

## Editorial

# Alzheimer's Association Dementia Care Practice Recommendations

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## Background and Introduction

Alzheimer's disease is a degenerative brain disease and the most common cause of dementia. Dementia is a syndrome—a group of symptoms—that has a number of causes. The characteristic symptoms include difficulties with memory, language, problem solving, and other cognitive skills that affect a person's ability to perform everyday activities (Alzheimer's Association, 2017).

According to the *Alzheimer's Association 2017 Alzheimer's Disease Facts and Figures*, an estimated 5.5 million Americans are living with Alzheimer's dementia. One in 10 people aged 65 years and older (10%) has Alzheimer's dementia, and almost two-thirds of Americans with Alzheimer's are women. In addition to gender differences, Alzheimer's dementia affects racial and ethnic groups disproportionately. Compared to older white adults, African Americans are about twice as likely to have Alzheimer's or other dementias, and Hispanics are approximately 1.5 times as likely (Alzheimer's Association, 2017).

Almost 60% of older adults with Alzheimer's or other dementias reside in the community, only 25% of who live alone. As their disease progresses, people with Alzheimer's or other dementias generally receive more care from family members, unpaid caregivers, and community-based and residential care providers. Forty-two percent of residents in assisted living communities have Alzheimer's or other dementias (Caffrey et al., 2012; Zimmerman, Sloane, & Reed, 2014), and 61% of nursing home residents have moderate or severe cognitive impairment (Centers for Medicare and Medicaid Services, 2016). Further, by age 80, 75% of people with Alzheimer's dementia are admitted to a nursing

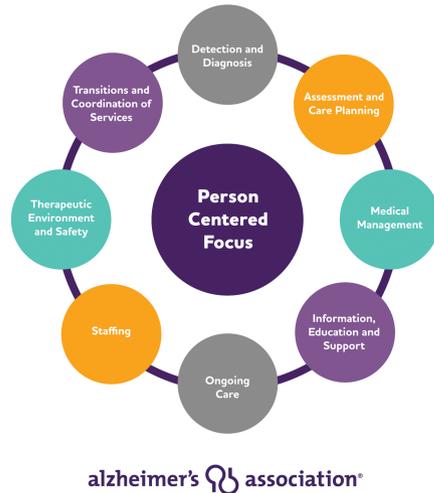
home, compared with only 4% of the general population (Arrighi, Neumann, Lieberburg, & Townsend, 2010).

Since its inception, the Alzheimer's Association has been a leader in outlining principles and practices of quality care for individuals living with dementia. Early on, the *Guidelines for Dignity* described goals for quality care, followed by *Key Elements of Dementia Care* and the *Dementia Care Practice Recommendations*, as more evidence became available. In this new iteration, the *Alzheimer's Association Dementia Care Practice Recommendations* outline recommendations for quality care practices based on a comprehensive review of current evidence, best practice, and expert opinion. The Dementia Care Practice Recommendations were developed to better define quality care across all care settings, and throughout the disease course. They are intended for professional care providers who work with individuals living with dementia and their families in residential and community-based care settings.

With the fundamentals of person-centered care as the foundation, the Dementia Care Practice Recommendations (see Figure 1) illustrate the goals of quality dementia care in the following areas:

- Person-centered care
- Detection and diagnosis
- Assessment and care planning
- Medical management
- Information, education, and support
- Ongoing care for behavioral and psychological symptoms of dementia, and support for activities of daily living
- Staffing
- Supportive and therapeutic environments
- Transitions and coordination of services

## 2018 DEMENTIA CARE PRACTICE RECOMMENDATIONS



**Figure 1.** Dementia Care Practice Recommendations.

This article highlights the recommendations from all 10 articles in the Supplement Issue of *The Gerontologist* entitled, *Alzheimer's Association Dementia Care Practice Recommendations*. Each article provides more detail about the specific recommendations, as well as the evidence and expert opinion supporting them. This supplement includes two areas that generally are not included in recommendations for providers in community and residential care settings, although these topics are frequently included in recommendations for physicians and other medical care providers—detection and diagnosis and ongoing medical management. Different from existing recommendations on these two topics, the articles are written for nonphysician care providers and address what these providers can do to help with these important aspects of holistic, person-centered dementia care. Throughout all of the articles, Alzheimer's disease and dementia are used interchangeably. Care partner is used to refer to those people supporting individuals in the early stages of dementia, and caregivers is used to refer to those supporting individuals in the middle and late stages; care provider is used for paid professionals. Lastly, the closing article by [Thornhill and Conant \(2018\)](#) outlines the interplay of policy and practice rounds out the supplement.

The Alzheimer's Association is hopeful that these Recommendations will greatly inform and substantially influence dementia care standards, training, practice, and policy.

### Practice Recommendations for Person-Centered Care ([Fazio, Pace, Flinner, & Kallmyer, 2018](#))

#### 1. *Know the person living with dementia*

The individual living with dementia is more than a diagnosis. It is important to know the unique and complete person, including his/her values, beliefs, interests,

abilities, likes, and dislikes—both past and present. This information should inform every interaction and experience.

#### 2. *Recognize and accept the person's reality*

It is important to see the world from the perspective of the individual living with dementia. Doing so recognizes behavior as a form of communication, thereby promoting effective and empathetic communication that validates feelings and connects with the individual in his/her reality.

#### 3. *Identify and support ongoing opportunities for meaningful engagement*

Every experience and interaction can be seen as an opportunity for engagement. Engagement should be meaningful to, and purposeful for, the individual living with dementia. It should support interests and preferences, allow for choice and success, and recognize that even when the dementia is most severe, the person can experience joy, comfort, and meaning in life.

#### 4. *Build and nurture authentic, caring relationships*

Persons living with dementia should be part of relationships that treat them with dignity and respect, and where their individuality is always supported. This type of caring relationship is about being present and concentrating on the interaction, rather than the task. It is about “doing with” rather than “doing for” as part of a supportive and mutually beneficial relationship.

#### 5. *Create and maintain a supportive community for individuals, families, and staff*

A supportive community allows for comfort and creates opportunities for success. It is a community that values each person and respects individual differences, celebrates accomplishments and occasions, and provides access to and opportunities for autonomy, engagement, and shared experiences.

#### 6. *Evaluate care practices regularly and make appropriate changes*

Several tools are available to assess person-centered care practices for people living with dementia. It is important to regularly evaluate practices and models, share findings, and make changes to interactions, programs, and practices as needed.

### Practice Recommendations for Detection and Diagnosis ([Maslow & Fortinsky, 2018](#))

#### 1. *Make information about brain health and cognitive aging readily available to older adults and their families*

Within their scope of practice and training, nonphysician care providers who work with older adults and their families in community or residential care settings should either talk with them or refer them to other experts for information about brain health, changes in cognition that commonly occur in aging, and the importance of lifestyle behaviors and other approaches

to maintain brain health. They should suggest print and online sources of additional information as appropriate.

2. *Know the signs and symptoms of cognitive impairment, that signs and symptoms do not constitute a diagnosis of dementia, and that a diagnostic evaluation is essential for diagnosis of dementia*

All nonphysician care providers who work with older adults in community or residential care settings should be trained to recognize the signs and symptoms of cognitive impairment. They should be trained that signs and symptoms are not sufficient for a diagnosis of dementia and that a diagnostic evaluation must be conducted by a physician who can make the diagnosis.

3. *Listen for concerns about cognition, observe for signs and symptoms of cognitive impairment, and note changes in cognition that occur abruptly or slowly over time*

Depending on their scope of practice, training, and agency procedures, if any, nonphysician care providers who work with older adults in community or residential care settings should listen for older adults' concerns about dementia and observe for signs and symptoms of cognitive impairment and changes in cognition. As appropriate and in accordance with agency procedures and respect for individuals' privacy, nonphysician care providers should communicate with coworkers about observed signs and symptoms, changes in cognition, and concerns of older adults and family members about the older adult's cognition. Depending on their scope of practice and training, they should encourage the older adult and family to talk with the individual's physician about the signs and symptoms, changes in cognition, and older adult and family concerns.

4. *Develop and maintain routine procedures for detection of cognition and referral for diagnostic evaluation*

Administrators of organizations that provide services for older adults in community or residential care settings and self-employed care providers should develop and maintain routine procedures for assessment of cognition. They should, at a minimum, maintain an up-to-date list of local memory assessment centers and physicians, including neurologists, geriatricians, and geriatric psychiatrists, who can provide a diagnostic evaluation for older adults who do not have a primary care physician or have a primary care physician who does not provide such evaluations. Ideally, nonphysician care providers and organizations that work with older adults should partner with physicians, health plans, and health care systems to establish effective referral procedures to ensure that older adults with signs and symptoms of cognitive impairment can readily receive a diagnostic evaluation.

5. *Use a brief mental status test to detect cognitive impairment only if:*
  - such testing is within the scope of practice of the nonphysician care provider, and

- the nonphysician care provider has been trained to use the test; and
- required consent procedures are known and used; and
- there is an established procedure for offering a referral for individuals who score below a preset score on the test to a physician for a diagnostic evaluation.

6. *Encourage older adults whose physician has recommended a diagnostic evaluation to follow through on the recommendation*

Within their scope of practice, training, and agency procedures, if any, nonphysician care providers who work with older adults in community or residential care settings and are aware that an older adult's physician has recommended a diagnostic evaluation should encourage the older adult and family, if appropriate, to follow through on the recommendation. They should talk with the older adult and family about the reasons for and importance of getting a diagnostic evaluation and provide print and online sources of additional information.

7. *Support better understanding of a dementia diagnosis*

Within their scope of practice, training, and agency procedures, if any, nonphysician care providers who work with older adults in community or residential care settings and are aware that the older adult has received a dementia diagnosis but does not understand the diagnosis (or the older adult's family does not understand the diagnosis) should encourage the older adult and family to talk with the diagnosing physician. The care provider should also offer print and online sources of additional information as appropriate.

### Practice Recommendations for Person-Centered Assessment and Care Planning (Molony, Kolanowski, Van Haitsma, & Rooney, 2018)

1. *Perform regular, comprehensive person-centered assessments and timely interim assessments*

Assessments, conducted at least every 6 months, should prioritize issues that help the person with dementia to live fully. These include assessments of the individual and care partner's relationships and subjective experience and assessment of cognition, behavior, and function, using reliable and valid tools. Assessment is ongoing and dynamic, combining nomothetic (norm-based) and idiographic (individualized) approaches.

2. *Use assessment as an opportunity for information gathering, relationship-building, education, and support*

Assessment provides an opportunity to promote mutual understanding of dementia and the specific situation of the individual and care partners, and to enhance the quality of the therapeutic partnership. Assessment should reduce fear and stigma and result in referrals to community resources for education, information and

support. Assessment includes an intentional preassessment phase to prepare the assessor to enter the experience of the person living with dementia and their care partner(s).

3. *Approach assessment and care planning with a collaborative, team approach*

Multidisciplinary assessment and care planning are needed to address the whole-person impact of dementia. The person living with dementia, care partners, and caregivers are integral members of the care planning team. A coordinator should be identified to integrate, document and share relevant information and to avoid redundancy and conflicting advice from multiple providers.

4. *Use documentation and communication systems to facilitate the delivery of person-centered information between all care providers*

Comprehensive, high-quality assessment is of benefit only if it is documented and shared with care providers for use in planning and evaluating care. Information must be current, accessible, and utilized.

5. *Encourage advance planning to optimize physical, psychosocial, and fiscal wellbeing and to increase awareness of all care options, including palliative care and hospice*

Early and ongoing discussion of what matters, including values, quality of life and goals for care, are essential for person-centered care. The person living with dementia's preferences and wishes should be honored in all phases of the disease, even when proxy decision making is required. The individual and family should be referred to health care team members to provide ongoing education and support about symptom management and palliative care.

### Practice Recommendations for Medical Management (Austrom, Boustani, & LaMantia, 2018)

1. *Take a holistic, person-centered approach to care and embrace a positive approach to the support for persons living with dementia and their caregivers that acknowledges the importance of individuals' ongoing medical care to their well-being and quality of life*

Nonphysician care providers must adopt a holistic approach to providing care and ongoing support to the person living with dementia and their family caregivers. They should work to reduce existing barriers to coordination of medical and nonmedical care and support. Adopting a positive approach towards care can reduce real or perceived messages of hopelessness and helplessness and replace these with positive messages and an approach that encourages persons living with dementia and their caregivers to seek support and care over the course of the disease.

2. *Seek to understand the role of medical providers in the care of persons living with dementia and the contributions that they make to care*

Nonmedical care providers and family caregivers should work with medical providers towards developing a shared vision of care to support the person living with dementia.

3. *Know about common comorbidities of aging and dementia and encourage persons living with dementia and their families to talk with the person's physician about how to manage comorbidities at home or in residential care settings*

Common comorbidities can negatively impact a person living with dementia, and conversely, a diagnosis of dementia can make the treatment and management of comorbid conditions quite challenging. Nonmedical care providers should encourage persons living with dementia and their families to report acute changes in health and function to the person's physician, and to let the physician know about difficulties they encounter in managing acute and chronic comorbidities at home or in a residential care facility.

4. *Encourage persons living with dementia and their families to use nonpharmacologic interventions for common behavioral and psychological symptoms of dementia first*

Increasing evidence suggests nonpharmacological interventions are effective at managing behavioral and psychological symptoms of dementia. Community care providers should encourage persons with dementia and their families to try these interventions first before considering pharmacological treatments.

5. *Understand and support the use of pharmacological interventions when they are necessary for the person's safety, well-being, and quality of life*

Although nonpharmacological interventions are preferred, there are times when pharmacological treatment is warranted for behavioral and psychological symptoms. It is important for community care providers to understand that pharmacological treatment can have value for the person living with dementia in certain situations and to help them and their family caregiver to accept such treatment. Community care providers should also understand the general principles for starting and more importantly, ending pharmacological treatments and encourage the person living with dementia and family caregivers to ask their medical providers for regular medication reviews and to consider the discontinuation of medications when appropriate.

6. *Work with the person living with dementia, the family, and the person's physician to create and implement a person-centered plan for possible medical and social crises*

It is helpful for persons living with dementia and their caregivers to have a plan in place should a medical or

social crisis occur, such as an illness, hospitalization or the death of a caregiver. Having a plan in place will help the person's physician and community care providers provide care and support that reflects the preferences of the person living with dementia and reduce stress for family members and care providers who have to make decisions for the person during a crisis.

7. *Encourage persons living with dementia and their families to start end-of-life care discussions early*

Persons living with dementia and their caregivers should understand options available for care during the later stages of Alzheimer's disease. Having discussions early with the person's physician and other care providers and communicating the preferences of the person and family across care settings can make the transitions during the progression of dementia more manageable.

### Practice Recommendations for Information, Education, and Support for Individuals Living with Dementia and their Caregivers (Whitlatch & Orsulic-Jeras, 2018)

1. *Provide education and support early in the disease to prepare for the future*

Intervening during the early stages creates opportunities to identify, meet, and, in turn, honor the changing and future care needs and preferences of individuals living with dementia and their family caregivers. Discussing the individual's care values and preferences early in the disease can aid in planning during the moderate and advanced stages, as well as at end of life. Early intervention gives individuals living with dementia a voice in how they are cared for in the future, while giving their caregivers piece of mind when making crucial care-related decisions.

2. *Encourage care partners to work together and plan together*

In recent years, interventions have been developed that bring together individuals living with dementia and their family caregivers, rather than working with each person separately. This person-centered approach supports, preserves, and validates the individual living with dementia's care values and preferences while acknowledging the concerns, stressors, and needs of the caregiver. By discussing important care-related issues earlier on, the individual with dementia's desires and wishes for their own care will remain an important part of their caregiver's decision-making process as the care situation changes.

3. *Build culturally sensitive programs that are easily adaptable to special populations*

It is very important to design effective evidence-based programming that is sensitive to the unique circumstances of families living with dementia, such as minority, LGBT, and socially disadvantaged populations. However, many minority or socially disadvantaged families living

with dementia do not seek out or accept support from nonfamilial sources. Highlighting multicultural issues when training professionals and providing guidance for reaching out to these special populations will lead to more effective programs that embrace the unique needs of all care partners.

4. *Ensure education, information, and support programs are accessible during times of transition*

There are many transitional points throughout the disease trajectory that have variable effects on both care partners. For example, transitioning from early to middle to late stage often introduces new symptoms and behaviors that, in turn, increase care partners' questions and concerns about what to expect in the future. Progression through the various stages of dementia also brings about other types of transitions, such as changes in living arrangements or care providers (i.e., from in-home to nursing home care). Providing education, information, and support that honor the individual with dementia's values and preferences during these transitions will be reassuring to caregivers as they make hard choices on behalf of the individual living with dementia.

5. *Use technology to reach more families in need of education, information, and support*

Supportive interventions and programs that use technology (such as Skype, Facetime, etc.) to reach those in need of services are expectedly on the rise. As technology continues to advance and become more accessible and reliable, delivering programs using electronic devices (computer, tablet, smart phone) could help reach more families. These programs would be especially useful in rural communities where caregivers and individuals living with dementia are often isolated with little access to supportive services.

### Practice Recommendations for Care of Behavioral and Psychological Symptoms of Dementia (BPSD) (Scales, Zimmerman, & Miller, 2018)

1. *Identify characteristics of the social and physical environment that trigger or exacerbate behavioral and psychological symptoms for the person living with dementia*

Behavioral and psychological symptoms of dementia (BPSDs) result from changes in the brain in relation to characteristics of the social and physical environment; this interplay elicits a response that conveys a reaction, stress, or an unmet need, and affects the quality of life of the person living with dementia. The environmental triggers of BPSDs and responses to them differ for each person, meaning that assessment must be individualized and person-centered.

2. *Implement nonpharmacological practices that are person-centered, evidence-based, and feasible in the care setting*

Antipsychotic and other psychotropic medications are generally not indicated to alleviate BPSDs, and so nonpharmacological practices should be the first-line approach. Practices that have been developed in residential settings and which may also have applicability in community settings include sensory practices, psychosocial practices, and structured care protocols.

3. *Recognize that the investment required to implement nonpharmacological practices differs across care settings*

Different practices require a different amount of investment in terms of training and implementation, specialized caregiver requirements, and equipment and capital resources. Depending on the investment required, some practices developed in residential settings may be feasible for implementation by caregivers in home-based settings.

4. *Adhere to protocols of administration to ensure that practices are used when and as needed, and sustained in ongoing care*

Protocols of administration assure that there is a “guideline” for care providers as they strive to alleviate BPSDs. These protocols may evolve over time, responsive to the particular components of the practice that are most effective for the person living with dementia.

5. *Develop systems for evaluating effectiveness of practices and make changes as needed*

The capacity and needs of persons living with dementia evolve over time, and so practices to alleviate BPSDs also may need to evolve over time. Therefore, it is necessary to routinely assess the effectiveness of the practice and, if necessary, adapt it or implement other evidence-based practices.

### Practice Recommendations for Support of Activities of Daily Living (ADLs) (Prizer & Zimmerman, 2018)

1. *Support for ADL function must recognize the activity, the individual's functional ability to perform the activity, and the extent of cognitive impairment*

Dementia is a progressive disease, accompanied by progressive loss in the ability to independently conduct ADLs. Needs for supportive care increase over time—such as beginning with support needed for dressing, and later toileting, and later eating—and must address both cognitive and functional decline as well as remaining abilities.

2. *Follow person-centered care practices when providing support for all ADL needs*

Not only are dignity, respect, and choice a common theme across all ADL care, but the manner in which support is provided for functionally-specific ADLs must attend to the individualized abilities, likes, and dislikes of the person living with dementia.

3. *When providing support for dressing, attend to dignity, respect, and choice; the dressing process; and the dressing environment*

In general, people living with dementia are more able to dress themselves independently if, for example, they are provided selective choice and simple verbal instructions, and if they dress in comfortable, safe areas.

4. *When providing support for toileting, attend to dignity and respect; the toileting process; the toileting environment; and health and biological considerations*

In general, people living with dementia are more able to be continent if, for example, they are monitored for signs of leakage or incontinence, have regularly scheduled bathroom visits and access to a bathroom that is clearly evident as such, and avoid caffeine and fluids in the evening.

5. *When providing support for eating, attend to dignity, respect and choice; the dining process; the dining environment; health and biological considerations; adaptations and functioning; and food, beverage and appetite*

In general, people living with dementia are more likely to eat if, for example, they are offered choice, dine with others and in a quiet, relaxing, and homelike atmosphere, maintain oral health, are provided adaptive food and utensils, and offered nutritionally and culturally appropriate foods.

### Practice Recommendations for Staffing (Gilster, Boltz, & Dalessandro, 2018)

1. *Provide a thorough orientation and training program for new staff, as well as ongoing training*

A comprehensive orientation should be provided that includes the organization's vision, mission and values, high performance expectations, and person-centered dementia training. This training is essential for new staff, and should be included in ongoing education for all staff members.

2. *Develop systems for collecting and disseminating person-centered information*

It is important that all staff know the person living with dementia as an individual. Establish procedures for collecting person-centered information that includes choices, preferences, and life history. It is also essential that an effective process be developed to share this information with all staff.

3. *Encourage communication, teamwork, and interdepartmental/interdisciplinary collaboration*

An organization should promote staff participation and interdepartmental/ interdisciplinary collaboration through routinely scheduled inservice programs and meetings. Training is most effective when designed to include ongoing education, communication and support. Offering inservices and conducting meetings on

all shifts is important, and will impact attendance, participation and facilitate relationships between staff.

4. *Establish an involved, caring and supportive leadership team*

Creating a person-centered “community” is not possible without service-oriented leaders, managers and supervisors. It is also vital that the leadership team be vision-driven, open, and flexible. High performing leaders know that staff are the foundation of success, and when staff are valued, recognized, and feel served themselves, they in turn will more likely value and serve others.

5. *Promote and encourage resident, staff, and family relationships*

Encouraging relationships among persons living with dementia, staff and families is central to person-centered care, and is fostered in part by implementing consistent staff assignment. The involvement of all parties in planning care, activities, education, and social events may cultivate successful relationships as well.

6. *Evaluate systems and progress routinely for continuous improvement*

It is important that an organization routinely collect and evaluate information on all staff processes, including hiring, orientation, training and satisfaction. Analysis of the data should be used to evaluate the effectiveness of all systems and identify areas for improvement. In addition, leaders should share this information with staff, and act upon the results.

### Practice Recommendations for Supportive and Therapeutic Environments (Calkins, 2018)

1. *Create a sense of community within the care environment*

The care community includes the person receiving care, their family and other chosen care partners, and professional care providers. The environment should support building relationships with others as a result of sharing common attitudes, interests, and the goals of the individuals living with dementia, their caregivers, and other care providers.

2. *Enhance comfort and dignity for everyone in the care community*

It is important that members of the care community are able to live and work in a state of physical and mental comfort free from pain or restraint. Environments are designed to maintain continuity of self and identity through familiar spaces that support orientation to place, time, and activity.

3. *Support courtesies, concern, and safety within the care community*

Members of the care community should show politeness and respect in their attitudes and behavior toward each other. Doing so includes creating a supportive

environment that does not put unnecessary restrictions on individuals and helps them feel comfortable and secure, while also ensuring their safety. The environment compensates for physical and cognitive changes by maximizing remaining abilities and supporting caregiving activities.

4. *Provide opportunities for choice for all persons in the care community*

The culture of the care community supports a range of opportunities for all persons to make decisions concerning their personal and professional lives, as well as their health and welfare. The environment can provide opportunities for self-expression and self-determination, reinforcing the individual’s continued right to make decisions for him/herself.

5. *Offer opportunities for meaningful engagement to members of the care community*

Relationships are built on knowing the person, which itself is based on doing things together. An environment that provides multiple, easily accessible opportunities to engage in activities with others supports deeper knowing and the development or maintenance of meaningful relationships.

### Practice Recommendations for Transitions in Care (Hirschman & Hodgson, 2018)

1. *Prepare and educate persons living with dementia and their family caregivers about common transitions in care*

Preparing and educating persons living with dementia and their care partners/caregivers about transitions in care should occur before, during and after transitions. Because family caregivers are integral to the care of individuals living with dementia, it is important to understand their need for information about common transitions, including across care settings, such as home to hospital or skilled nursing facility, nursing home to emergency department; within care settings, such as from an emergency department to an intensive care unit; or from one team of clinicians or care providers to another. For example, tools are publically available from the Alzheimer’s Disease Education and Referral Center (ADEAR) and the Alzheimer’s Association that can be provided to persons living with dementia and their caregivers to help them prepare for the possibilities of hospitalization and transition to long-term care settings such as nursing homes or assisted living.

2. *Ensure complete and timely communication of information between, across and within settings*

Individuals living with dementia are frequently transferred across facilities without essential clinical information. Careful attention is essential to ensure a safe “handoff.” Finding timely and standardized ways to share medical records and advance care planning forms

between patients, caregivers and providers throughout transitions is needed. Linking electronic health records across care settings also offers this potential. Open communication between providers, across settings, and within organizations or clinical practices is essential (both written and verbal). Assisting persons living with dementia and their caregivers in accessing and sharing information in a person- and family-centered way can help to avoid poor outcomes often associated with transitions in care (e.g., rehospitalizations, emergency department visits, medication errors, and caregiver stress). Information must be clinically meaningful, appropriate in amount; it should be communicated by a method useful to the receiving site of care. Achieving these objectives by using standardized forms or standardized approaches to communicate hand-offs can increase the accuracy of information and minimize risk of error.

3. *Evaluate the preferences and goals of the person living with dementia along the continuum of transitions in care*

Revisiting preferences and goals for care, including treatment preferences, advance directives, and social and living situation, while the person living with dementia can participate is essential during transitions in care. If a person living with dementia is unable to participate, including caregivers or others who know the person well is vital. After any hospitalization or other significant change requiring a transition in care or level of care, a review and reassessment of the preferences and goals of the person living with dementia should include an assessment of safety, health needs, and caregiver's ability to manage the needs of the person living with dementia. This requires improved competencies of the entire interprofessional team in conducting goals of care conversation, and more effective processes to ensure appropriate assessments are performed before the decision to move a person with dementia to another setting of care is made.

4. *Create strong interprofessional collaborative team environments to assist persons living with dementia and their care partners/caregivers as they make transitions*

Creation of a strong interprofessional collaborative team environment to support the person living with dementia throughout transitions in care is crucial. Each member of the team needs to have a basic set of competencies in the fundamentals of caring for individuals living with dementia at all stages and their family caregivers. All of the evidence-based interventions described here were specifically designed to address the challenges for individuals living with dementia and other complex chronic conditions as well as the needs of their family caregivers. For example, in the MIND study case, managers were trained in dementia care management over a 4-week period of time, in another study, [Naylor and colleagues \(2014\)](#) developed a set

of web-based education modules designed specifically on how to manage the care needs of older adults living with dementia and their family caregiver as they transition from the hospital to home. Furthermore, this type of work requires continuity of the same clinicians (whenever possible) to support the person living with dementia and their family as they move between providers and across setting. Every member of the health care team must be accountable and responsive to ensure the timely and appropriate transfer of responsibility to the next level or setting of care. Optimally clinicians from the sending site of care should maintain responsibility for individuals with dementia until the caregivers at the receiving site assume clinical responsibility.

5. *Initiate/Use evidence-based models to avoid, delay, or plan transitions in care*

The seven evidence-based models of care in this review focused on avoiding unnecessary transitions (such as hospitalization, or emergency department visits), delaying or supporting placement in residential care settings (such as nursing homes or assisted living communities). Although many evidence-based models have excluded or limited the inclusion of persons living with dementia, adaptations of these models should be considered whenever possible to improve transitions. Among the interventions that targeted hospitalizations and emergency department visits, it is important to note that these events are often tied to nondementia-related conditions. Furthermore, targeting avoidable hospitalizations or rehospitalization for persons living with dementia has the potential to interrupt poor outcomes more common with this population such as risk of delirium and falls. As evidence-based models of care are adapted and modified to meet the needs of persons living with dementia transitioning between, across and within settings of care it is critical to share the findings from these adapted transitions in care models.

## About the Alzheimer's Association

The Alzheimer's Association is the leading voluntary health organization in Alzheimer's care, support, and research. Founded in 1980 by a group of family caregivers and individuals interested in research, the Association includes a home office in Chicago, a public policy office in Washington, D.C., and a presence in communities across the country.

Currently, an estimated 47 million people worldwide are living with dementia. In the United States alone, more than 5 million have Alzheimer's, and over 15 million are serving as their caregivers. The Alzheimer's Association addresses this global epidemic by providing education and support to the millions who face dementia every day, while advancing critical research toward methods of treatment, prevention and, ultimately, a cure.

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