

## IN-HOME

### Identifying Needs to Help Older adults Maintain Everyday community living

**Study Goal:** The objective of our study is to validate an assessment tool aimed to identify measures that would support older adults with dementia's ability to maintain everyday community living. This assessment tool would be particularly important to the hospital and nursing home discharge process for residents reintegrating into the community, when needing to identify what residents being discharged will need to maintain community living. Preliminary findings will be used to generate actionable, evidence-based health policy recommendations and inform the management of care transitions for older adults.

**Study Methods.** We will test the assessment tool with a diverse regional sample of 150 persons living with dementia (PLWD) who meet eligible criteria described below and 150 family care partners.

#### **IN-HOME Aim 3 Goals:**

- Recruit 10 eligible Nursing Homes (NHs).
- Conduct in-person 30-minute survey with 15 PLWDs in each NH.
- Conduct virtual 30-minute survey with 15 FCPs in each NH.

#### **Request for Nursing Home:**

- Provide a NH liaison who will assist with identifying 30 PLWDs and their 30 FCPs.
  - Provide a list of eligible residents with current BIMS (Brief Interview for Mental Status) and room location.
  - Provide contact information of eligible FCPs.
    - FCPs will be mailed an invitation letter and IN-HOME survey instrument by NYU research team requesting their participation.
- Confirm time/dates for NYU team member to come on-site to interview 15 PLWDs.
- Provide a private space where in-person interviews can take place (interviews can take place in the resident's room).

#### **Benefits to Nursing Home:**

- NH will receive an honorarium of \$1500.
- NH liaison will receive a \$300 Visa gift card.
- NH will receive summarized results in aggregate at the conclusion of the study.
- Participating in the IN-HOME study will prepare nursing homes for the CMS' 2027 Discharge to Community—Post-Acute Care (DTC-PAC) Measures by refining discharge processes and focusing on successful community transitions without hospital readmissions post-discharge.
- Possibility of co-authorship (contingent upon contribution to manuscript development).
- Optional acknowledgement of NH's participation (only if requested otherwise confidentiality is upheld).
- Optional free onsite evidence-based training to your staff on any of the three topics:
  1. Integration of nurse aides into the interdisciplinary care team meetings and care planning process.
  2. Assessment, recognition, and reporting of signs of changes in residents' condition.
  3. Effective use of communication tools that ensure resident safety.

#### **Benefits to Interviewee:**

- PLWD will receive a NYU blanket.
- FCP will receive a \$30 Visa gift card.

## Appendix:

Inclusion and Exclusion Criteria	
NH PLWD Inclusion Criteria	NH PLWD Exclusion Criteria
<ul style="list-style-type: none"><li>-Adults age 65+ years</li><li>-Within 90 days-5 years of NH admission</li><li>- &gt;=8 on the Brief Interview for Mental Status</li><li>-Black, White, Latino</li><li>-*Low and intermediate care need</li><li>-Diagnosis of dementia</li></ul>	<ul style="list-style-type: none"><li>-Enrolled in hospice</li><li>-Hearing or speech impairment</li><li>-Active psychiatric disorders impairing perceptions of reality</li><li>-Severe cognitive impairment</li><li>-Chronic or skilled care need (e.g., tracheostomy, parenteral therapy, hip replacement, etc.)</li></ul>

\*Low care requires no physical assistance with ADLs. Intermediate care most commonly consists of assistance with everyday ADLs such as bathing, eating, toileting, and medication.