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Specialized Co-Management Care for People Living With Dementia

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The John A. Hartford Foundation

ADC Alzheimer's and Dementia Care PROGRAM

UCLA Health

Financial Disclosures

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- Michelle Moccia, DNP, ANP-BC, GS-C
  - Genentech
- Michelle Panlilio, DNP, GNP-BC
  - Biogen, Eisai, Genentech, & Sunbird Bio

Speakers

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- Michelle Moccia, DNP, ANP-BC, GS-C
  - Independent Gerontology Consultant

- Michelle Panlilio, DNP, GNP-BC
  - UCLA Alzheimer's and Dementia Care Program
  - National Lead Dementia Care Specialist

Learning Objectives

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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.

Polling question: What best describes your place of employment?

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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

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

Medication List

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

Psychosocial History

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Retired	• Congressman and attorney
Family Unit	• Single • 1 brother (Frank) and 2 nieces (Jeannie and Christina)
Sexuality	• Family believed he was homosexual
Finances	• Managed independently • Pension, SS, savings, investments, and long-term care insurance

Everything is not what it seems…

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Family vacation visit to NY

Family concerns:

Weight loss	Forgetful	Personality changes	Living alone	Unpaid bills	Lack of social network

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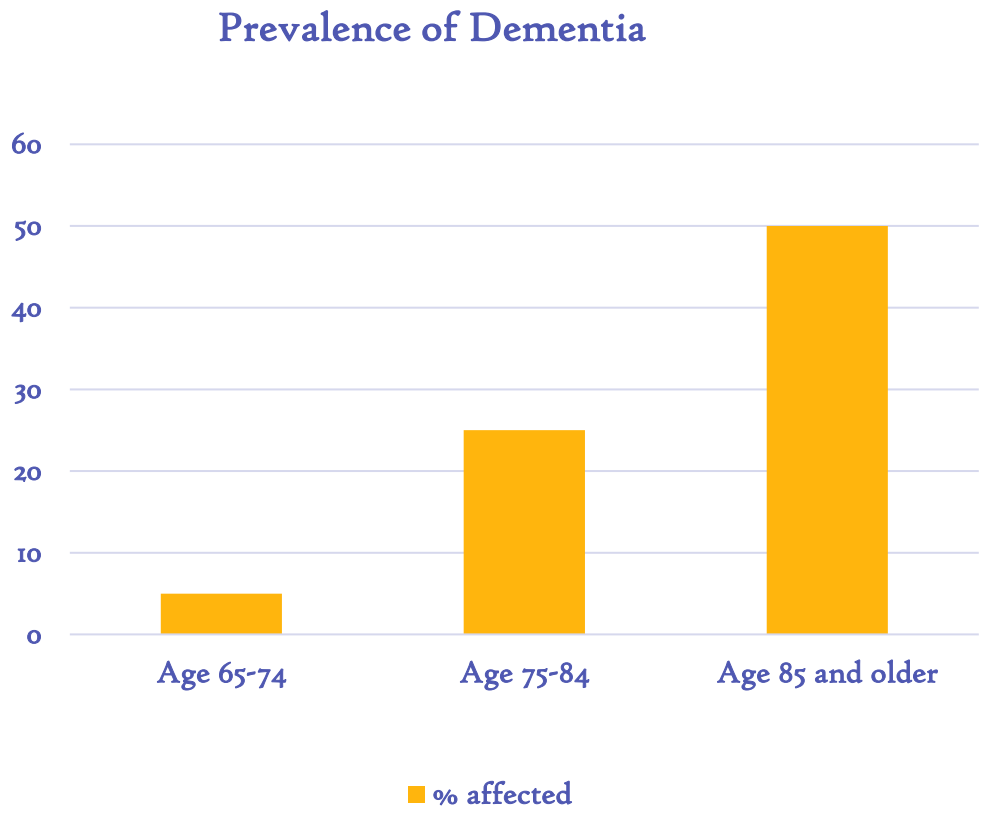
The Clinical Problem: Late Onset Alzheimer's Dementia

The Gray Plague



6.5 million Americans have Alzheimer's

By 2025, it will be **7.2 million**

Higher prevalence in African Americans (much higher) and Latinos

Stages of Dementia

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Mild

Difficulty with:

- Finances
- Driving
- Medications
- ↓ insight & judgement
- Short term memory
- Social withdrawal
- Mood changes

Moderate

Difficulty with:

- Instrumental ADLs
- Some ADLs
- Gait and balance
- Disorientation
- Worsening memory
- Getting lost
- Repeating questions
- Delusions/Agitation

Severe

Difficulty with:

- ADLs
- Mobility
- Swallowing
- ↓ verbal output
- Remote memory
- Recognizing family
- Apathy/depression
- Sundowning

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COMPREHENSIVE CARE

New Models of Comprehensive Care for Dementia

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Community-based-Implemented at CBOs or home by SWs, RNs, MFTs

- BRI Care Consultation
- MIND at Home (Hopkins)
- The Care Ecosystem (UCSF)

Health System-based-Implemented in health systems by NP or MD-led staff

- Indiana University Healthy Aging Brain Center (HABC)
- The UCLA Alzheimer's and Dementia Care Program (UCLA ADC)
- Integrated Memory Care Clinic (Emory)

How Comprehensive Care Models Differ

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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

The UCLA Alzheimer's and Dementia Care Program

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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

The Program: A Dyad approach

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Approaches the patient and caregiver as a dyad; both need support

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

Recognizes that this care is a long journey.

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 Benefits

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- *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

Community-Based Organizations (CBOs) Partnerships

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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

What is a Dementia Care Specialist?

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- 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

DCS Training

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- 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

ADC Program: Core Elements

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- 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

Comprehensive Dementia Care Management

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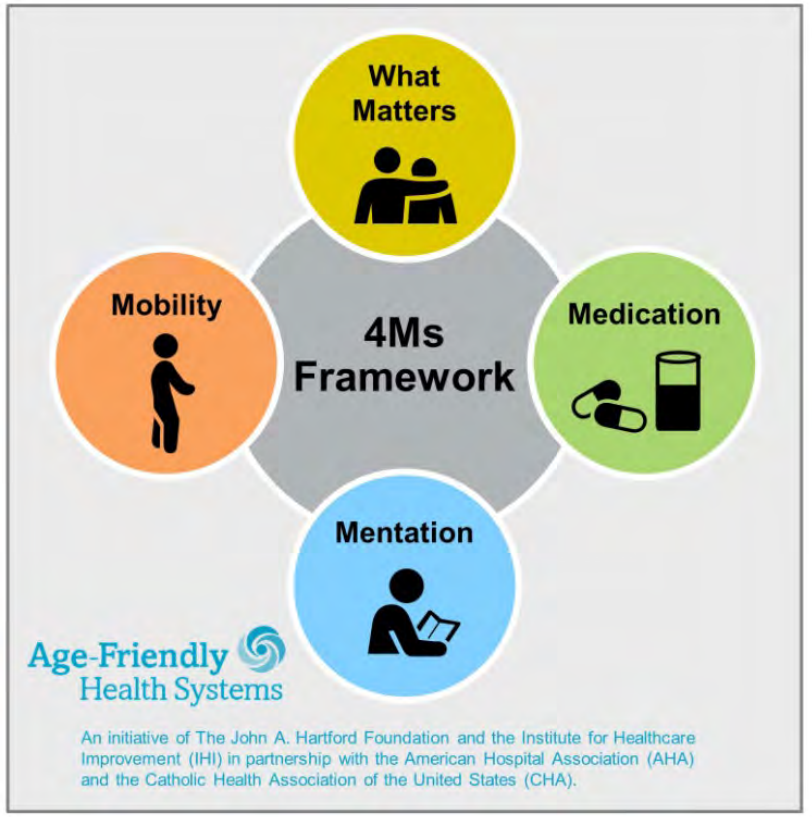
- Focused on the patient and caregiver "dyad"
  - Continuous monitoring and assessment
  - Ongoing "age-friendly" care plans
  - Medication management
  - Psychosocial Interventions for dyad
  - Coordinated care
    - Transitions of care (palliative care, hospice)
    - Emergency Room Visits
    - Inpatient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



ADC Program Outcomes

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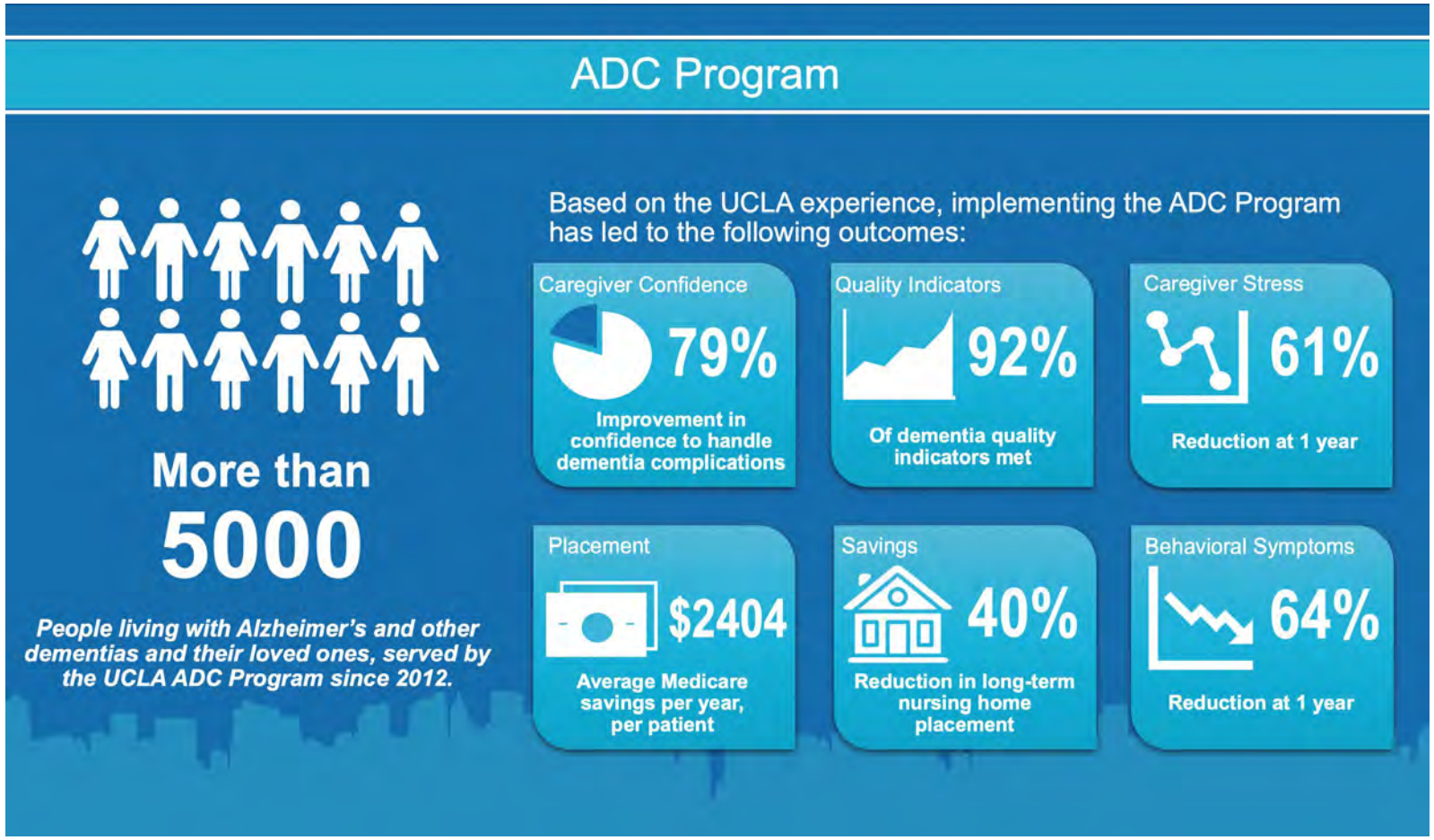
Type of Care Impact	
Hospitalizations	▼ 12%
ED visits	▼ 20%*
ICU stays	▼ 21%
Hospital days	▼ 26%*
Hospice in last 6 months	▲ 60%*



* p<.05

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

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Mr. Harold establishes care with ADC program

Initial Assessment

Cognitive Assessment

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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,

Functional Assessment

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Task	No Help Needed	Help Needed	Who Helps?
Katz ADLs			
Feeding	●		
Getting from bed to chair	●		
Getting to the toilet	●		
Getting dressed	●		
Bathing or showering	●		
Walking across the room (includes using cane 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 toiletries or medicines		●	
Shopping for groceries		●	
Driving		●	
Climbing a flight of stairs		●	
Getting to places beyond walking distance (e.g. by bus, taxi, or car)		●	

Neuropsychiatric Assessment

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- 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

Poll

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

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**

Jeannie's Testimony (Interval History)

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New Safety Concerns Emerge

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

Poll

- The organization where I work invests in LGBTQ+ education program.
  - Strongly agree
  - Agree
  - Neither agree or disagree
  - Disagree
  - Strongly disagree

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 Sexual & Gender Minority Research Office | DPCPSI (nih.gov)

LGBTQ+ Healthcare concerns

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Single, live alone, no children	Lack of family involvement	Financial insecurity	Provider knowledge gaps
Discrimination, pro vide 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

Care Plan Recommendations

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

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

Advance Care Planning

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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)

Coordinating Dementia Care takes a village...

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Long Term Management

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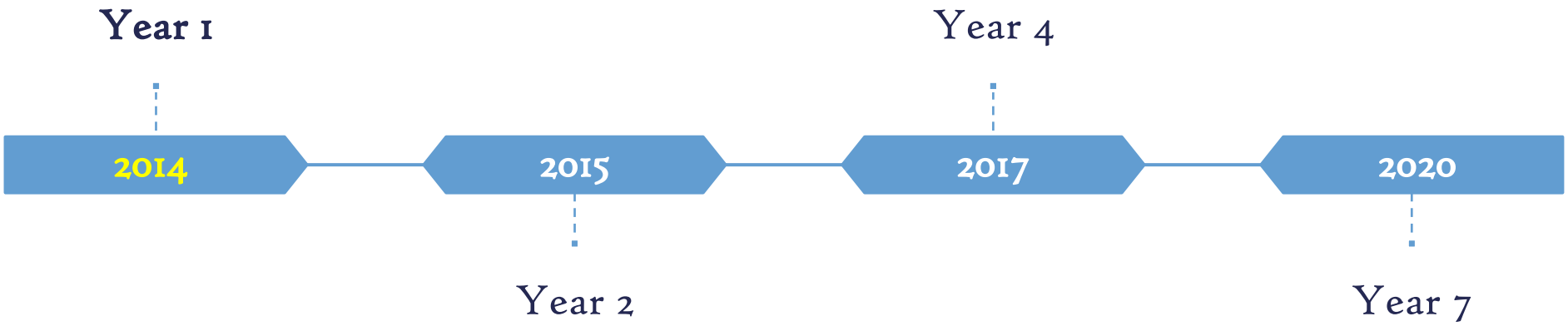
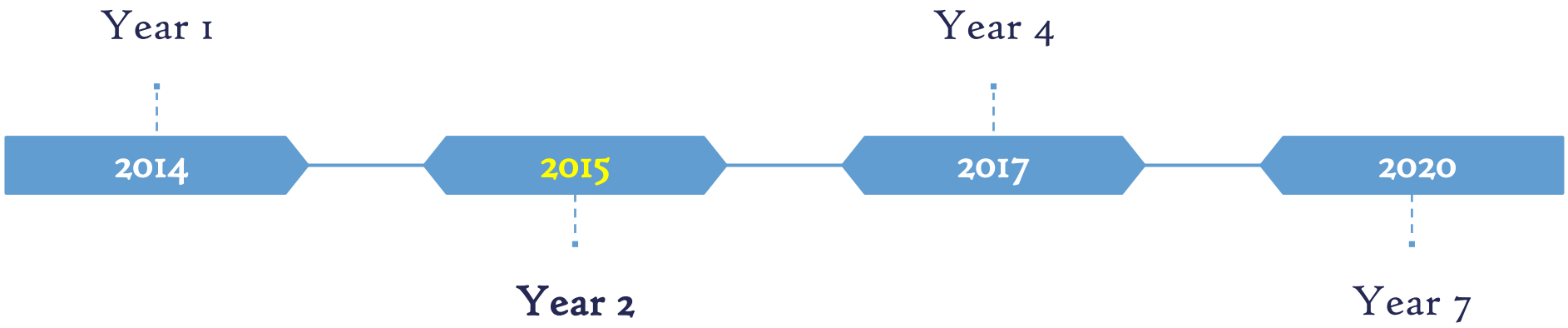
1 year after establishing care with ADC

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



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



4 years after establishing care with the ADC Program…

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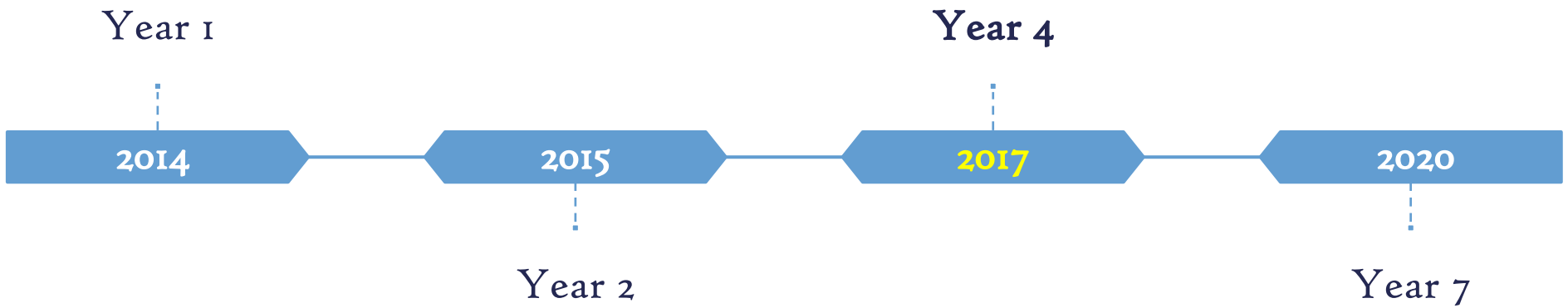
- Worsening behavioral issues
  - Verbal threats to staff and refusing care
- Medications:
  - Donepezil 10 mg po qhs
  - Namenda 10 mg bid
  - Mirtazapine 15 mg po qhs
  - Gabapentin 100 mg bid
  - Olanzapine 5 mg po bid
- Inpatient psychiatric hospitalization for 2 weeks



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

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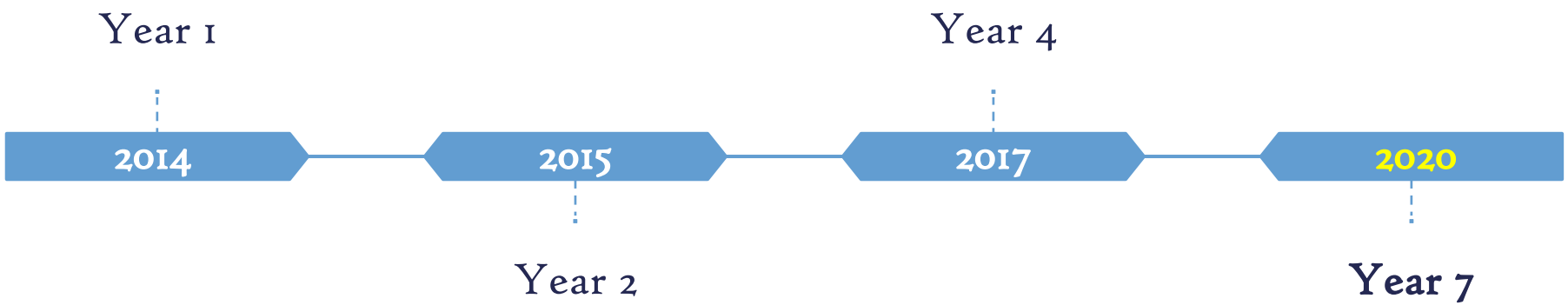
"Our ultimate goal after all, is not a good death but a good life to the very end" (Atul Gawande)

- 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

Billing: 99483 Code

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- 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

Service elements of CPT® code 99483
Cognition-focused evaluation, including a pertinent history and examination of the patient
Medical decision making of moderate or high complexity (defined by the E/M guidelines)
Functional assessment (for example, Basic and Instrumental Activities of Daily Living), including decision-making capacity
Use of standardized instruments to stage dementia
Medication reconciliation and review for high-risk medications, if applicable
Evaluation for neuropsychiatric and behavioral symptoms, including depression and including use of standardized instruments
Evaluation of safety (for example, home safety), including motor vehicle operation, if applicable
Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports and the willingness of caregiver to take on caregiving tasks
Development, updating or revision, or review of an Advance Care Plan
Creation of a care plan, including initial plans to address any neuropsychiatric symptoms and referral 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 initial education and support

Billing: Ongoing care

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

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ADC Program Dissemination

The Power of Philanthropy

The John A. Hartford Foundation

2019

3-year grant to:

- Implement the UCLA ADC program in 8-10 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

Dissemination Sites

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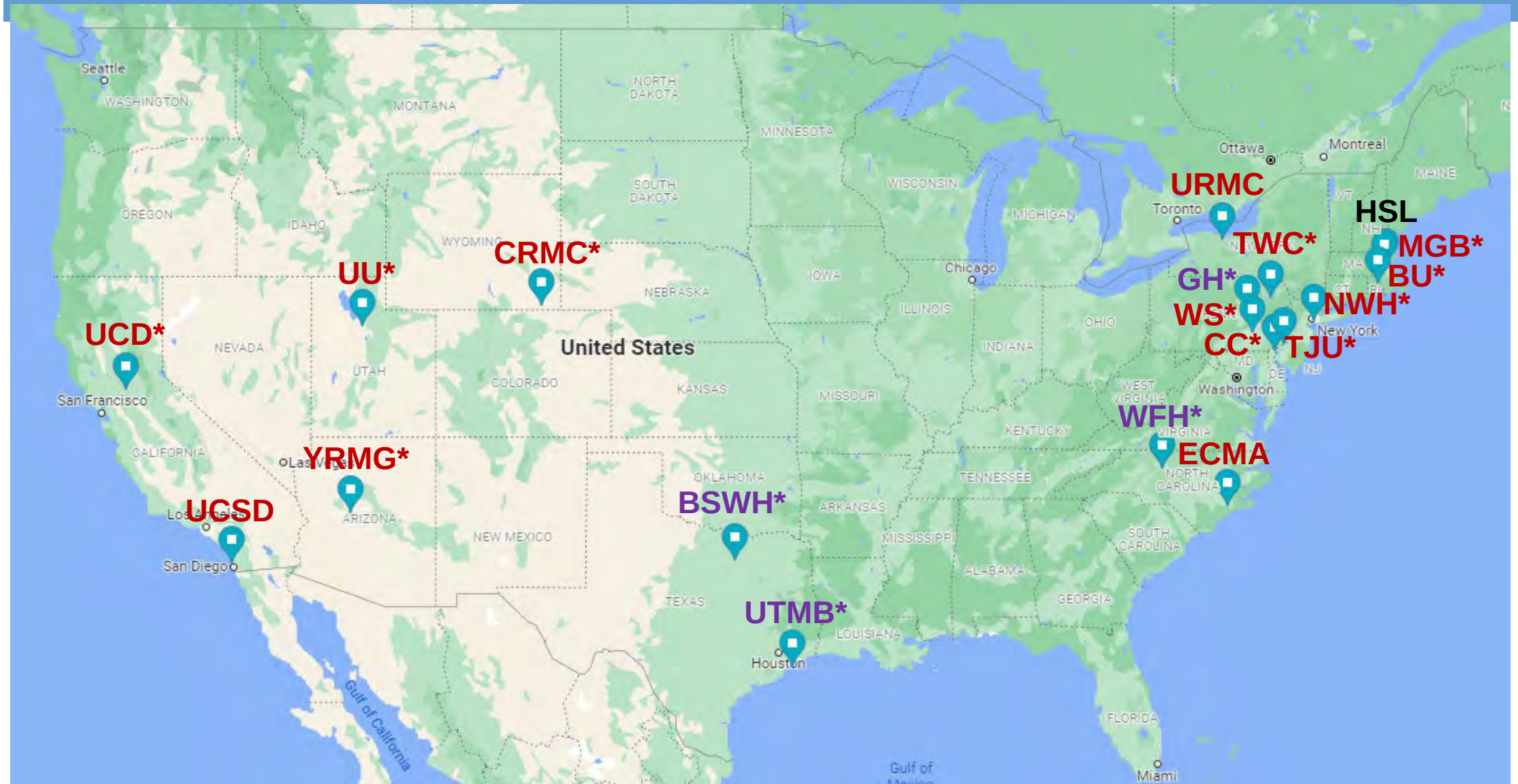

ADC Program Dissemination

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

What did we learn?

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- "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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