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

OCTOBER 25, 2019

Patient-Centered Primary Care COLLABORATIVE

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

PCPCC Annual Conference

Save the Date: November 4 - 5, 2019

Patient-Centered Primary Care COLLABORATIVE

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 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)

Patient-Centered
Primary Care
COLLABORATIVE

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**.

alzheimer's association®

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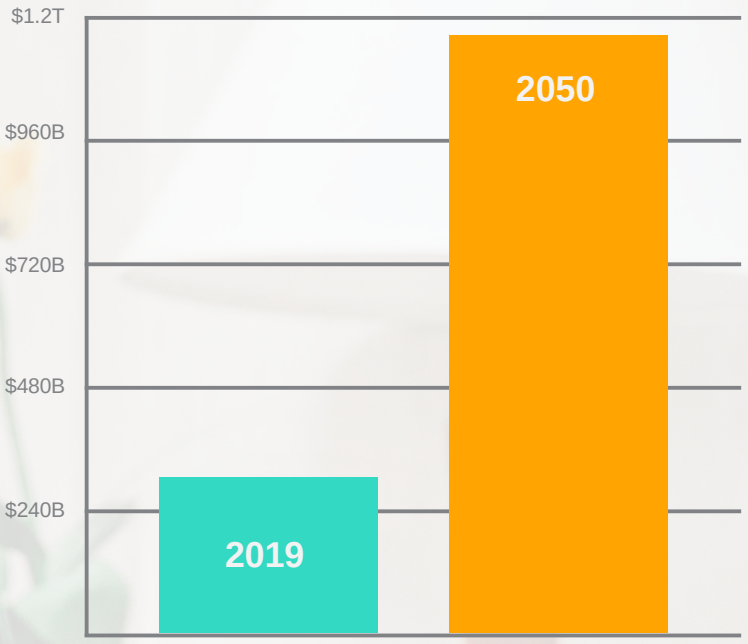
In 2019, total payments for caring for Americans age 65 and older with Alzheimer's or other dementias will **surpass a quarter of a trillion dollars**, an increase of nearly $13 billion since last year.

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

alzheimer's association®

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Clarity. Care. Community.

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
Mercer University School of Medicine Macon • Savannah
Rosalynn Carter Institute for Caregiving
MERCER UNIVERSITY School of Medicine
Aging & Disability Resource Connection
An Initiative of the U.S. Department of Health and Human Services
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

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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

CARE PLAN DEVELOPED

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

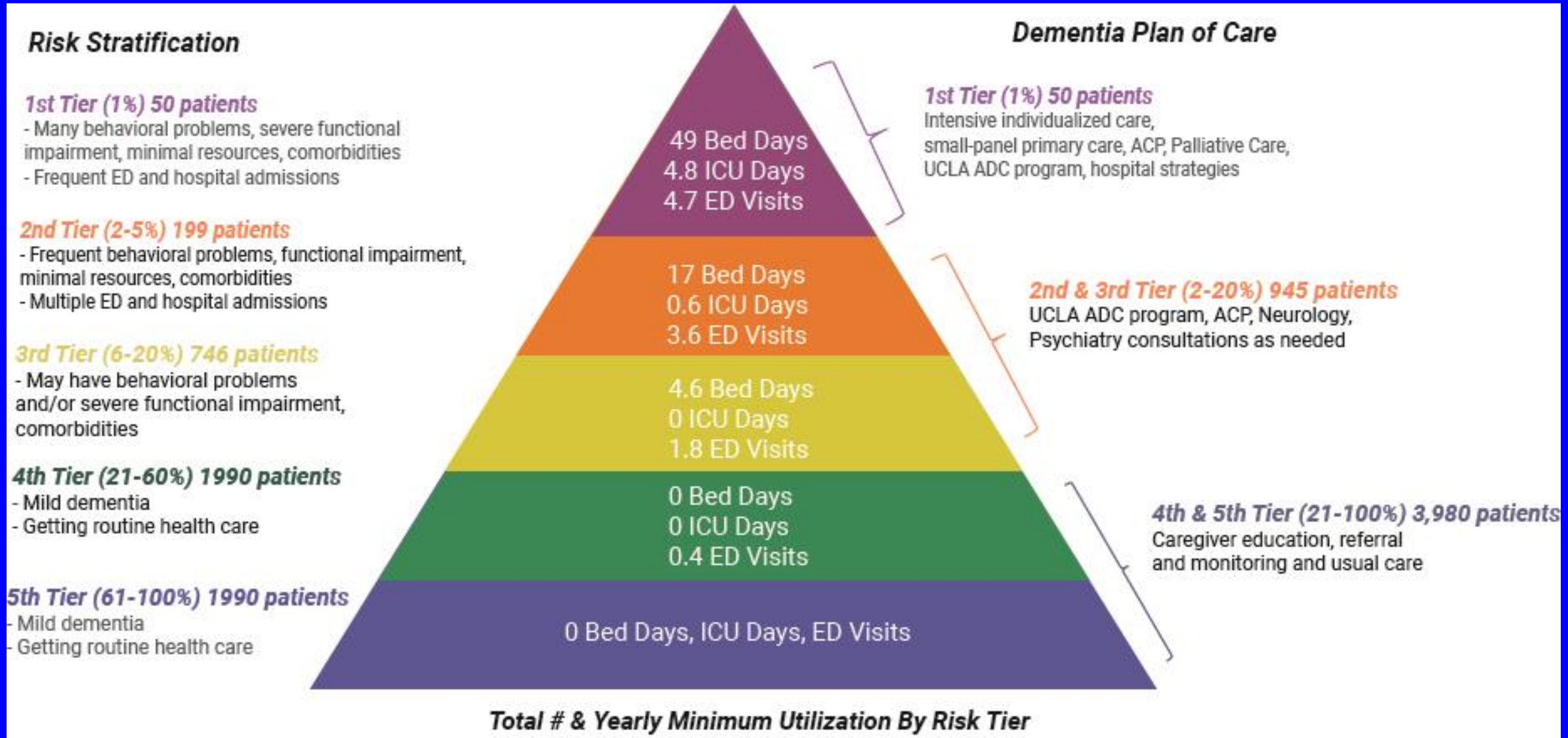
FOLLOW UP WITHIN 1-MONTH OF 2ND VISIT

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

Population-based Dementia Care Model



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

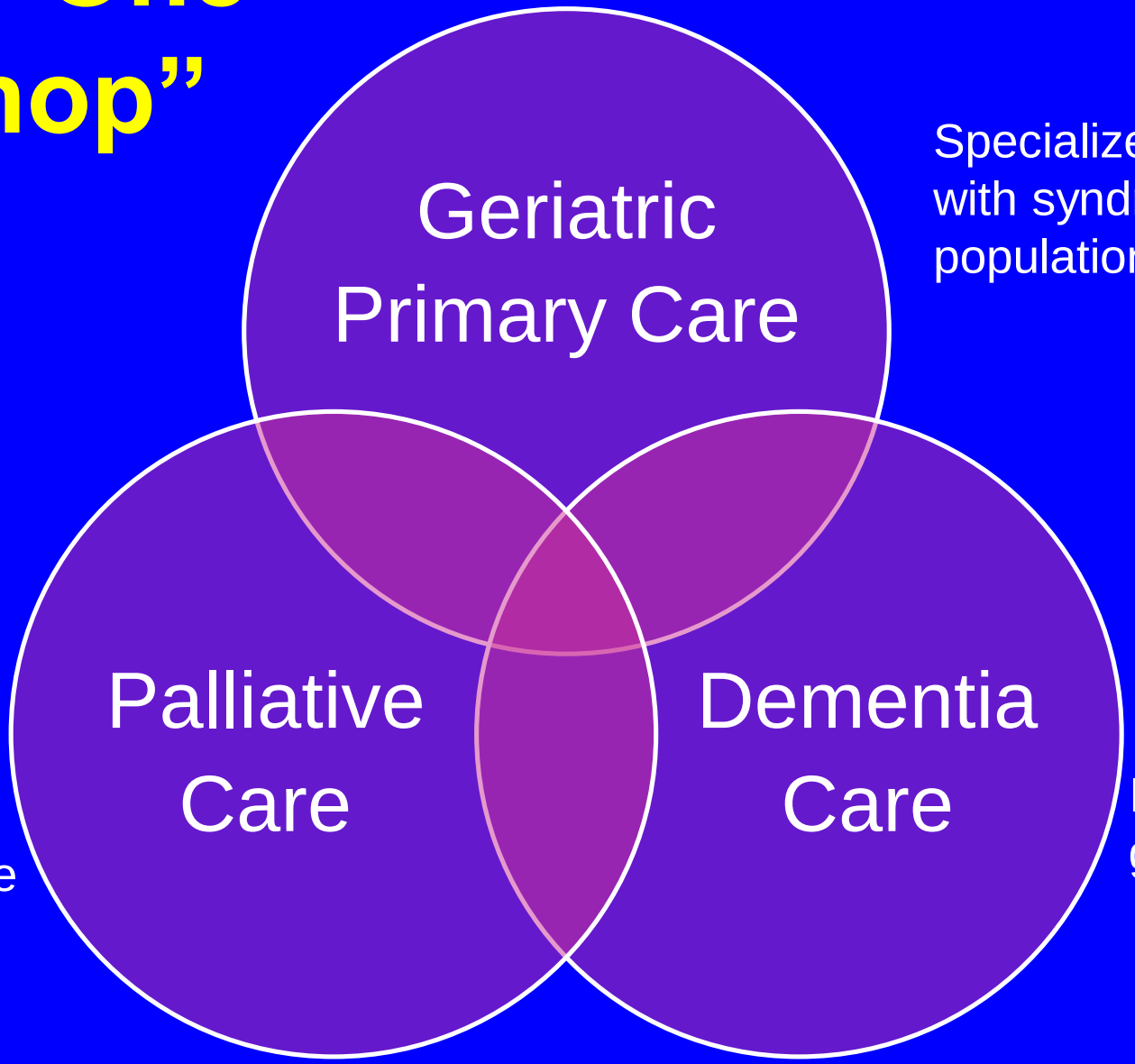
Health-system Based

- 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

IMCC: A “One-Stop Shop”



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

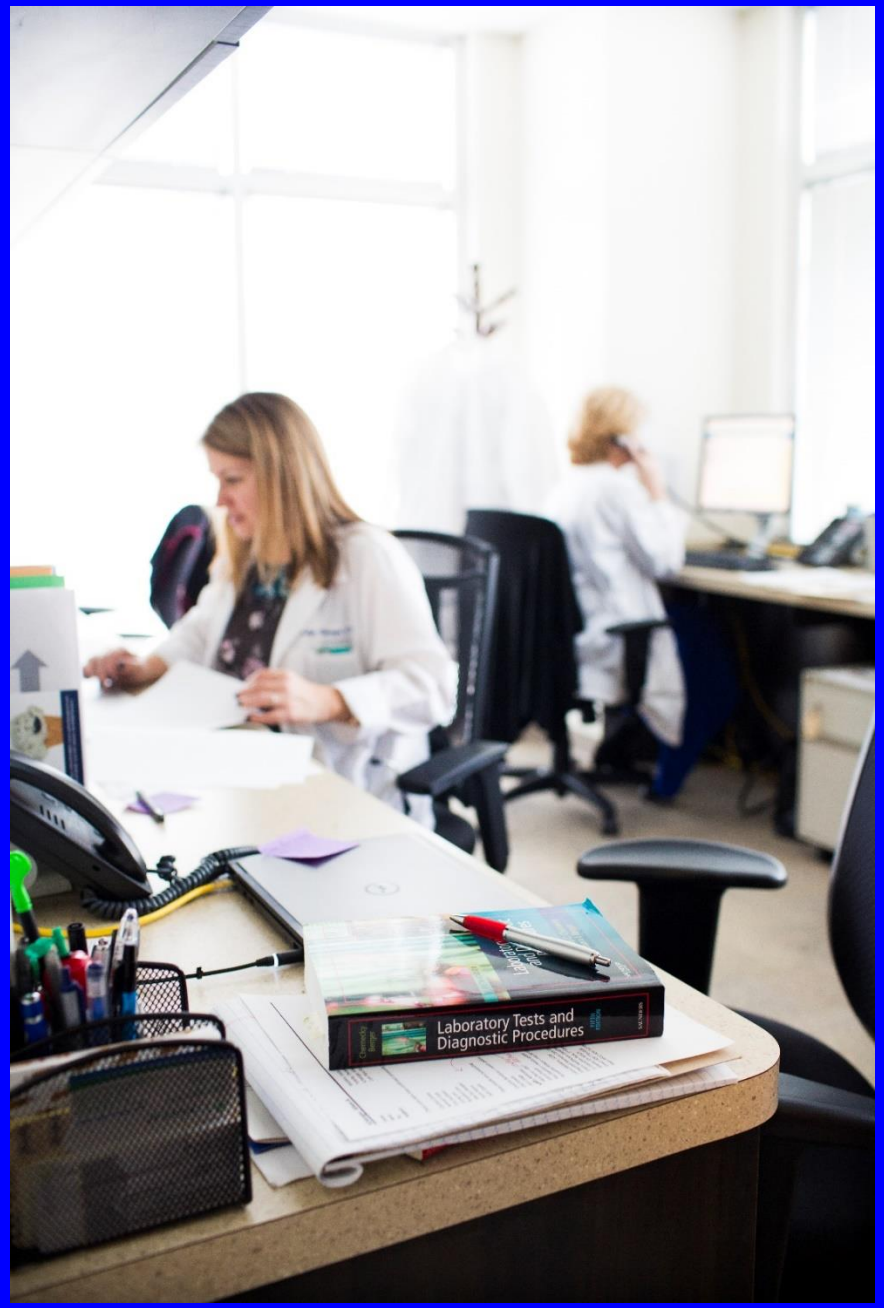
Aggressive symptom management to improve quality of life

Including neurological and geriatric psychiatry care

“Primary Care for People Living with Dementia”

INTEGRATED MEMORY CARE CLINIC

A nurse-led medical home for people with dementia and their caregivers



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.

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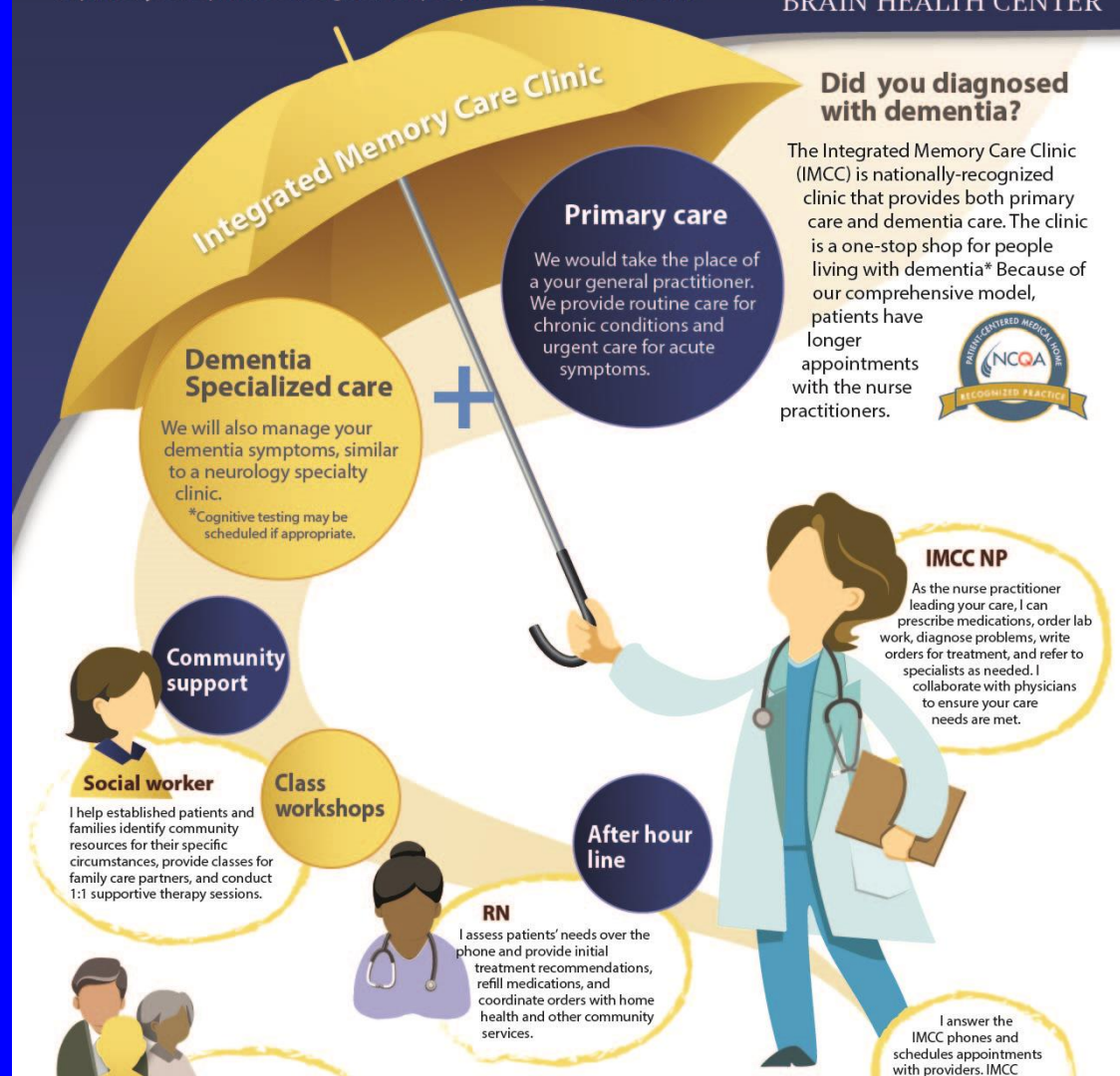
Emory Integrated Memory Care Clinic (IMCC)

A primary care practice designed for people living with dementia

EMORY BRAIN HEALTH CENTER



Did you diagnosed with dementia?

The Integrated Memory Care Clinic (IMCC) is 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.

How to star dementia care with IMCC?

Call us. Our PCC 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.

404-712-6929

https://www.emoryhealthcare.org/imcc

I answer the IMCC phones and schedules appointments with providers. IMCC patients call the PCC instead of Emory's call center.

Pt. coordinator

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

MULTI-DISCIPLINARY CARE TEAM:

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

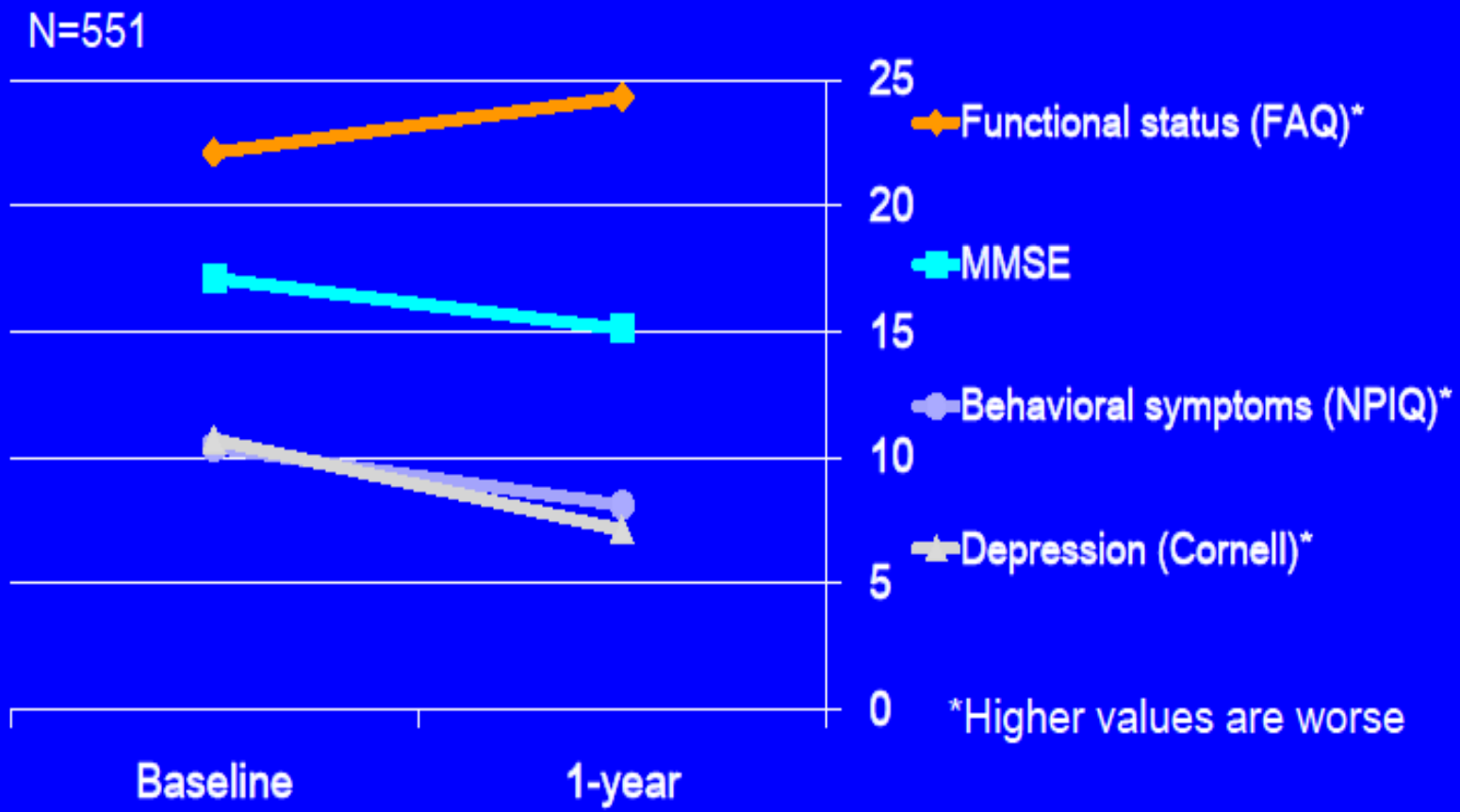
The UCLA Alzheimer's and Dementia Care Program

- 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

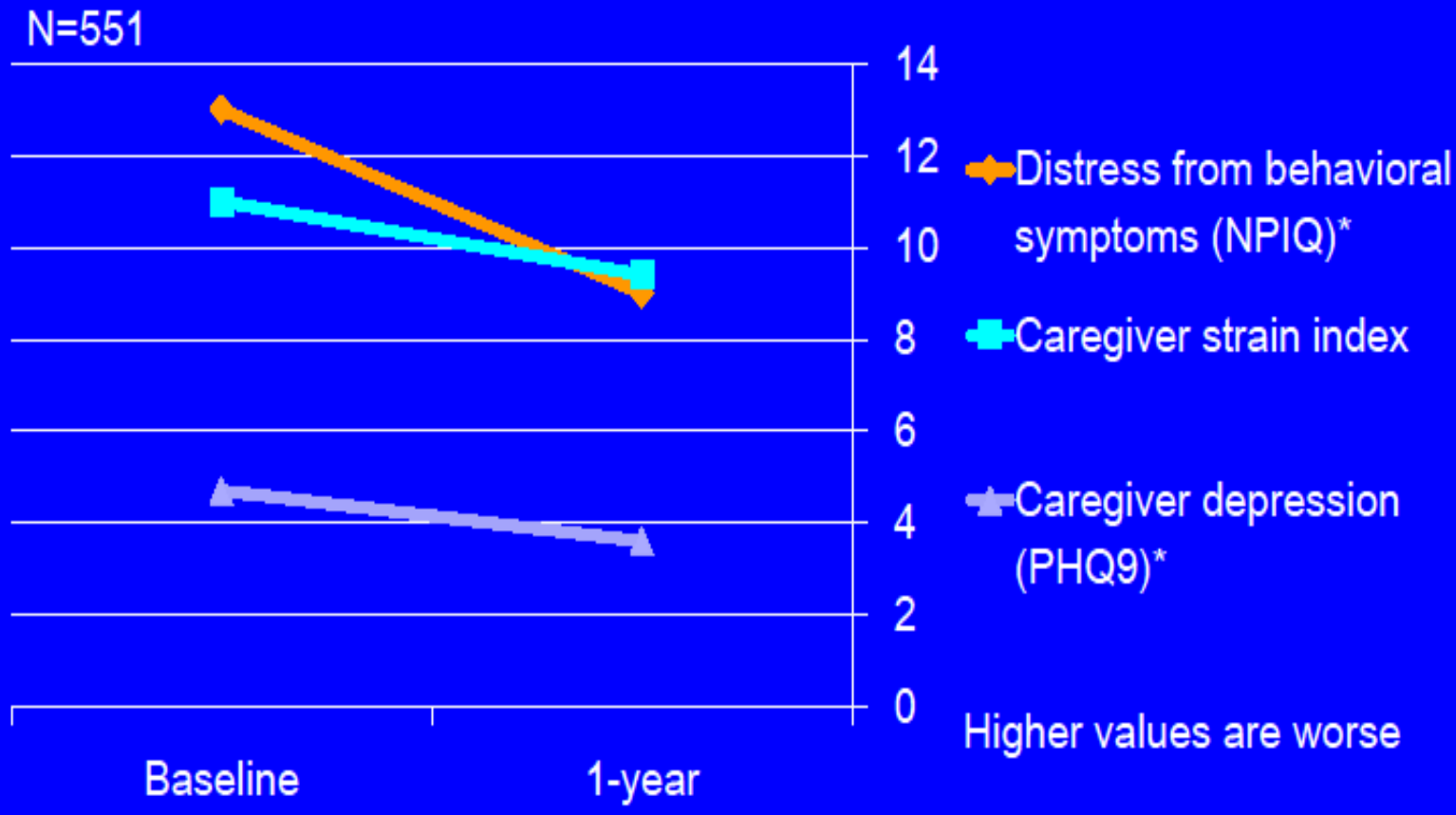
- DCM works with physicians to care for patients by:
  - Conducting in-person needs assessments
  - Developing and implementing individualized dementia care plans
  - Monitoring response and revising as needed
  - Providing access 24 hours/day, 365 days a year
- Caseload 250-300 patients

1-year Outcomes: Patients



For all baseline and year 1 comparisons, $p<0.001$.

1-year Outcomes: Caregivers



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

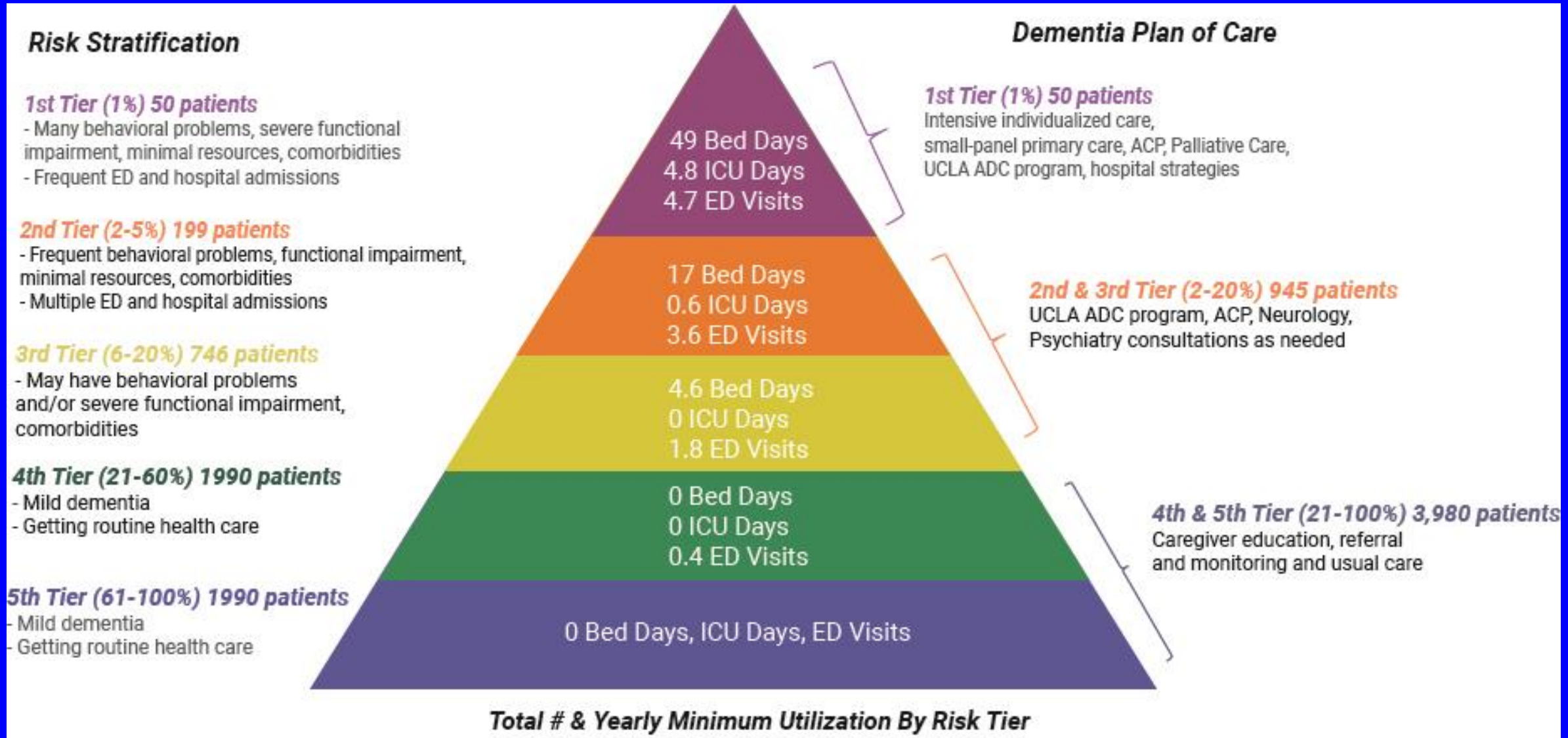
Utilization and Costs

- 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



Dementia Care Pathway Initiatives

Tiers	Initiatives
1 (Top 1%)	• Referrals to Extensivist 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 models are effective and choices should be guided by the population served, local resources, and institutional goals.

Questions