Dementia Medical Home

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#GAGAPNA15
Agenda

How
Where
What
When
Why
Whose
Who
THE WHY
Case in Point

- 78-year old with probable Alzheimer’s dementia
- Blood sugar is wildly variable throughout the day, ranging from 75-295. Agitation ensues at each end of the range
- Can you just manage her DM?
Specialist Perspective

• Managing DM is not the role of neurology

• Stepping into an ongoing management plan represents discontinuity of care
Case in Point

- Caregiver of 86 year-old female with dementia wants immediate appointment
- Mother is behaving out of character
Primary Care Perspective

• Same day appointments are reserved for emergencies

• Behaving ‘out of character’ is not an emergency
Working in our Favor

• We happened to have family caregivers on each side of this dilemma

• Partnered with us financially to develop a new model
The Convergence

- Value-based
- Meaningful use

Primary Care

- PCP Shortage
- Team models

Healthcare Workforce

- AAN Quality Measures

Dementia

- ACOVE Quality Measures

Geriatrics
Healthcare Workforce

• Need
  – More primary care practitioners
  – +/-Right practitioners

• Team-Based Care
  – High-functioning
  – Team member skills
  – Team member functions
The Convergence

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Healthcare Workforce

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Dementia

- ACOVE Quality Measures

Geriatrics
Primary Care

• Value vs Volume
  – Quality measures: process, outcome, 😊
  – Capitated, shared risk payment models
  – CMS goal: 50% payments as alternative model by 2018

• Capitalizes on Health Information Technology
  – Communication with patients and families
  – Communication with other entities
The Convergence

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- Meaningful use

Primary Care

Healthcare Workforce

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- Team models

Dementia

Geriatrics

- AAN Quality Measures

- ACOVE Quality Measures
Geriatrics

• Assessing Care of Vulnerable Elders (ACOVE)
• Non-institutionalized
• 26 Clinical Conditions
  – 392 process indicators
  – Screening and prevention (31% of QI’s)
  – Diagnosis (20%)
  – Treatment (35%)
  – Follow-up and Continuity (14%)
The Convergence

- Value-based
- Meaningful use

- PCP Shortage
- Team models

Primary Care

Healthcare Workforce

Dementia

Geriatrics

- AAN Quality Measures
- ACOVE Quality Measures
Dementia Care

• American Academy of Neurology
  – AMA Physician Coalition Performance Improvement
  – National Highway and Traffic Safety Administration

• 10 Quality Measures

• Ready for update 2015!
Dementia Care

1. Staging of Dementia
2. Cognitive Assessment*
3. Functional Status Assessment
4. Neuropsychiatric Symptom Assessment
5. Management of Neuropsychiatric Symptoms

*Now managed by AMA PCPI
Dementia Care

6. Screening for Depressive Symptoms
7. Counseling Regarding Safety Concerns
8. Counseling Regarding Risks of Driving
9. Palliative Care Counseling and Advance Care Planning*
10. Caregiver Education and Support

*After 2 years diagnosed or assumed care
THE WHAT
Dementia Medical Home

- Cognitive Neurology
- Geriatrics
- Palliative Care
# Triple Support for the Triple Aim

<table>
<thead>
<tr>
<th>Cognitive Neurology</th>
<th>Geriatrics</th>
<th>Palliative Care</th>
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<tbody>
<tr>
<td>• Gold standard diagnosis</td>
<td>• Best practices for geriatric syndrome</td>
<td>• Expertise in advance care planning, family meetings</td>
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<td>• Back-up for atypical symptoms of dementia</td>
<td>• Guidance for medication reduction, safety concerns</td>
<td>• Focus on late/end-stage dementia</td>
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<td>• Back-up for general primary care issues, home health signoff</td>
<td>• Back-up for hospice signoff</td>
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Patient-Centered Medical Home

The medical home model holds promise as a way to improve health care in America by transforming how primary care is organized and delivered.

Building on the work of a large and growing community, the Agency for Healthcare Research and Quality (AHRQ) defines a medical home not simply as a place but as a model of the organization of primary care that delivers the core functions of primary health care.
Quality Assurance

• Isn’t our practice always ‘patient-centered’?

• Official certification qualification recognition by NCQA
Patient-centered

• A partnership among practitioners, patients, and their families ensures that decisions respect patients’ wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care.
Comprehensive

• A team of care providers is wholly accountable for a patient’s physical and mental health care needs, including prevention and wellness, acute care, and chronic care.

1. Age- and gender appropriate immunizations and screenings.
2. Family/social/cultural characteristics.
3. Communication needs.
4. Medical history of patient and family.
5. Advance care planning (NA for pediatric practices).
7. Mental health/substance use history of patient and family.
8. Developmental screening using a standardized tool (NA for practices with no pediatric patients).
9. Depression screening for adults and adolescents using a standardized tool.
10. Assessment of health literacy.
Coordinated

- Care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, community services and supports.

1. Considers available performance information on consultants/specialists when making referral recommendations.
2. Maintains formal and informal agreements with a subset of specialists based on established criteria.
3. Maintains agreements with behavioral healthcare providers.
4. Integrates behavioral healthcare providers within the practice site.
5. Gives the consultant or specialist the clinical question, the required timing and the type of referral.
6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.
Accessible

- Patients are able to access services with shorter waiting times, "after hours" care, 24/7 electronic or telephone access, and strong communication through health IT innovations.

1. Providing same-day appointments for routine and urgent care. (CRITICAL FACTOR)
2. Providing routine and urgent-care appointments outside regular business hours.
3. Providing alternative types of clinical encounters.
4. Availability of appointments.
5. Monitoring no-show rates.
6. Acting on identified opportunities to improve access.
Committed to Quality and Safety

- Clinicians and staff enhance quality improvement to ensure that patients and families make informed decisions about their health.

1. Set goals and analyze at least three clinical quality measures from Element A.
2. Act to improve at least three clinical quality measures from Element A.
3. Set goals and analyze at least one measure from Element B.
4. Act to improve at least one measure from Element B.
5. Set goals and analyze at least one patient experience measure from Element C.
6. Act to improve at least one patient experience measure from Element C.

Examples from 2014 PCMH Criteria and Standards, NCQA
BUT WE DO THIS ALREADY
How is that different?

Provider-Centered

Staff buzz around the provider, feeding info and patients

Patient-Centered

All staff work with the patient as a team
How is that different?

We know we give good care; the waiting room is always full.

Quality Feeling

Quality Measurement

We measure what we do and constantly work to improve quality and outcomes.
How is that different?

Limited Access

We treat patients who come to us, when they request a visit

Accessible

We reach out to patients when we know they need something
Chronic Care Management

• Payment for non-face-to-face services for patients with >2 chronic conditions with potential for decline

• Communication with patient and/or other members of the treating team**
  – Phone or email
  – In addition to office visits

• For 24/7 availability
Chronic Care Management

- Comprehensive Care Plan created by CCM clinician (NP, PA, or MD)
  - “...physical, mental, cognitive, psychosocial, functional, and environmental assessments... all recommended preventive care services, medication reconciliation with review of adherence and potential interactions and oversight of patient self-management of medications, an inventory of clinicians, resources, and supports ... including how the services...will be coordinated. Including assurance of care appropriate for patient’s choices and values.”

Chronic Care Management Tool Kit, American College of Physicians. www.acponline.org
Chronic Care Management

Caveats

- Pays $42.60/month
  - Co-pay applies

- Code 99490
  - 20 minutes minimum by clinical staff
  - There are others for longer visits—but not CMS reimbursable

- Care plan and Informed consent
  - Shared with patient (family)

- Must have EHR eligible for incentive program
Caregiver Support

• *The Savvy Caregiver*
  – Multi-week psychoeducational program

• *Tele-Savvy*
  – Distance learning method
  – iPad delivered: Self-paced and FaceTime
THE HOW
Team Function and Process

• Roles and Responsibilities
  – NP’s are relatively interchangeable
  – Everyone sees geriatric psychiatry
  – Everyone sees clinical social worker
  – Everyone enrolls in CCM
Process Map: Example Management

Visit 1
NP, LCSW
- New pt visit, CCM enrollment
- Phone check-in: acute issues?
- Assessments and screenings

Visit 2
GeriPsych, NP
- E/M visit, advance care planning
- Caregiver education and support
- Potl referrals: OT, finance, pharmacy

Visit 3
NP +/- team
- E/M visit, Annual wellness visit
- Phone check-in: acute issues?
- Assessments and screenings
Our Team

- Gero NP
- Neuro NP
- GeriPsych CNS
- Palliative Care NP
- Clinical SW
- Care Coordinator RN
- Patient Family Advisors
- Patient + Caregiver

Care Coordinator RN
Patient Family Advisors

• Advises clinic on important decisions
  – Name
  – Communication methods
    • Letters
    • Website***
  – Education
    • Staff***
    • Family caregivers***
  – Services we offer***

*** Upcoming
THE HOW-WELL
How Will We Know It Works?

• VALUE

Donabedian Model as shown at VA Rehab R&D, rehab.research.va.gov
Structure

• Source: Patients, families

• Method: Interviews

• Measure: Do we employ or partner with the right services/providers?

Considering preferred vendors for aging service providers
Process

• Source: Data warehouse (EHR)

• Method: Audits, reports, dashboards

• Measure: AAN measures
  Select ACOVE measures
  PCMH recognition criteria
Outcomes

• Source: Patients, families
  Health system and Medicare database

• Method: Monthly CCM calls
  Costs/charges

• Measure: Acute care utilization, institutional placement, symptom management for patients and caregivers, death with hospice
VALUE

• Outcomes achieved per dollar spent

• Outcomes
  – Goals as defined by patients

• Dollar spent
  – Also consider other ‘costs’
VALUE

Clinical Value Compass

Functional Health Status
- Physical
- Mental
- Social/Role
- Risk Status

Clinical Outcomes
- Mortality
- Morbidity
- Complications

Satisfaction Against Need
- Care evaluations
- Perceived Health Benefit

Total Costs
- Direct medical care costs
- Indirect social costs

VALUE to our Patients

Patient-Centered Outcomes Research Institute, www.pcori.org
Integrated mEmory Care

• Executive Park, Building 12, 5th floor
• Appointments at 404-712-6929 (direct line)

• http://www.emoryhealthcare.org/IMC
Enrollment

Open to General Public

Emory Healthcare

Memory Disorders Clinic
Summary

- Patients with dementia have needs often unmet in traditional primary care
- Models such as PCMH and CCM may yield significant value for persons with dementia, a vulnerable population
Questions

@ccleven  #GAGAPNA15