

Improving Dementia-Specific Referrals From the Acute Care Setting

A Quality Improvement Project

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ABSTRACT

Purpose of Study: The purpose of this quality improvement project was to design and implement an education and referral protocol for care coordination staff to use when working with hospitalized patients with dementia and their families. The goal was to increase delivery of dementia resource education and dementia-specific referrals during the discharge planning process.

Primary Practice Setting: The practice setting for this project was an acute care hospital in Northern California. The care coordination department collaborated with the Northern California Chapter of the Alzheimer's Association to improve the delivery of referrals and follow-up with patients and families who were interested in additional information and support related to dementia.

Methodology and Sample: Twenty-one members of the care coordination department received education on the dementia disease process as well as community resources available to the patient population. The registered nurse care coordinators (RNCCs) and social workers (SWs) within the department then implemented a referral protocol to connect patients with dementia and their families to the Alzheimer's Association. Referral volume was captured over a 60-day preimplementation period, a 60-day implementation period, and a 60-day postimplementation period. The Northern California Chapter of the Alzheimer's Association tracked referral volume. A paired-sample *t* test was used to examine pre/postimplementation Dementia Knowledge Assessment Scale (DKAS) scores to evaluate the impact of the education intervention. Care coordination staff completed a pre/postimplementation survey on knowledge of community resources for dementia and confidence in connecting patients to these resources. They also completed a postimplementation survey about the benefit of the project to their care coordination practice.

Results: There was a modest, yet positive increase in referral volume over the 60-day implementation period ($n = 6$) compared with the preimplementation period ($n = 1$). An increase was sustained during the 60-day postimplementation period ($n = 4$). Pre/postimplementation DKAS scores significantly improved for care coordination staff postimplementation ($p < .001$) by an average of 7 points. Fifty-three percent of RNCC and SW staff responded to the postimplementation survey, and results indicated they thought the project was beneficial ($n = 8$) or somewhat beneficial ($n = 1$) to practice. In addition, RNCC and SW staff reported an increase in awareness of available community resources and confidence in connecting patients and families to these resources.

Implications for Case Management Practice: Case management professionals have an important role in providing education and support to patients and families across the continuum of care. The complexity and trajectory of illness, shortage of qualified providers, and gaps in provider knowledge about resources place patients with dementia and their families in an increasingly vulnerable position within the health care system. This quality improvement project demonstrates that care coordination staff can improve referrals to resources when in contact with patients and families in the acute care setting. Case managers can ensure patients with dementia and their families have access to the resources in the community that may prevent return to the emergency department or rehospitalization.

Key words: *care coordination, community resources, dementia, patient referrals, transitions of care*

“Dementia” is an umbrella term used to describe the syndrome of symptoms related to brain changes that impact an individual's ability to perform everyday activities. These symptoms commonly include problems with thinking, memory, and language and problem-solving. Although there are different causes of dementia, the most common cause is Alzheimer's disease, accounting for 60%–80% of cases (Alzheimer's Association, 2022). Alzheimer's disease is a degenerative and progressive disease that eventually impacts areas of the brain that interfere with basic bodily functions such as swallowing and walking,

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“Dementia” is an umbrella term used to describe the syndrome of symptoms related to brain changes that impact an individual’s ability to perform everyday activities. These symptoms commonly include problems with thinking, memory, and language and problem-solving. Although there are different causes of dementia, the most common cause is Alzheimer’s disease, accounting for 60%–80% of cases.

leading to death. Alzheimer’s disease is currently the seventh leading cause of death in the United States (Centers for Disease Control and Prevention, 2022). Global estimates indicate that dementia will increase from 57.4 million cases in 2019 to 152.8 million cases in 2050 (Nichols et al., 2022). As the number of individuals and families living with dementia increases, persistent challenges exist for this patient population related to an inadequate supply of qualified providers, limited dementia education and training in the health care workforce, and difficult navigation of available resources and support.

An inadequate number of specialty providers for the population with dementia leave primary care providers responsible for their diagnosis and plan of care. Drabo et al. (2019) reviewed dementia diagnosis and care data for a random sample of Medicare beneficiaries and found that 85% of the beneficiaries received their dementia diagnosis from a nondementia specialist. Furthermore, care provided by a dementia specialist was low within 1 year (22%) and within 5 years (36.2%) of diagnosis. Researchers’ estimates suggest that the number of specialty providers would need to triple by 2050 to fully support patients with Alzheimer’s disease and other dementias (Alzheimer’s Association, 2022).

Surveys conducted by the Alzheimer’s Association reveal that half of primary care physicians believe the medical profession is not prepared for the increase in patients and families living with dementia. More than half also report that there are not enough specialists to receive referrals (Alzheimer’s Association, 2022). In addition, most primary care physicians surveyed reported they received very little training in medical school on diagnosis and care of Alzheimer’s disease and other dementias.

There is limited education and training on best practices in dementia care available to the general health care professional workforce (National Institute on Aging, 2019). Furthermore, although valuable community resources exist to help support patients with dementia, these are challenging to navigate and not well

integrated into the health care system (Jennings et al., 2019). The U.S. National Plan to Address Alzheimer’s Disease (U.S. Department of Health and Human Services, 2020) recognizes a knowledge gap among health care providers related to resources and services available for this patient population. A specific ongoing strategy outlined in this plan includes increasing knowledge among providers on available long-term services and supports for patients with dementia and their families.

Family members experience significant caregiver burden when supporting a patient with dementia (Chiao et al., 2015). Caregiver burden contributes to chronic health problems, depression, social isolation, and financial struggles. Interventions targeting caregivers are important to help relieve the negative effects of caregiving and reduce or delay out-of-home placement for patients with dementia. These interventions include case management (information, referrals, planning, care coordination, advocacy), education, respite, day treatment, and support groups (Alzheimer’s Association, 2020).

To address the needs of family caregivers of patients with dementia, the UT Health San Antonio School of Nursing developed the Caring for the Caregiver program (White et al., 2018). In preparation, they assessed caregivers and community stakeholders. Participants expressed a need for increased awareness of the role of family caregivers. Caregivers may view caregiving as part of their normal family role. In addition, social norms may prevent them from discussing their needs. These factors may interfere with their ability to connect to agencies or services in the community. Participating caregivers also reported they did not know where to go for help. They were given limited information about resources in the community at diagnosis; health care providers may not have been aware of available resources. They also expressed frustration when they were provided late or random information about available services. Earlier and streamlined information was preferred. Finally, they found that a lack of understanding of

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the disease process and trajectory inhibited appropriate future planning for patients and families. White et al.'s (2018) findings demonstrate the importance of connecting dementia caregivers with support and resources that they may not otherwise be aware of, especially early in the disease process.

In 2014, individuals with dementia had twice as many hospital stays compared with those without dementia. Furthermore, use of health care services for other serious medical conditions was higher for those with dementia than those without dementia (Alzheimer's Association, 2020). Therefore, increasing opportunities exist within the acute care setting to connect patients with dementia and their families to resources. This may help alleviate the burden on primary care while also improving support to family caregivers of this patient population.

In 2022, we piloted a quality improvement project within a care coordination department of an acute care hospital in Northern California. The purpose was to develop and implement a structured process of referral for patients with dementia and their families to available community resources. The goal was to increase care coordination staff knowledge of dementia and dementia-specific resources and increase referrals to these resources.

CASE MANAGEMENT ROLE

Case management professionals are in a unique position to help assess patient and family needs and connect them to services across the health care continuum. The Commission for Case Manager Certification (2022) and the American Case Management Association established a unified definition of case management:

Case Management is a dynamic process that assesses, plans, implements, coordinates, monitors, and evaluates to improve outcomes, experiences, and value. The practice of case management is professional and collaborative, occurring in a variety of settings where medical care, mental health care, and social supports are delivered. Services are facilitated by diverse disciplines in conjunction with the care recipient and their support system. In pursuit of health equity, priorities include identifying needs, ensuring appropriate access to resources/services, addressing social determinants of health and facilitating safe care transitions. Professional case managers help navigate complex systems to achieve mutual goals, advocate for those they serve, and recognize personal dignity, autonomy, and the right to self-determination. (Paras 1–3)

This definition highlights the integral role case management professionals, such as nurses and social workers, have in ensuring access to and use of resources across the continuum. The overarching role of the case manager is a holistic approach to supporting and advocating for patients and families as they navigate transitions of care in the complex U.S. health care system (Powell & Tahan, 2019).

METHODS

Setting and Sample

The setting for this quality improvement project was a general acute care hospital with 106 licensed acute care beds and 25 emergency department beds in Sacramento County, CA. At the time of implementation, the care coordination department at the hospital included 12 registered nurse care coordinators (RNCCs), six social workers (SWs), as well as a social work manager and a department director. In addition, the department had two care coordination assistants who support the department and one substance abuse navigator who connects patients and families to resources for addiction treatment. The department is responsible for assessing and coordinating posthospitalization needs for patients and families throughout the hospital. Each day of the week, two to three SWs and three to four RNCCs provided care coordination to patients and families. The sample for this project included the RNCCs and SWs in the department. The target patient population was patients with dementia or concern for dementia and an involved family member. Prior to this quality improvement project, there was no formal process for incorporating dementia-specific referrals in the discharge planning process. The primary purpose of the project was to develop and test a referral protocol so that SWs and RNCCs increased dementia-specific referrals during care coordination for patients with dementia and their families.

Program Development and Approval Process

The Director of Care Coordination at the hospital provided local departmental approval for this project. Institutional approval was received through the health care system's Health Evidence-Based Approval Committee and approved as an evidence-based practice improvement project. In addition, the local chapter of the Alzheimer's Association agreed to support the project.

Alzheimer's Association Partnership

The Alzheimer's Association is a nonprofit organization with the mission of advancing research, advocacy, and support for those impacted by Alzheimer's disease and other dementias (Alzheimer's Association, n.d.). They offer education and support to patients, families, and clinicians. Referring a patient or family allows the members of the Alzheimer's Association to connect the family to resources related to respite, support groups, legal and financial information, adult day health centers, health care directives, caregiver education, information related to safety and wandering, and other resources. The Alzheimer's Association has educational resources available online, or via a 24/7 free helpline.

The local Northern California Chapter of the Alzheimer's Association has an existing referral form called the Alzheimer's Association Direct Connect form (B. Rea, personal communication, June 28, 2022). This form was developed 10 years ago with the intent of improving outreach to and referrals from physicians so that they could know how to connect patients and families to education, support, and resources. Outpatient physicians and providers primarily use this form; however, acute care hospitals and other providers can send a referral after obtaining consent from patients and families.

Guiding Framework

The Knowledge-to-Action (KTA) framework guided this project. The KTA framework consists of a knowledge creation/production component and an action or implementation component, the latter of which provided the structure and process for this project (Straus et al., 2013; White, 2016). Using this framework, a problem was identified, knowledge around this problem was adapted to the local context, barriers and facilitators to knowledge use were assessed, and interventions were selected, tailored, and implemented. Next, monitoring of knowledge use by the target population was observed and then evaluated. Finally, plans to sustain the knowledge were suggested. The KTA framework recognizes the important relationship between knowledge generation and knowledge implementation, and it allows for the two components to occur simultaneously (Straus et al., 2013). Adapting the intervention to the local context and identifying and addressing barriers and facilitators allow for individualization of the implementation to best suit the specific setting and situation. In addition, the cyclical nature of the KTA framework suggests the iterative process of translation of current evidence into practice.

Knowledge Assessment Tool

The Dementia Knowledge Assessment Scale (DKAS) is a valid and reliable tool that can be used to assess

dementia knowledge. It has been tested across populations including health professionals, students, caregivers, and the general public (Annear et al., 2017). This scale can be used to measure baseline knowledge of dementia as well as knowledge change as a result of a targeted intervention. An important and unique aspect of this tool is the inclusion of not only biomedical aspects of dementia but also biopsychosocial domains that include causes and characteristics, communication and engagement, care needs, risks, and health promotion (Annear et al., 2015). A confirmatory factor analysis supported a 25-item version of this tool. The 25-item DKAS can effectively assess dementia knowledge with a total score, subscale scores, and item-level analysis. Cronbach's alpha for the total score was 0.85 (Annear et al., 2017). The DKAS was used to measure changes in dementia knowledge pre/postimplementation.

Intervention Overview

Referral Process

Prior to implementation, the local chapter of the Alzheimer's Association was contacted to review the referral process and confirm accuracy of the referral form. In addition, the local representative agreed to provide pre- and postimplementation data on the total number of referrals received from the hospital. A step-by-step protocol was created to help guide the RNCCs and SWs in supporting patients with dementia and their family caregivers (see Figure 1). This protocol was posted in all care coordination RNCC and SW offices. The first step was to identify a patient with a diagnosis of Alzheimer's disease or other dementias or a patient or family member with concern about the patient's memory loss, confusion, or cognitive impairment. To make a referral, the patient needed to have an involved family member/caregiver. The second step was to provide the patient and the family member/caregiver with educational information from the Alzheimer's Association if they were interested and/or in need of additional support and resources. The Alzheimer's Association provided a caregiver packet of information and stage-appropriate packets of information based on the patient's needs. The third step was to provide the patient and/or the family member/caregiver with an overview of the Alzheimer's Association and get consent to send a referral to the Alzheimer's Association to follow up with them. The fourth step entailed filling out and faxing the Alzheimer's Association Direct Connect form to the local chapter of the Alzheimer's Association. The fifth step instructed the RNCC or SW to complete discharge planning and documentation.

Project Planning

Prior to implementation, care coordination staff completed a preimplementation survey about what

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Step 1 - Identify eligible patient and family:

- Patient with diagnosis of Alzheimer's Disease or other dementia, or with concern over memory loss, confusion, or cognitive impairment and has involved family member/caregiver

Step 2 – Provide the patient and family caregiver with appropriate educational resource information based on need/interest:

1. Provide Caregiver Profile packet if caregiver is overwhelmed or requests resources (includes):
 - Caregiver Profile to identify potential caregiver needs
 - My Stress Thermometer to help bring awareness to caregiver current stress level
 - Alzheimer's Association End-of-Life Checklist to identify potential needs
 - Patient and Caregiver Resources Sheet for resources to follow up with
2. Provide most appropriate stage-appropriate patient packet to patient/caregiver:
 - Suspect Alz Diagnosis Packet
 - Newly Diagnosed Packet
 - Early Stage Packet
 - Mid/late Stage
 - Spanish Packet

Step 3 – RNCC/SW reviews Reasons for Referral on the Alz Association Connect Referral Form with the caregiver and asks if they would like a referral sent to the Alzheimer's Association to learn more about any of the listed support services for caregivers.

Step 4 - Make direct referral to Alzheimer's Association if requested by filling out:

- RNCC/SW fills out Alz Direct Connect Referral Form completely (make sure to document permission as outlined on the form).
- RNCC/SW or CCA faxes Alz Direct Connect Referral Form to The Alzheimer's Association (see fax number on referral form).

Step 5 - Place hard copies of referral documents in patient chart. Complete discharge planning and document all referrals in Care Coordination note.

FIGURE 1

Quality improvement project referral protocol.

dementia-related topics they were interested in learning about. During a monthly staff meeting, the first author provided an overview of the project and answered any questions. Preimplementation 25-item DKAS scores were collected, using self-generated identification codes (SGICs), in order to achieve anonymity (Audette et al., 2020). The four-item SGIC used for this project included mother's first initial of first name, number of siblings, the two-digit birth month, and the first initial of the individual's middle name. Hard copies of the referral protocol and a prefilled-out sample of the Alzheimer's Association Direct Connect referral form were posted in each care coordination RNCC and SW office for reference. In addition, hard copies of the Alzheimer's Association education packets were placed in these locations.

Weekly Dementia Education

During the 60-day implementation period, care coordination staff received education blasts via email twice a week (De Angelis et al., 2016). Content for emails sent early in the week included dementia facts based on information from the Alzheimer's Association (2022). Content for emails sent later in the week included local resources in the community available to support patients with dementia and their families. Each educational email also reminded the staff to apply the project protocol to help identify patients and families interested in an Alzheimer's Association referral.

Data Collection

The Alzheimer's Association provided aggregate referral volume and a breakdown of referral type by

provider for the 60 days prior to implementation, the 60-day implementation period, and the 60-day period postimplementation, as well as historical referral data from the previous year.

Because of cancellation of staff meetings related to COVID-19 precautions during this project, care coordination staff completed the postimplementation 25-item DKAS individually during normal working hours. In addition, the postimplementation satisfaction survey was administered via email.

Outcomes Measures

Outcome measures for this quality improvement project included total referral volume, as well as dementia knowledge and satisfaction among care coordination staff. Aggregate referral volume to the Alzheimer's Association from the hospital was collected during the 60-day implementation period between March 24, 2022, and May 22, 2022, as well as the 60-day postimplementation period from June 1, 2022, through July 30, 2022. These referral volumes were compared with referral volume received in the 60 days preceding the intervention from January 23, 2022, through March 23, 2022.

DKAS assessments scores were compared pre- and postimplementation. Because of departures within the department and difficulty coordinating schedules, the number of completed DKAS assessments varied from preimplementation ($n = 17$) to postimplementation ($n = 14$). Therefore, final statistical analysis using paired-sample t tests was completed for the 14 care coordination staff members who completed both pre- and postimplementation DKAS assessments. Staff who completed both DKAS assessments included RNCCs, SWs, a substance abuse navigator, and a care coordination assistant. Because of the small number of care coordination staff, analysis was included for the single group only ($n = 14$).

RESULTS

Referral Volume

The referral volume to the Alzheimer's Association from the hospital was six times greater during the 60-day implementation period than for the preimplementation period. An increase in referrals was observed through the 60-day postimplementation period as well (see Figure 2). Preimplementation, the single referral was from an RNCC. During the implementation and postimplementation periods, referrals from RNCCs and SWs increased. For historical reference, from January 1, 2021, through July 31, 2021, the Alzheimer's Association received no referrals from the hospital.

Dementia Knowledge Change

A paired-sample t test was used to examine whether a significant change occurred in care coordinators' pre- and postimplementation 25-item DKAS scores. Difference scores met normality assumptions for parametric testing as indicated by the Shapiro-Wilk normality test. Care coordination staff scores significantly improved from pre- to postimplementation, with an average 7-point score improvement, $t(13) = -5.62, p < .001$ (95% CI [-10.18, -4.53]), with a sample estimate of -7.36 . This indicates that postassessment scores were significantly greater than preassessment scores, with an average of 7-point score change and a true population estimate of a 5- to 10-point score improvement (see Figure 3).

Staff Satisfaction and Knowledge of Community Resources

RNCC and SW satisfaction was assessed through a single-item postimplementation survey asking whether they thought the quality improvement project was beneficial to their practice. Furthermore, a pre/postimplementation survey assessed RNCC and

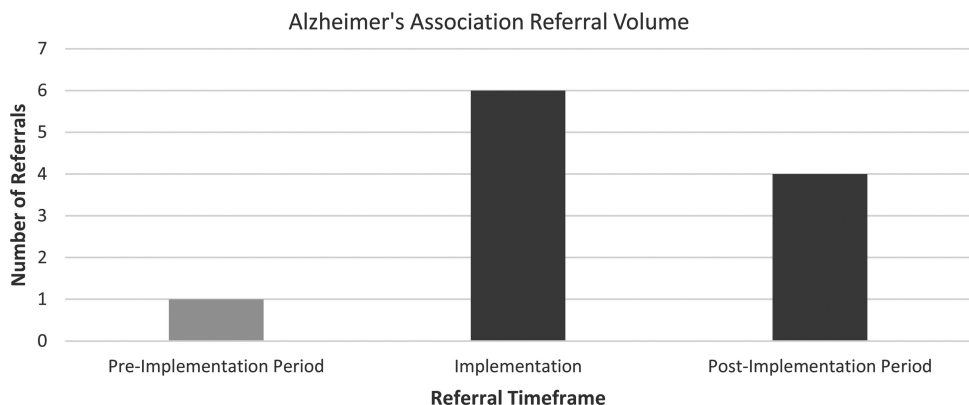


FIGURE 2
Referral volume.

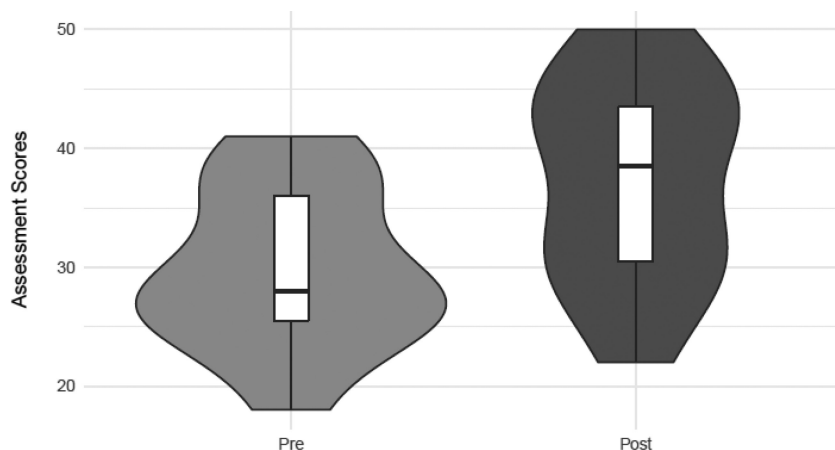


FIGURE 3 Distribution of pre- and postimplementation DKAS assessment scores. DKAS = Dementia Knowledge Assessment Scale.

SW knowledge of community resources for patients with dementia and how confident they were about referring patients with dementia and their families to community resources. They were asked about their confidence level using a Likert scale from 1 (not confident) to 5 (extremely confident).

Nine SW and RNCC staff members completed the project satisfaction survey for a response rate of 53%. Respondents indicated that they felt the project was beneficial ($n = 8$) or somewhat beneficial ($n = 1$) to practice (see Figure 4). In addition, they reported a pre/postimplementation increase in their awareness of available community resources (see Figure 5) and confidence in connecting patients and families to these resources (see Figure 6). Preimplementation confidence levels were lower, with 56% responding their confidence was either a 1 or 2 on a Likert scale and 44% selecting 3–5. Postimplementation, 100% selected 3–5 for their level of confidence about referring patients and families to dementia resources in the community.

DISCUSSION

This quality improvement project demonstrated the feasibility of developing and implementing a dementia-

specific education and referral protocol for care coordination staff in the acute care setting. This project provided an additional avenue for patients with dementia and their families to connect to community resources beyond referrals from outpatient providers (U.S. Department of Health and Human Services, 2020). First, the project strengthened a collaborative relationship between the hospital and the Alzheimer’s Association, a community resource for dementia. In addition, the project established a protocol to guide SW and RNCC care coordination staff in providing education, resources, and direct referrals to the Alzheimer’s Association from the acute care setting. For patients and families interested in a referral, the Alzheimer’s Association then provided additional follow-up.

This project was implemented without any change to staffing or increase in funding. A modest, yet positive practice change occurred within the care coordination department at the hospital during and following implementation of this project. Referrals to the Alzheimer’s Association increased during implementation, compared with the preimplementation period, and remained increased in the 2-month postimplementation period. These changes in provider practice and knowledge about dementia-specific



FIGURE 4 RNCC and SW satisfaction. RNCC = registered nurse care coordinator; SW = social worker.

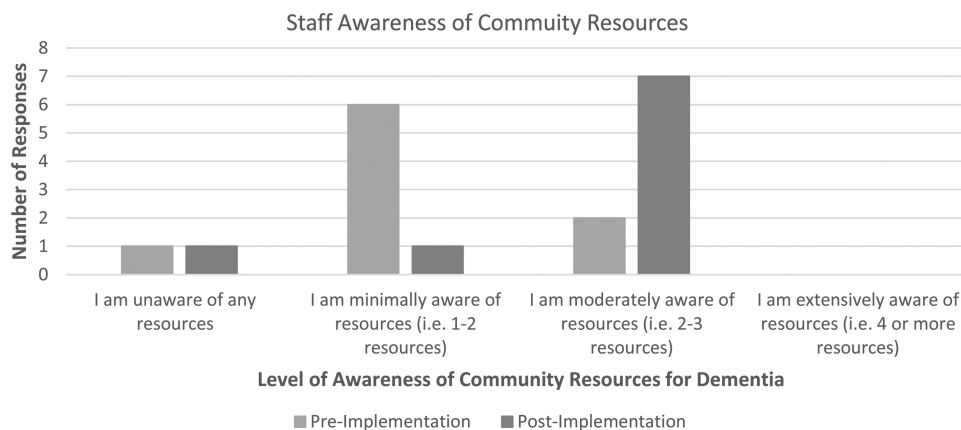


FIGURE 5
RNCC and SW awareness of community resources. RNCC = registered nurse care coordinator; SW = social worker.

resources and care are important to address the barriers patients with dementia and their families face in navigating the health care system (White et al., 2018).

LIMITATIONS

Duration of Intervention and Patient Volume

The length of the intervention period was 60 days, demonstrating a brief data collection period. This period may have been too short to capture a significant number of patients with dementia and their families. This quality improvement project focused on patients with dementia who also have a family member/caregiver involved in their care. Patients with dementia who were living in memory care settings or with advanced dementia may not have had family or caregivers available during their hospital stay; families may have declined referrals due to the patient’s advanced stage of dementia. In addition, some patients and family members may have declined an Alzheimer’s Association referral because they did not feel they needed the services provided. In some situations, patients with dementia and their families may have already been connected to the Alzheimer’s Association.

From January 2022 through June 2022, a total of 523 patients had a care encounter in the hospital and had either a primary or a secondary diagnosis of dementia. These cases were identified from a query of the electronic health record using the list of *International Classification of Disease, Tenth Revision* codes (DiSantostefano, 2018). During this period, encounters with patients with dementia averaged about 87 patients per month. These encounters included patients seen in the emergency department, placed in observation status, or admitted as an inpatient. Given the volume of patients with dementia, there is continued opportunity to support this patient population. The hope is that the care coordination staff will continue to yield increases in referrals and support for this patient population; however, they could work with nurses on the inpatient units most impacted by dementia to improve the referral process. Karlekar et al. (2017) implemented a similar quality improvement project to increase nursing staff referrals of older adults with frailty and cognitive impairment to palliative care. Further analysis would be appropriate to understand the specific needs and interventions appropriate



FIGURE 6
RNCC and SW confidence. RNCC = registered nurse care coordinator; SW = social worker.

for patients based on disease stage, family involvement, and other factors.

Staffing and the COVID-19 Pandemic

Environmental constraints such as workload and workflow may have affected project implementation (Geerligs et al., 2018). The COVID-19 pandemic affected the department through both high patient census and staffing shortages. During implementation and data collection periods of this project, the care coordination department was frequently understaffed, resulting in high daily case-loads for RNCCs and SWs. The stress of these conditions may have contributed to decreased staff engagement with education emails and lower referral rates. In addition, postimplementation DKAS scores were not obtained from some staff members due to cancellation of staff meetings and absences related to COVID-19 precautions. One SW also left the department during the implementation period and was unable to complete the postimplementation DKAS.

Educational Intervention

Surr et al. (2017) conducted a systemic review of international literature between 2000 and 2015 to identify components associated with effective dementia-related education and training for health care and social care staff across health care settings. They reviewed 152 articles and identified themes associated with successful dementia-specific education. These included the relevance of content to role, teaching and learning approaches, quality and clarity of training materials, and the skills/qualities of the trainer. The researchers suggested that information presented should be relevant to the provider receiving it in terms of role, experience, and practice. The facilitator should be an experienced trainer knowledgeable about adult learning principles who can create a comfortable environment and adapt the content to the needs of the group. In addition, face-to-face sessions with active participation are recommended. Education that spanned a total of roughly 8 hr with individual sessions of 90 min was also preferred. Furthermore, educational content should be clear, straightforward, and easy to follow and ideally include a tool or guide to apply to practice.

The components outlined as being successful were initially proposed for this quality improvement project (Surr et al., 2017). The facilitator was experienced in education and adult learning principles, and content was carefully selected to be relevant to the providers, including information specifically requested by some staff members. However,

face-to-face sessions, 8 hr of training in 90-min sessions, and inclusion of active teaching/learning strategies were not included because of departmental constraints. Leadership could only accommodate a single 15-min session to provide an overview of the project at the beginning of implementation. Education on dementia, as well as local community resources relevant to dementia, was therefore provided passively through informational emails sent twice a week. Staff reported difficulty reviewing even brief informational emails due to time constraints during their workday, despite expressing interest and desire to learn about the content.

Future Opportunities and Sustainability

Opportunities for future implementation should include dedicated time for staff to receive information over several sessions, active involvement of the Alzheimer's Association through staff in-services to broaden understanding of various topics, ongoing evaluation and support related to the referral process, and tracking of outcomes over time to establish the impact of support from the Alzheimer's Association. Together, these actions may help promote lasting practice change.

Expansion to additional facilities is another opportunity. This project was implemented in a single acute care hospital in a geographic area serviced by a local Alzheimer's Association chapter office. Participation was limited to existing staff in the care coordination department at this single hospital, so results cannot be generalized to acute care hospitals in regions without a local Alzheimer's Association chapter. However, the Alzheimer's Association is a national organization. Other acute inpatient hospital affiliates in the same geographic area have plans to implement components of this project at their facilities. There were minimal costs associated with implementation other than the cost of printing referral forms and patient education packets. Larger health care and hospital systems could replicate this quality improvement project without significant increases in terms of staffing or funding.

IMPLICATIONS FOR CASE MANAGEMENT PRACTICE

Case management professionals are skilled at identifying patient and family needs and connecting them to available resources and services (Commission for Case Manager Certification, 2022). This quality improvement project provided a simple and cost-effective intervention for case managers in the acute care setting to enhance support for patients with dementia and their families. This step-by-step protocol guides case managers in providing dementia

education and facilitating dementia-specific referrals to a community resource, such as the Alzheimer's Association, that can continue to work with patients and connect them to valuable information, support, and services (Alzheimer's Association, n.d.). Through implementation of this quality improvement project, RNCCs and SWs were able to both increase their knowledge of dementia and increase support for patients and families impacted by dementia.

CONCLUSION

Through a collaborative partnership with a community organization, the care coordination department at an acute care hospital improved support for patients with dementia and their families. After implementation of this quality improvement project, we observed an increase in Alzheimer's Association referrals initiated by RNCCs and SWs in the acute care setting. As a result of the project, care coordination staff demonstrated increased dementia-specific knowledge and confidence in connecting patients and families to resources. This project helped highlight the importance of building relationships between acute care and community resources to provide meaningful assistance for patients and families outside the health care setting. The burden of dementia affects not only the patient but also family caregivers. Upstream assistance across the continuum of care can help facilitate necessary planning, preparation, and support for patients with dementia and their families.

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