instead, if a patient is agitated, meet them in their reality as part of the de-escalation process.	x Yes, with a caveat: Do not argue. Instead, if a patient is agitated, provide a neutral statement and use distraction techniques and movement as part of the de-escalation process.
Speak calmly, slowly, clearly, directly	x	x	x
Explain what you are going to do before you do it	x	x	x
Avoid sudden grabbing or touching of patient	x	x	x
Do not crowd patient	x	x	x
Formally end the interaction as patient may not be aware of normal social cues	x	x	x
Allow amble time to process information and formulate responses	x	x	x
Provide choices instead of commands	x	x	x
Break down difficult tasks into small steps	x	x	x
Positive reinforcement	x	x	x
Consistent Schedule		x	x
Consistent Staff			x
Consider limiting visitors to one at at time as behaviour warrants	x	x	x

Gap Analysis for Acute and Chronic Cognitive Impairment

The following checklist assesses a hospital's ability to manage care for patients with diagnosed or suspected delirium or dementia, in accordance with New Hampshire Laws of 2019, Chapter 194.

Evidence Based Best Practice	Implementation Status			Action Plan/Next Steps
	FULL	PARTIAL	NONE	
ORGANIZATIONAL BEST PRACTICES				
Hospital has a leader or leadership team that supports best practices for delirium and dementia management.				
Hospital develops and tracks process and outcome measures for patients with cognitive impairment, e.g., delirium assessment, nutrition, ambulation, readmission, etc.				
Hospital routinely provides departments and physicians with education on management of acute and/or chronic cognitive impairment in the acute care setting.				
PATIENT ASSESSMENT				
Standardized assessments are utilized in inpatient units to assess and identify delirium at least every 12 hours				
Identify patients with diagnosed cognitive impairment				
A full patient history and assessment of current medications (prescription and over the counter) is completed, including history from the Care Partner, EMS, and/or other care facility (acute, rehab or long term)				
PATIENT MANAGEMENT (IHI 4Ms Age-Friendly Guidelines)				
Align goals of care with the patient's wishes.				
The Care Partner is engaged throughout the hospital stay.				
Avoid use of physical and pharmacologic restraints.				
Ensure access to personal adaptive equipment (eyeglasses, hearing aids)				
Ensure sufficient oral hydration.				
Prevent sleep interruptions				
Use non-pharmacologic methods to facilitate sleep				
Orient to time, person, and place.				
Ensure early and frequent mobility.				
PROTOCOLS				
The hospital develops, implements, and reviews protocols that support patients with acute and chronic cognitive impairment				
Consult with EMS on arrival at hospital for background.				
Pain assessment (consider use of PAIN AD or similar tool) for pain management protocol.				
Include Advanced Directives, Health Care Proxy, POLST				
CARE TEAM EDUCATION				
The hospital strongly supports ongoing education on acute and chronic cognitive impairment for all clinical and non-clinical patient-facing staff.				
INTRA-HOSPITAL TRANSFERS				
Transfers for people with cognitive impairment are prioritized (e.g., ED to floor; floor to procedure/testing; etc.)				
Provide orientation of new care setting to patient and care partner				
Include Care Partner in ongoing care decisions				
DISCHARGE PLANNING				
Include Care Partner/Guardian/Legal Representative in discharge planning decisions				
Ensure that patients suspected of having undiagnosed chronic cognitive impairment are referred to a specialty practice for diagnosis.				
Ensure that patients who experienced delirium during stay are referred to Primary Care				
Patients with suspected chronic cognitive impairment and/or their Care Partners are provided with community resources (e.g., the Alzheimer's Association Helpline, Area Agency on Aging, local Senior Center, etc.).				

What's working well

- Electronic health records support standardization- Assessments, Screenings, Order Sets, Care Plans, Notifications, Referrals
- Interdisciplinary care team approach
- Increased education and training is increasing earlier recognition of dementia/delirium
- Ongoing support and learning opportunities for hospitals

Challenges

- Passage of legislation isn't a light switch- full implementation takes time.
- Implementation takes resources in an environment of many competing priorities.
- Finding 'champions' can be difficult- especially in CAHs where staff wear many hats. Lack of geriatricians.
- Staffing shortages and turn-over increase education & training burden.
- Lack of family/ caregiver support.