Alzheimer's Disease: Rural Community

Rural Geriatric Dementia Evaluation

Helping Families in Their Homes

Rural Community

Developed by Community Health and Counseling Services, the Maine Alzheimer's Project

Alzheimer's Disease Demonstration Grants to State Program

A Program of the U.S. Administration on Aging

As part of the Maine demonstration project, Community Health and Counseling Services developed five evaluation teams to serve four isolated counties in rural, northeastern Maine. Each team was made up of a Social Worker and a Registered Nurse. The teams provided the only dementia evaluation service in these remote areas. The evaluation includes two home visits by the team, consultation with a geriatric physician, the development of an individualized care plan, and two telephone follow-ups.

In their initial visit, the team administers a battery of assessment measures and tests. Each team member spends separate time with the caregiver and the elder. Following the visit, the team reports all the information gathered to the geriatric physician consultant. This information includes the team's observations of how the family is living, what coping strategies they are using and any environmental safety issues or dementia education needs the family may have. The geriatric physician and the team confer by conference call to develop an appropriate care plan.

The second in-home visit by the team is to explain and assist in implementing the care plan with the family. The geriatric physician also sends a copy of the care plan to the family's primary care physician and may follow up with a call when warranted.

Why the Team Approach Makes Sense in Maine

Most of Maine is rural and sparsely populated. Though it is a geographically large state, there is only one Geriatric Diagnostic center in the central part of the state. Thus, to obtain an assessment and diagnosis, most of Maine's elderly population had to travel long distances which often included overnight stays. Given the long winters and extreme weather, such travel can be difficult even when feasible. Many families were simply unwilling or unable to travel for this service. The in-home evaluation team model takes into account the geographic size of Maine. It is an effective way to overcome transportation problems and to increase access to assessment and diagnosis for rural families. In-home assessment also has the benefit of respecting the rural cultural mores of family privacy and "tending out" (taking care of one's own). The assessment process is tailored to each family's needs, which places the family in control.

How the Team Approach Was Established

Some Health staff at Community Health and Counseling Services identified the need for dementia services in rural areas. Some of the needs the staff discovered went beyond routine home health issues. The social work coordinator and the geriatric physician put together a proposal to address the need for dementia assessments. The Maine demonstration project funded the proposal for serving rural families with dementia needs.

The project began by building community awareness. Letters were sent to all physicians in the four-county area to introduce the services. Currently, almost 35% of referrals come from physicians. Physicians are willing to refer their patients to the service because they have trust in the Home Health Agency and the local team. The Home

Health Agency is well- known in the four service counties. Many of the local physicians and team members have prior working relationships through community hospitals and nursing homes. The limited care options in rural areas also encourage physician referrals.

Referrals also come from other community agencies. The teams meet with hospital discharge planners, other home health agencies, other providers, and professionals in the communities. Brochures are widely distributed and local media are used (radio programs, television news shows, and local television programs).

How the Maine Program Works

Attention was given to communicating with local primary care physicians. The presence of the team's geriatric physician was helpful in reaching physicians. This facilitated communication from doctor to a doctor, even though the team was gathering the information. The geriatric physician's approach was very important. He was cognizant of the fact that he had not seen the patient. He had seen only the assessment measures, reports, and test results. He approached the primary care physicians as the "experts" about the family and patient because the primary care physicians had seen the patients and often had been treating the family for a long time. The team's geriatric physician served as a consultant with specific expertise rather than as an expert telling the primary care doctors how to treat their patients. He gave his recommendations as suggestions and offered to assist the primary care physicians. The teams benefit because the geriatric physician's role was critical in gaining the trust of the local primary care physicians.

Barriers and Obstacles

Previous programs had been unable to communicate effectively with physicians. Having a registered nurse as a component of the team helped legitimize the medical issues when conveying assessment information to primary physicians. Lack of other options for assessment also may have contributed to a willingness to use or refer to the team.

There is a general lack of knowledge about dementia in rural areas among both providers and families. The geriatric physician's role, in part, is as an educational resource to primary physicians. He is the only geriatric specialist outside of Bangor in the four-county service region. Additionally, the assessment teams became local resources. Some teams were asked to train staff of residential care facilities on dementia issues and others gave talks to the general public.

Expanding the Service Capacity

Service capacity has been increased at multiple levels through this program. In the initial phase of the project, contracts were negotiated with the staff of the only Geriatric Diagnostic Center in the entire state of Maine to provide training to the social worker and nurse teams. The home health agency now includes dementia training for all social workers, nurses and aides. Local physicians have also become more aware of dementia issues. Teams are recognized as local experts and asked to provide dementia information locally. General community

awareness and knowledge has also increased.

How the Project Benefits Maine

This model has been so successful in serving rural families in a sensitive and culturally appropriate manner that the Maine demonstration project is planning to replicate the model in other areas of their state.

Teams bring service to families who would otherwise not be served. Teams work within the existing support network of each family (families do not need to change physicians, etc.). This is possible because the teams visit the family at home and thus have a first-hand understanding of how the family is coping with dementia issues.

This model has also increased the general awareness of the needs of dementia families. Now there is a greater likelihood that families will seek help sooner. Having local dementia teams has also decreased their feelings of isolation. Family members now know someone who understands their situation and can help link them to available resources.

Project Costs

The team assessment costs approximately $600 per family to deliver. This cost covers two visits by the team, physician consultation and two follow-up calls by the team. Also included in this estimate are the associated costs for telephone and travel. The social work coordinator, who also oversees the program, provides some in-kind contributions. The coordinator arranges for training and provides information and other support to the teams. To reduce the per-client costs, the service has recently been changed. Now, only one team member returns to make the second in-home visit with the family.

Keys to Success

1. The project became a partner with respected organizations that are already integrated into the service community.
2. Team staff are employed as home health nurses and social workers. This alleviates financial stress during the start-up time or slow times when staff can serve other clients.
3. The teams include medical staff to talk with physicians.
4. The teams travel to the families, instead of vice versa.
5. In-home visits provide the teams useful insight into the family environment.
6. Teams make practical, informed suggestions for behavior management.

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