Innovations in Caring for Persons with Alzheimer’s and Related Dementias

OCTOBER 25, 2019
Welcome & Announcements

Welcome – Rob Dribbon, *Strategic Innovation, Merck*

Upcoming PCPCC Webinars

Interested in PCPCC Executive Membership? Email Jenifer Renton (jrenton@pcpcc.org) or visit [www.pcpcc.org/executive-membership](http://www.pcpcc.org/executive-membership)

PCPCC Annual Conference
Save the Date: November 4 - 5, 2019
2019 PCPCC Annual Conference
#PCPCC2019 is 10 DAYS AWAY!

This year’s conference features exciting sessions and a dynamic group of speakers including:

- The PCPCC Tech Pre-conference, Digital Disruption: Activating Primary Care with keynote from James Weinstein, SVP, Microsoft Health Care
- Keynote presentations from Eric Topol, MD, Scripps Research, and Asaf Bitton, MD, Ariadne Labs, Harvard Medical School
- Fireside chat, featuring Richard Baron, President and CEO, American Board of Internal Medicine Foundation, (former Group Director of Seamless Care Models, CMMI) and Amy Bassano, Acting Director, Center for Medicare and Medicaid Innovation (CMMI) as they discuss CMMI’s efforts, results to date, and what they hope to accomplish in the future with CPC+ and the Primary Care Models, with a particular focus on Primary Care First
- and much more!

Visit pcpccevents.com today to view the agenda, full list of speakers, conference prospectus, and to register for this year’s conference.

Today’s webinar attendees can receive $100 off conference registration with discount code, webinar2019
Today’s Speakers

David B. Reuben, MD
Director, Multicampus Program in Geriatrics Medicine and Gerontology
University of California, Los Angeles

Morgan Daven, MA
Senior Director for Health Systems,
Alzheimer’s Association

Carolyn Clevenger, RN, DNP
Clinical Director and Nurse Practitioner
Integrated Memory Care Clinic
Emory University

Robert Dribbon
Strategy and Innovation
Merck
(Moderator)
Innovations in Caring for Persons with Alzheimer’s and Related Dementias

Morgan Daven Senior Director, Health Systems
Alzheimer's Association

Carolyn Clevenger, RN, DNP, Associate Dean for Clinical and Community Partnerships at the Nell Hodgson Woodruff School of Nursing

David B. Reuben, MD, Archstone Professor of Geriatrics
David Geffen School of Medicine at UCLA
What We Will Cover

• Overview: the magnitude of the problem
• New guidelines for diagnoses of dementia
• Outreach programs to identify persons with dementia
• A population-based approach to caring for persons with dementia
• Examples of innovative programs
• Questions and answers
More than 5 million Americans are living with Alzheimer’s, the most expensive disease in the United States.
In 2019, total payments for caring for Americans age 65 and older with Alzheimer’s or other dementias will surpass a quarter of a trillion dollars, an increase of nearly $13 billion since last year.
By 2050, these costs could rise as high as $1.1 trillion.
Alzheimer’s adds to the difficulty and cost of managing care for adults, creating more expensive hospitalizations and increased emergency department visits.
Early detection has medical, social, emotional, planning and financial benefits.

A cornerstone of early detection is **assessment of cognitive impairment**.

Primary care providers may be especially well-positioned to perform this evaluation and ensure **timely follow-up**.
Benefits of Early Detection

- Accurate Diagnosis
- Medical Benefits
- Participation in Clinical Trials
- Planning for the Future
- Emotional and Social Benefits
Practice Guidelines for Clinical Evaluation of Alzheimer's Disease and Other Dementias for Primary and Specialty Care (for publication in 2020)

- For use by primary care and specialty care physicians and nurse practitioners
- Best practices for partnering with the patient and their loved ones, to improve patient autonomy, care, and outcomes
georgia memory.net
the need:

385k with self-reported cognitive impairment
80% have not yet been evaluated or treated

$2B in preventable admissions expenses

the goals:

All citizens of GA will be within 90 miles of a Memory Assessment Clinic
Connect patients with local services for continued care
Encourage annual wellness visits, administer the Mini-Cog™ assessment tool

our collaborators:

Alzheimer's Association Georgia Chapter
MCG
Georgia Department of Human Services
Morehouse School of Medicine
Reynolda Carter Institute for Caregiving
Mercer University School of Medicine
Aging & Disability Resource Connection
Emory
Setting Our Goals:
It’s only a wish without a plan.

Our objective is to improve outcomes and quality of life for people dealing with memory loss, while streamlining services and offering more efficient care.

- Improve Assessment During Annual Wellness Visits
- Diagnose Accurately at Memory Assessment Clinics
- Improve Care with PCPs and Community Services
- Provide Oversight and Evaluation of Performance and Data Collection
Memory Assessment Clinic Locations

- Atlanta
- Augusta
- Macon
- Columbus
- Albany
GMN Model for State CSE Workflow

1. BEFORE MAC VISIT
   PCP Identifies cognitive impairment & refers to MAC; MAC contacts patient

2. MAC VISIT 1
   Care partner: Initial visit with Community Services Educator; Assessment: FAQ, CNA, BRI

3. INTERIM & HUDDLE
   Interim: Pt has imaging, labs, other workup & MAC Providers review results to make dx
   Huddle: MD/ CSE should discuss case & dx prior to the second visit

4. MAC VISIT 2
   MD reviews dx with patient & patient care partner
   CSE meets with patient & patient care partner: Identify patient goals

- RETURNS TO PCP
  Patient returns to care of PCP with diagnosis and finalized Care Plan

- EDUCATE FAMILY
  CSE finalizes the Care Plan and sends mails to the family

- REFERRAL TO COMMUNITY CARE
  CSE send referral (Face Sheet, Consent, Care Plan Summary) to AA & AAA

- FOLLOW UP WITHIN 1-MONTH OF 2ND VISIT
  CSE calls Pt/Care Partner to check in post visits, ensures they have been contacted by AA and AAA and to answer any questions
GMN: Statewide Initiative

• Core Collaborators
  – Coordinating Center
  – Memory Assessment Clinics
  – Primary Care Practices
  – Alzheimer’s Association
  – Area Agencies on Aging
  – Aging and Disability Resource Centers
New Models of Comprehensive Care for Dementia

• Focus on patient and caregiver
• Community-based
  – BRI Care Consultation
  – MIND at Home
• Health System-based
  – Indiana University Healthy Aging Brain Center (HABC)
  – The UCLA Alzheimer’s and Dementia Care Program (UCLA ADC)
  – The Care Ecosystem
  – Emory Primary Care Program
Community-based

• Implemented at CBOs by SWs, RNs, MFTs
  – Systematic assessment
  – Care planning
  – Delivery or referral care, services, and support
  – May or may not have in-person visits, home visits
• Reduced caregiver burden/strain/depression
• Better guideline care, QoL, behaviors
• Reduced NH placement
• No effect on health care use or costs
Health-system Based

- Implemented in health systems by nurse practitioner or physician-led staff
  - Face-to-face annual visits
  - Coordination within health system and EHR
  - Order writing
  - May or may not have home visits
- Better quality of care
- Reduced caregiver burden/strain/depression
- Reduced NH placement
- Lower health care costs
The Integrated Memory Care Clinic: Primary Care for People with Dementia

Website: www.emoryhealthcare.org/imcc
Geriatric Primary Care

Palliative Care

Dementia Care

Specialized care for aged or people with syndromes of the aged population

Including neurological and geriatric psychiatry care

Aggressive symptom management to improve quality of life

IMCC: A “One-Stop Shop”
“Primary Care for People Living with Dementia”

INTEGRATED MEMORY CARE CLINIC
A nurse-led medical home for people with dementia and their caregivers

EVIDENCE-BASED PRIMARY CARE AND SYMPTOM MANAGEMENT
- Managing dementia-related symptoms
- Managing chronic co-morbid conditions
- Managing minor acute illnesses and injuries

COMPREHENSIVE PALLIATIVE CARE
- Early and ongoing goals of care discussions
- Risks and burdens of tests and treatments
- Advanced care planning

CARE WITH PATIENTS AND CAREGIVERS
- Patient and family-centered care plans
- Fully engaged Patient and Family Advisory Council
- Ongoing feedback guides process improvement

CAREGIVER SUPPORT
- Psychoeducational training
- Counseling and support groups
- Respite care when needed
Dementia + Primary Care

1. Intentional assessment and appropriate, aggressive treatment
2. Availability of clinicians to families
3. Connection to community-based aging service providers
4. Input from patient/family advisors
5. Leveraging the interprofessional team.
Emory Integrated Memory Care Clinic (IMCC)
A primary care practice designed for people living with dementia

Did you diagnosed with dementia?
The Integrated Memory Care Clinic (IMCC) is a nationally recognized clinic that provides both primary care and dementia care. The clinic is a one-stop shop for people living with dementia because of our comprehensive model, patients have longer appointments with the nurse practitioners.

Dementia Specialized care
We will also manage your dementia symptoms, similar to a neurology specialty clinic.
*Cognitive testing may be scheduled if appropriate.

Primary care
We would take the place of your general practitioner. We provide routine care for chronic conditions and urgent care for acute symptoms.

Community support
Support established patients and families identify community resources for their specific circumstances, provide classes for family care partners, and conduct support therapy sessions.

Social worker
I help established patients and families identify community resources for their specific circumstances, provide classes for family care partners, and conduct support therapy sessions.

Class workshops
I ensure patients’ needs are met and provide initial treatment recommendations, refill medications, and coordinate orders with home health and other community services.

After hour line
I ensure patients’ needs are met and provide initial treatment recommendations, refill medications, and coordinate orders with home health and other community services.

You
Patient Family Advisory Committee
The IMCC has a Patient Family Advisory Committee that provides feedback on issues related to the clinic. This PAC is made up of current and former family care partners.

How to start dementia care with IMCC?
Call us. Our PCP will help guide you through the process. New patients need to provide outpatient medical records showing a dementia diagnosis for the clinical director to review before an appointment can be made.

IMCC NP
As the nurse practitioner leading your care, I can prescribe medications, order lab work, diagnose problems, write orders for treatment, and refer to specialists as needed. I collaborate with physicians to ensure your care needs are met.

IMCC RN
I fulfill patients’ needs over the phone and provide initial treatment recommendations, refill medications, and coordinate orders with home health and other community services.

IMCC Pt. Coordinator
I ensure the IMCC phones and schedule appointments with providers. IMCC patients call the Pt. Coordinator instead of Emory’s call center.

404-712-6929
https://www.emoryhealthcare.org/imcc
Outcomes

• Primary Care
  – Outperform the system goals for hypertension, diabetes care
  – Outperform the system goals for immunizations, [appropriate] screenings

• Value
  – Ambulatory sensitive admission rate less than 2%*
  – 99th percentile Patient Experience scores

*(published national rate typically ~13-15%)
Healthy Aging Brain Center (HABC): Indiana University

- Care management services focused on improving self-management, problem solving and coping skills
  1. Patient and family education and counseling
  2. Data collection via standardized tools
  3. Coordination of care transitions across multiple settings
  4. Design and delivery of person-centered, non-pharmacological interventions to reduce physical and psychological burden
  5. Modification of physical and social environment
  6. Engagement of palliative and hospice care as appropriate
Non-licensed Care Coordinator Assistants are the primary liaison between the care team, our patients and their informal caregivers.

- Conduct visits anywhere in the community convenient to the patient and their informal caregivers
- Care is delivered through a variety of mechanisms including in person, phone and email
HABC Benefits

• Fewer ED visits
• Fewer hospitalizations
• Shorter lengths of stay
Care Ecosystem

• Telephone and internet-based care delivery (15.3 calls/y)
• Team of unlicensed Care Team Navigators plus dementia specialists (APN, SW, pharmacist)
• Care plan protocols (immediate needs, meds, safety, referrals and caregiver education, caregiver well-being, behavior management, advance care planning)
• Improved: person with dementia quality of life
• Reduced: ED utilization, caregiver depression and burden
The UCLA Alzheimer’s and Dementia Care Program

• Clinical program with goals:
  – Maximize patient function, independence, & dignity
  – Minimize caregiver strain
  – Reduce unnecessary costs

• Provides comprehensive care based in the health system that reaches into the community

• Uses a co-management model with Nurse Practitioner Dementia Care Specialist (DCS) who does not assume primary care of patient
The UCLA Alzheimer’s and Dementia Care Program

• DCM works with physicians to care for patients by:
  – Conducting in-person needs assessments
  – Developing and implementing individualized dementia care plans
  – Monitoring response and revising as needed
  – Providing access 24 hours/day, 365 days a year

• Caseload 250-300 patients
1-year Outcomes: Patients

N=551

- Functional status (FAQ)*
- MMSE
- Behavioral symptoms (NPIQ)*
- Depression (Cornell)*

*Higher values are worse

For all baseline and year 1 comparisons, p<0.001.
1-year Outcomes: Caregivers

N=551

- Distress from behavioral symptoms (NPIQ)*
- Caregiver strain index
- Caregiver depression (PHQ9)*

Higher values are worse

*For all baseline and year 1 comparisons, p<0.001.
Utilization and Costs

• Hospitalizations: 12% reduction
• ED visits: 20% reduction*
• ICU stays: 21% reduction
• Hospital days: 26% reduction*
• Hospice in last 6 months: 60% increase*
• Total Medicare costs of care: $2404/year*
• Nursing home placement: 40% reduction*

* p<.05

Based on NORC external evaluation of CMMI Award using fee-for-service claims data and UCLA ACO data September 2015- September 2017
Population-based Dementia Care Model

Risk Stratification

1st Tier (1%) 50 patients
- Many behavioral problems, severe functional impairment, minimal resources, comorbidities
- Frequent ED and hospital admissions

2nd Tier (2-5%) 199 patients
- Frequent behavioral problems, functional impairment, minimal resources, comorbidities
- Multiple ED and hospital admissions

3rd Tier (6-20%) 746 patients
- May have behavioral problems and/or severe functional impairment, comorbidities

4th Tier (21-60%) 1990 patients
- Mild dementia
- Getting routine health care

5th Tier (61-100%) 1990 patients
- Mild dementia
- Getting routine health care

Dementia Plan of Care

1st Tier (1%) 50 patients
Intensive individualized care, small-panel primary care, ACP, Palliative Care, UCLA ADC program, hospital strategies

2nd Tier (2-5%) 199 patients
UCLA ADC program, ACP, Neurology, Psychiatry consultations as needed

4th & 5th Tier (21-100%) 3,980 patients
Caregiver education, referral and monitoring and usual care

Total # & Yearly Minimum Utilization By Risk Tier
# Dementia Care Pathway Initiatives

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| 1 (Top 1%) | • Referrals to Extensivest Clinic or home visit program, if appropriate  
• Referrals to Alzheimer’s and Dementia Care (ADC), if appropriate  
• Referrals to Palliative Care  
• Referrals to Urogynecolgy (Frequent UTIs) |
| 2 & 3 (2-20%) | • Primary care with additional services  
• Optimized Referral to ADC Program  
• Referrals to Urogynecology (Frequent UTIs) |
| 4 & 5 (21-100%) | • Enhance Dementia Care within Primary Care  
• Enhance Memory Evaluation Referrals  
• Promote Advance Care Planning  
• UCLA Dementia Information and Referral (I&R) Service (ADIS) |
| All Tiers | • CareConnect Registry  
• Referrals to Pharmacy for Medication Reconciliation (15+ meds) |
Conclusions

• Despite the lack of very effective medications for dementia, the lives of persons with dementia and their caregivers can be improved with lower health care costs
• Several models are effective and choices should be guided by the population served, local resources, and institutional goals.
Questions