



**Specialized Co-Management Care for
People Living With Dementia**

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Financial Disclosures

- Michelle Moccia, DNP, ANP-BC, GS-C
 - Genentech
- Michelle Panlilio, DNP, GNP-BC
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Speakers

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Learning Objectives

At the end of this presentation, learners will	Describe the benefits of a co-management comprehensive dementia care model across settings and during transitions of care.
	Identify at least three assessment practice changes of persons living with dementia and their caregivers.
	Name at least three geriatric management approaches to persons living with dementia and their caregivers.

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Polling question: What best describes your place of employment?

- A. Long Term Care/Skilled Nursing Facility
- B. Assisted Living/Board & Care Facility
- C. Hospital
- D. Independent Living
- E. Continuum of Care
- F. Home care
- G. Group Home
- H. Other

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Case Study

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The patient: Mr. Harold

- 82 y/o year old Caucasian male with Late Onset Alzheimer's Dementia with an estimated onset x 4 years
- Lives alone in NY
- Past Medical History
 - Late Onset Alzheimer's Dementia
 - Anxiety
 - Depression
 - Hypertension
 - Cataracts
 - Hyperlipidemia

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Medication List

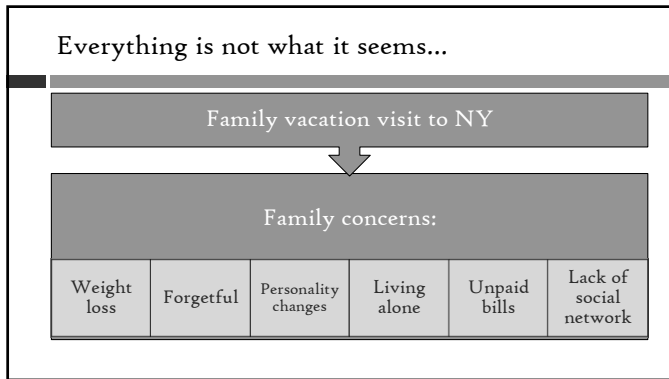
- Donepezil 10 mg po qhs
- Cholecalciferol 2,000 units po qd
- Simvastatin 40 mg po qhs
- Trazodone 25 mg po qhs
- Vitamin b-12 1,000 mcg qd

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Psychosocial History

Retired	<ul style="list-style-type: none"> • Congressman and attorney
Family Unit	<ul style="list-style-type: none"> • Single • 1 brother (Frank) and 2 nieces (Jeannie and Christina)
Sexuality	<ul style="list-style-type: none"> • Family believed he was homosexual
Finances	<ul style="list-style-type: none"> • Managed independently • Pension, SS, savings, investments, and long-term care insurance

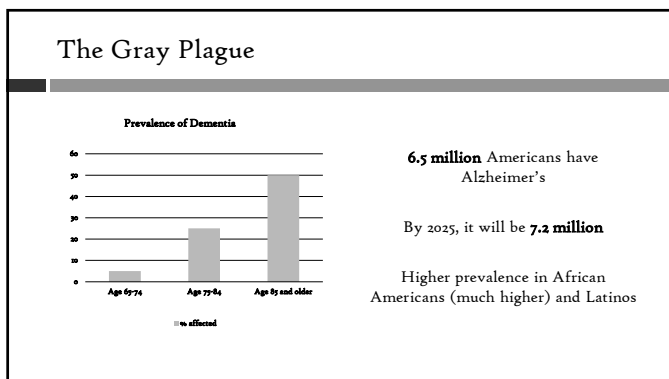
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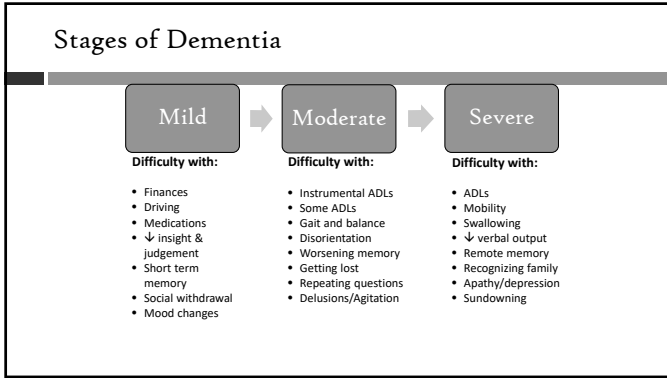
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The Clinical Problem:
Late Onset Alzheimer's Dementia

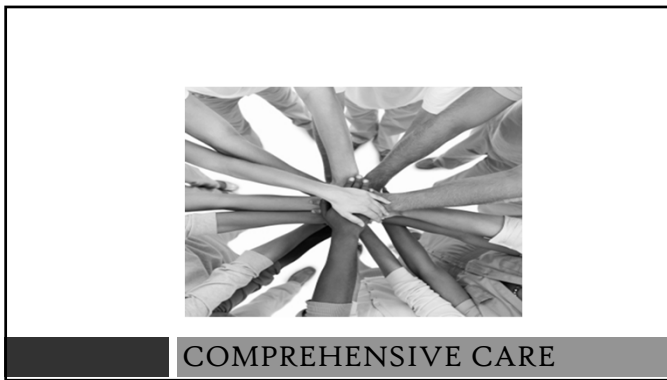
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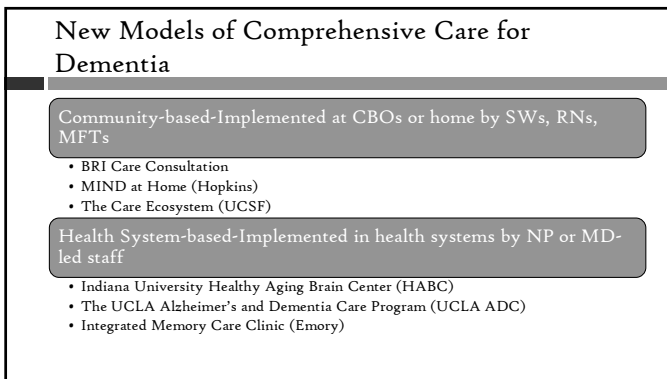
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How Comprehensive Care Models Differ

 STAFFING	 BASE OF OPERATIONS	 SCOPE OF SERVICES	 INTENSITY	 COST
	 EFFICACY OR EFFECTIVENESS (PRAGMATISM)	 POTENTIAL ROI	 LEVEL OF EVIDENCE	

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The UCLA Alzheimer's and Dementia Care Program

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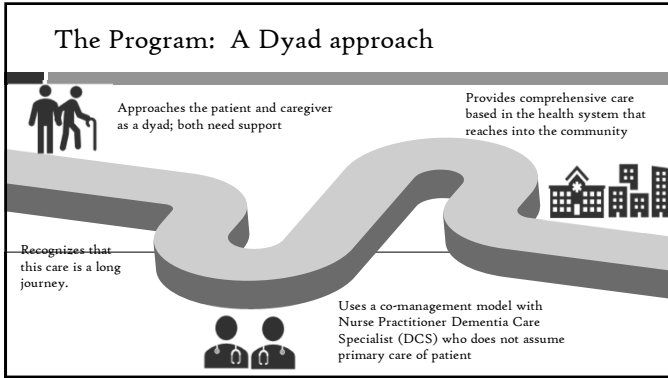
The UCLA Alzheimer's and Dementia Care Program

Mission: To partner with families, physicians, and community organizations to:

- maximize person living with dementia function, independence, and dignity,
- while minimizing caregiver strain and burnout
- Reduce unnecessary costs

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- ### The UCLA Alzheimer's and Dementia Care Program Benefits
- Co-Management model of dementia care
 - Works with primary care and specialty physicians to care for patient-caregiver dyads 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

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- ### Community-Based Organizations (CBOs) Partnerships
- Services for patients:
 - Adult day services
 - Programs for enhancing brain health (for early stage memory loss)
 - Services for families/caregivers:
 - Education (workshops, classes, informational sessions, handouts)
 - Counseling and peer-to-peer support
 - Case management
 - Legal and financial counseling
 - Support groups

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What is a Dementia Care Specialist?

- Advance Practice Provider
 - Nurse Practitioner, Clinical Nurse Specialist (with prescribing authority), Physician Assistant
- Healthcare system-based, outpatient clinic setting
- Dementia Care Co-Management along with the individual's medical team (e.g., Primary Care, Neurologist, Psychiatrist)
- Each DCS follows approximately 250 patients

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DCS Training

- GAPNA: 22 on-line training modules created by expert clinicians
- To precede in-person skills training
 - Provides additional knowledge in order to provide high quality dementia care management
 - Convenient, complete at your own pace format
 - Continuing education hours
 - Supported by the JAHF



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ADC Program: Core Elements

- Staffing
 - Advance Practice Nurse
 - Medical Director
 - Dementia Care Assistant
 - Program Manager
- Longitudinal Dementia Care
- 24/7 coverage
- Infrastructure and support
 - Access to EHR
 - EHR modified to support dementia care work
 - Linkages to community-based services

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Comprehensive Dementia Care Management

- Focused on the patient and caregiver “dyad”
 - Continuous monitoring and assessment
 - Ongoing “age-friendly” care plans
 - Medication management
 - Psychosocial Interventions for dyad
 - Coordinated care
 - Transitions of care (palliative care, hospice)
 - Emergency Room Visits
 - Inpatient hospitalizations

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ADC Program Outcomes

Type of Care Impact

- Hospitalizations ▼ 12%
- ED visits ▼ 20%
- ICU stays ▼ 21%
- Hospital days ▼ 26%
- Hospice in last 6 months ▲ 60%

ADC Program

Based on the UCLA experience, implementing the ADC Program has led to the following outcomes:

79%

Improvement in compliance to dementia care standards

92%

ICU dementia quality indicator met

61%

Reduction at 1 year

\$2404

Average Medicare hospital per year per patient

40%

Reduction in long-term nursing home placements

64%

Reduction at 1 year

More than 5000

People living with Alzheimer's and other dementias and their loved ones served by the UCLA ADC Program since 2012.

*p<.05
Based on NORC external evaluation of CMMI Award using fee-for-service claims data and UCLA ADO data September 2015- September 2017

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Mr. Harold establishes care with ADC program

Initial Assessment

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Cognitive Assessment

Imaging

- MRI BRAIN: No evidence of acute ischemia/infarct, intracranial hemorrhage, mass effect, or hydrocephalus.
- CT Brain: No acute intracranial hemorrhage, mass effect, or hydrocephalus.

MMSE: 23/30

- Missed: 1 minute recall items, date, day of the week, city, & state

MOCA: 22/30

- Missed: 4 items for recall, date, day of the week, city, state,

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Functional Assessment

Task	No Help Needed	Help Needed	Who Helps?
Basic ADLs			
feeding	•		
getting from bed to chair	•		
getting to the toilet	•		
getting dressed	•		
brushing or showering	•		
walking across the room (includes long canes or walker)	•		
Lawton IADLs			
using the telephone		•	
taking your medicines		•	
preparing meals		•	
managing money (like keeping track of expenses or paying bills)		•	
Moderately strenuous housework such as doing the laundry		•	
shopping for personal items like clothes or medicines		•	
shopping for groceries		•	
driving		•	
transferring a flight of stairs		•	
getting to places beyond walking distance (e.g. by bus, taxi, or car)		•	

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Neuropsychiatric Assessment

- Neuropsychiatric Symptoms
 - Depression
 - Cornell Scale for Depression in Dementia: 11/38
 - Neuropsychiatric Inventory Scale (NPI-Q)
 - *** Indicates positive scores on behavioral disturbance

NPI-Q	
Delusions ***	Disinhibition ***
Hallucination	Euphoria/Elation
Agitation ***	Irritability
Depression	Motor Disturbances
Anxiety	Appetite Changes ***
Apathy	Sleep Disturbances

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Poll

- Do you use a tool to evaluate caregiver stress and depression?
 - Yes
 - No
 - N/A (Do not have interactions with caregivers)

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The Caregiver: Niece Jeannie

- Relationship:
 - Niece from Los Angeles, CA
 - DPOA for health and finances
- Distress & Strain
 - PHQ-9: **2**
 - Modified Caregiver Strain Index: **14/26**

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Jeannie's Testimony (Interval History)

New Safety Concerns Emerge

- Wandering
- Agitation & Aggression
- Disinhibition
 - Sexually-inappropriate comments to female staff
 - Food handling in cafeteria

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Poll

The organization where I work invests in LGBTQ+ education program.

- Strongly agree
- Agree
- Neither agree or disagree
- Disagree
- Strongly disagree

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Poll

During the initial resident's intake, how likely is the patient asked their preferred pronoun (she/her, him/his, they/them)?

- Highly likely
- Very likely
- Somewhat likely
- Not at all likely

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LGBTQ+ older adults

- By 2030, estimated 7 million LGBTQ+ adults 65 or older in the U.S. (National Resource Center on LGBT Aging, 2013).
- The plus (+) is added to be inclusive of other identities along the LGBTQ+ spectrum
- Sexual & Gender Minority "SGM" - inclusive term (NIH)
- Designated as health disparity population for NIH and AHRQ research [\(NIH Office of Minority Research and Health Disparities\)](#)

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LGBTQ+ Healthcare concerns

Single, live alone, no children	Lack of family involvement	Financial insecurity	Provider knowledge gaps
Discrimination, provide bias, negative experience	Deter seeking healthcare – poor physical health	Isolation, depression, smoke, substance abuse	Go back in the closet

Legacy Giving and Facts on LGBT Aging Infographics (sageusa.org)

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Where do we go from here? Management

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Care Plan Recommendations

- Medical Management
 - Late onset Alzheimer's
 - Depression/Anxiety
 - HTN
 - HLD
 - Advance Care Planning
 - Referral to Psychiatry (after a few years)

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Care Plan Recommendations (cont.)

- Behavioral Management
 - Family discussions about elevating his level of care (memory care)
 - Coordinating care with ALF/memory care
 - Behavioral Modifications

- Social Management (For the caregiver)
 - Support Groups
 - Private Counseling
 - Case Management

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Advance Care Planning

DPOA

- Niece Jeannie

Goals of Care

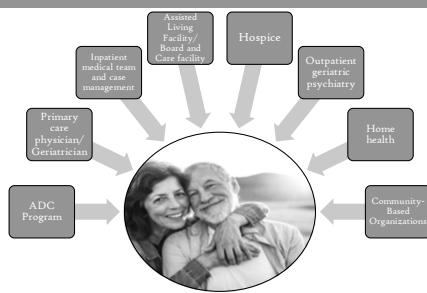
- Stay at his facility and be close to family

POLST Form

- Full code (at the time of initial assessment)

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Coordinating Dementia Care takes a village...



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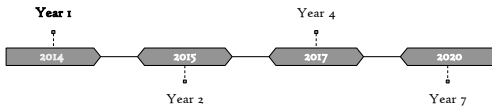


Long Term Management

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1 year after establishing care with ADC

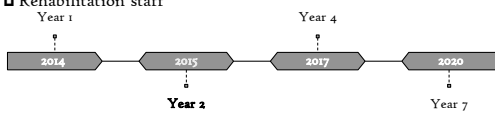
- Worsening behavioral issues
 - Behavioral modifications for the family and staff
- ADC coordination
 - Psychotropic medications
 - Transition to memory care
 - Grief Counseling for Jeannie



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2 years after establishing care with ADC Program...

- Fall in memory care, hospitalized for hip fracture and delirium
- ADC coordination
 - Psychotropic medications
 - Inpatient medical/surgical team and case management
 - Referral to geriatric psychiatry
 - Rehabilitation staff



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4 years after establishing care with the ADC Program...

- Worsening behavioral issues
 - Verbal threats to staff and refusing care
- Medications:
 - Donepezil 10 mg po qhs
 - Namenda 10 mg bid
 - Mirtazapine 15 mg po qhs
 - Gabapentin 100 mg bid
 - Olanzapine 5 mg po bid
- Inpatient psychiatric hospitalization for 2 weeks

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7 years later after establishing care: The final transitions of care

"Our ultimate goal after all, is not a good death but a good life to the very end" (Atul Gawande)

- Significant cognitive and functional decline
 - Moved to Board and Care Facility
 - Hospice care for 6 months
 - Much of the last few months were spent with family, passed away peacefully

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Documentation and Billing

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Billing: 99483 Code

- Initial Consult
 - 99483 Cognitive Assessment and Care Planning - Permanently added to the Medicare Telehealth list
 - 99354: For extended office visit (30 min increments), time beyond the primary visit code

<p>Service elements of CPT code 99483</p> <p>Cognitive focused evaluation, including a pertinent history and examination of the patient</p> <p>Medical decision making of moderate or high complexity (defined by the DSM guidelines)</p> <p>Functional assessment (for example, Basic and Instrumental Activities of Daily Living), including decision-making capacity</p> <p>Use of standardized instruments to stage dementia</p> <p>Medication reconciliation and review for high-risk medications, if applicable</p> <p>Evaluation for neuropsychiatric and behavioral symptoms, including depression and including use of standardized instruments</p>	<p>Evaluation of safety (for example, home safety), including motor vehicle operation, if applicable</p> <p>Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports and the willingness of caregiver to take on caregiving tasks</p> <p>Development, updating or revision, or review of an Advance Care Plan</p> <p>Creation of a care plan, including initial plans to address any neuropsychiatric symptoms and related to community resources as needed (for example, adult day programs and support groups), the care plan must be shared with the patient and/or caregiver at the time of evaluation and support</p>
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Billing: Ongoing care

99211-99215	99441-99443	99490	99358
In-person or telemedicine	Telephone Visits	Chronic Case Management	Non Face-to-face Prolonged Services (30 mins)

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ADC Program Dissemination

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The Power of Philanthropy

2019
3-year grant to:

- Implement the UCLA ADC program in 8- to health systems outside of UCLA
- Work with GAPNA to educate nurse practitioners to fulfill DCS roles
- Work with partners to promote payment changes

2022
3-year grant to:

- Create ADC Dissemination Center at UCLA
- Create a National Dementia Care Learning Collaborative
- Implement the UCLA ADC program in an additional 50 health systems beyond UCLA

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Dissemination Sites

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ADC Program Dissemination

- Education Development Center (EDC)
- American Geriatric Society
- GAPNA
- Alzheimer's Association
- IHI Age friendly health Systems
- CDC
- LEAD Coalition
- Milken Alliance

To learn more about establishing ADC at your site, our services, and pricing, contact us at info@adcprogram.org or visit our website, <https://www.adcprogram.org/>

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What did we learn?

- “Usual care” is not enough
- A co-management model of dementia care supports the patient and their family through the journey
- Billing codes to support a co-management model of dementia care has come a long way, however, is still a work in progress
- Providing dementia care through a medical model can reduce expenses for healthcare systems and the nation

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Questions?
Thank you!

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