Practice Redesign for Dementia: The UCLA Alzheimer's and Dementia Care Program

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Disclaimer

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Outline

• Overview of practice redesign
• Challenges and opportunities in delivering dementia care in a large academic health system
• The UCLA Alzheimer’s and Dementia Care Program
• Program outcomes thus far
The Silver Tsunami: Average Life Expectancy

By 2050, People Age 65 and Older Will Equal 20% of the Population
U.S. Population (and Forecast) by Age Category and Gender

1900
U.S. Population: 76 Million

1960
U.S. Population: 151 Million

2000
U.S. Population: 281 Million

2025
Population (forecast): 340 Million

2050
Population (forecast): 392 Million

Average Life Expectancy

- M
46.3
- F
73.1

- M
66.6
- F
79.3

- M
74.1
- F
83.6

- M
77.6
- F
86.6

- M
81.2
- F
86.6

Source: U.S. Census Bureau
The Gray Plague

• Prevalence of dementia

<table>
<thead>
<tr>
<th>Age range</th>
<th>% affected</th>
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<tbody>
<tr>
<td>– 65-74</td>
<td>5%</td>
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<tr>
<td>– 75-84</td>
<td>15-25%</td>
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<tr>
<td>– 85 and older</td>
<td>36-50%</td>
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• 5.2 million Americans have Alzheimer’s (5.1 million with heart failure)
The Dementia Quality Problem

- Poor quality of care: 38-44% of ACOVE Quality Indicators met
  - Cognitive evaluation if pos screen (25%)
  - Checking medications (9%)
  - Caregiver support (29%)
  - Monitoring for Behavioral/Psychological sx (45%)
- Poor linkages to community-based resources
The Consequences

• $130 billion in health care (2011)
• 3 x hospital stays
• Higher medical provider, nursing home, home health, and prescription costs
• 15 million caregivers provided 17 billion hours of care worth $203 billion (2010)
• Cost per person attributable to dementia:
  – $2752/year (2010 Medicare costs)
  – $41,689-$56,290/year (total costs)
Practice Redesign

• Aims to improve quality and/or increase efficiency by:
  – Fixing a problem or inefficiency in patient care
  – Using different people or people differently
  – Exploiting technology
A Model for Improving Chronic Illness Care

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Functional and Clinical Outcomes

Community

Resources and Policies

Health System

Organization of Health Care

Self-Management Support

Delivery System Design

Decision Support

Clinical Information Systems

Health System Resources and Policies

Community Organization of Health Care Delivery System Design

Clinical Information Systems

A Model for Improving Chronic Illness Care

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Functional and Clinical Outcomes
Co-management

- Two or more health care providers jointly managing the patient’s medical care to achieve the best quality and outcomes
- Many models, most focus on specific conditions (e.g., cancer, dementia) or on multiple conditions and coordination of care (e.g., Guided Care)
The UCLA Health System

- Ronald Reagan UCLA Medical Center
- UCLA Medical Center—Santa Monica
- Resnick Neuropsychiatric Hospital at UCLA
- UCLA Medical Plaza
- UCLA Medical Group
- Mattel Children’s Hospital
- David Geffen School of Medicine
UCLA Health System

- Serves the west Los Angeles & surrounding community
- 150 Primary care and Specialty Offices
- Regional referral center
Dementia Care at UCLA

• Great programs in geriatrics, geriatric psychiatry, dementia research
• Virtually no caregiver support
• Great programs in the community but no formal linkages
• Patients fall through the cracks
UCLA Alzheimer’s and Dementia Care

• Adapted to a large, academic health system
  – Competitive, fee-for-service environment
• Funded by philanthropy (Nov 2011), CMMI Innovation Award (June 2012), and UCLA Medical Center
• Administered from UCLA Geriatrics Division
  – Partnerships with Gen Med, Neuro, Psych, CBOs
Implementation

• Steering Committee & 7 Working Groups
  – Assessment
  – Software
  – Outcomes
  – Community-based organizations
  – Communications and referrals
  – Development
  – Media and marketing
UCLA Alzheimer’s & Dementia Care

- Medical
  - PCP
  - Neurologist
  - Psychiatrist
  - Specialists

- Social
  - Family
  - Paid Caregivers
  - Adult day care
  - Support groups
  - Financial planners
  - Legal
  - Spiritual

UCLA ADC
The Program: Key Components

1. Patient recruitment and dementia registry
2. Structured needs assessments of patients
3. Creation and implementation of individualized dementia care plans
4. Monitoring and revising care plans
5. 24/7, 365 days a year access for dementia assistance and advice
Recruitment and Registry

- Referrals from UCLA primary care and geriatrics practices
- Referrals from neurology, psychiatry and Alzheimer’s Disease Research Center
- Direct inquiries from patients
- Identification of patients through billing codes (ICD9 diagnosis codes) and problem lists
The UCLA Alzheimer’s and Dementia Care Program

• 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

• Co-management model that does not assume primary care of patient
Dementia Care Managers

• Geriatric nurse practitioners
• Expertise in dementia
  – Medical, behavioral, social issues
• Knowledge of community resources
• Familiarity with services offered by CBOs
• Supervised by a geriatrician
Patients

- Must have diagnosis of dementia
- Live outside nursing home
- Must have a referring UCLA physician
  - Referred spontaneously by physicians
  - Identified from EHR using problem lists
  - Presentations at practices
What the UCLA ADC provides
Needs Assessment

• Pre-visit questionnaires and instruments
• In-person, 90-minute visit with patient, family, and Dementia Care Manager
  – Cognitive assessment, including complications
  – Advance care planning
  – Financial and other resources
  – Discuss family concerns
  – Discuss services/programs
• Weekly supervision by Medical Director
The Care Plan: What Physicians get

• Draft care plan with specific recommendations through EHR in-basket
  – Medical (physician can accept or decline)
  – Education and social services (DCM does)
• Note in EHR
• Coordination of care and completing forms
• Phone call if there is a safety concern
• Periodic follow-up correspondence through EHR in-basket
The Care Plan: What Patients and Families Get

- Counseling and education
- Linkage to UCLA services
- Linkage to community-based services
- Ongoing follow-up at intervals determined by the care plan
- Usually first follow-up is within 1-2 weeks
- 24/7 access to help with dementia
UCLA Services

• Medication adjustments and medical recommendations related to dementia
• Advance care planning
• Specialty consultation
• Caregiver support and education
  – Patti Davis “Beyond Alzheimer’s” support group
  – UCTV video http://www.uctv.tv/alzheimers/
  – Webinars http://dementia.uclahealth.org/body.cfm?id=54
  – Caregiving 101 and videos
    http://dementia.uclahealth.org/body.cfm?id=68
UCLA Services

• Hospitalization, when needed
  – SM-UCLA Geriatrics Special Care Unit
  – Geriatric Psychiatry Unit at NPH
  – Structured discharge transition

• Referral to the Mary S. Easton Alzheimer’s Disease Research Center for appropriate clinical trials
Community-based organizations (CBOs)

- Alzheimer’s Association California Southland Chapter
- WISE and Healthy Aging
- OPICA Adult Day Care & Caregiver Support Center
- Leeza’s Place
- Jewish Family Service of Los Angeles
CBO Services

• Direct services to patients and families
• Workforce development focusing on training family and caregivers
• Paid for using voucher system with RFP
  – Liaison amount
  – Specific services
Monitoring

- All patients are seen at least yearly by Dementia Care Manager
- Most more frequently at intervals determined by the care plan
- Dementia Care Manager panel size = 250
Progress to date

- 1200 patients enrolled
- 214 referring physicians
- 342 of 482 patients seen for 1-year visit
- 47 of 73 patients seen for 2-year visit
Outcome Measures

• Better care
  – Process of care
  – Caregiver rating
  – Physician rating

• Better health
  – Neuropsychiatric symptoms
  – Function, depression, cognition
  – Caregiver depression/burnout

• Health utilization
Outcome Measures: Better Care

- Process of care
  - Previsit questionnaire
    - Who would you call if you were sick and needed help?
    - Do you have access to a medical professional for advice on dementia-related issues at all times (24 hours a day/7 days a week)?
  - Caregiver rating survey
  - Physician rating survey
Outcome Measures: Better Health

• Neuropsychiatric symptoms
  – NPI-Q, Cornell scale

• Function
  – Functional activities questionnaire

• Cognition
  – MMSE, MoCA

• Caregiver burnout
  – PHQ-9, Caregiver strain index
Outcome Measures: Utilization

- Emergency room visits
- Hospitalizations
- Nursing home placement
- Informal caregiver effort
Patients in Program

• Mean age 81.6; 66% female
• Diagnosis
  – Alzheimer’s disease: 40%
  – Lewy-Body: 3%
  – Vascular: 5%
  – Other, mixed or unknown: 48%
• Mean MMSE score 17.0
• Caregiver: 37% spouse, 51% child
Baseline Caregiver Findings

- Depressive symptoms; 14% moderate or severe
- Caregiver strain; 34% high stress
- 20% knew how to access community services
- 27% felt confident handling dementia problems
- 34% knew where to turn to for answers
- 77% felt patient's regular doctor understands
- 26% felt they have a healthcare professional who helps them work through dementia issues
Services Provided

- Referral to support groups: 76%
- Caregiver training: 60%
- Referral to Safe Return program: 64%
- Referral to CBO: 58%
- Medication adjustment: 22%
- Recommend for additional eval: 30%
- POLST: 20%
Caregiver Satisfaction

- 91% felt the intake visit was time well spent
- 93% felt concerns listened to and addressed
- 58% thought referral programs were helpful
- 74% thought educational materials were helpful
- 95% felt their caregiver role was supported
- 94% would recommend the program to others
Physician Satisfaction

- Valuable medical recommendations 58%
- Valuable behavioral recommendations 83%
- Valuable social recommendations 83%
- Enhanced MD relationship with patient 66%
- Saved MD time 60%
- Would recommend for other patients 87%
Caregiver Comments

• “Our DCM has supported us and provided us with resources and information that is invaluable. I wish more people had access to people like her and programs like this”

• “For a terrible situation, I always felt better after our visits and conversations. I wouldn't have made it through this year without both of you. Thank goodness your organization exists.”
Overall Dementia Quality of Care (ACOVE-3 and PCPI QIs)*

- Community-based physicians 38%
- Community-based physicians & NP 60%
- UCLA Alzheimer’s and Dementia Care 92%

* Based on medical record abstraction
The Quality Provided: % QIs passed

Annual cognitive assessment 94
Annual functional assessment 97
Medication review 99
D/c or justify meds w/ mental status changes 27
Labs done 82
Depression screening 99
Discussion about AchE inhibitors 86
Received CVA prophylaxis 73
Caregiver counseling 99
  Dx/prognosis/behavioral symptoms
  Safety
  Community resources
### The Quality Provided: QIs % passed

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screen for behavior symptoms</td>
<td>99</td>
</tr>
<tr>
<td>Behavioral interventions for symptoms:</td>
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</tr>
<tr>
<td>Behavioral</td>
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<tr>
<td>Psychological</td>
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<tr>
<td>Sleep</td>
<td></td>
</tr>
<tr>
<td>Risks/benefits new antipsychotic</td>
<td>50</td>
</tr>
<tr>
<td>Driving counsel</td>
<td>93</td>
</tr>
<tr>
<td>ID surrogate decision maker</td>
<td>97</td>
</tr>
<tr>
<td>Counseling about advance care planning</td>
<td>98</td>
</tr>
</tbody>
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1-year Outcomes: Patients

- MMSE
- Functional status*
- Depression*
- Behavioral symptoms*

* higher is worse

Baseline vs 1-year:
- MMSE: p<0.0001
- Functional status*: p<0.0001
- Depression*: p<0.0001
- Behavioral symptoms*: p=0.006
1-year Changes in Caregiver Experience and Self-efficacy

- Know how to get community services: Pre-ADC 40%, 1-year 60% (P<0.0001)
- Confident can handle dementia problems: Pre-ADC 30%, 1-year 50% (P<0.0001)
- Know where to turn to get answers: Pre-ADC 50%, 1-year 70% (p<0.0001)
- Have a healthcare professional who helps: Pre-ADC 20%, 1-year 60% (p<0.0001)
1-year Outcomes: Caregivers

- Caregiver strain
  - Baseline
  - 1-year
  - p=0.02

- Caregiver depression
  - Baseline
  - 1-year
  - p=0.0006

- Distress from behavioral symptoms
  - Baseline
  - 1-year
  - P<0.0001
Spinoffs

- UCLA Memory Evaluation program
- PCORI Methodology Grant
  - Goal Attainment Scaling
- Time Out: students doing recreational activities with seniors to provide respite
  [http://geronet.ucla.edu/timeout](http://geronet.ucla.edu/timeout)
- Archstone grant for caregiver training
- Dementia Care Software
Practice Redesign: Co-management

• Challenges
  – Defining scope of responsibility
    • Range of clinical problems
    • Dementia Care Manager versus primary care physician
    • Order writing
    • Acute clinical problems
  – Communication
    • With primary care physician
    • With other health providers (e.g., specialists, therapists)
Future of the UCLA ADC Program

• Following outcomes
• Examining utilization data
• Sustaining program beyond 6/30/2015
• Spreading the program beyond UCLA
  – Cognition & Mobility Care Management (CM²) at Riverside County primary care practices (UCLA GWEP proposal)
Summary

• Dementia co-management program has a place in primary care practice redesign
• Dementia care management can bridge clinical care silos and facilitate communication among providers, services and CBOs
• Dementia care management has potential to improve clinical performance metrics and lower costs
Visit us:
dementia.uclahealth.org