CREATING DEMENTIA-CAPABLE HEALTH CARE SYSTEMS

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WA State Alzheimer's Disease Working Group
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DISCLOSURES

- No financial conflicts of interest
- Copyright holder, dementia care tools
- Member, Alzheimer's Association Workgroup on Implementation of Cognitive Assessment; AMA Workgroup on Dementia Care Quality Measures; International Consortium for Health Outcome Measurement (Dementia)
- Consultant: Twin Cities Consortium for Alzheimer's Research; ACT on Alzheimer's; Benefis Health System; Allina Health; Eisenhower Health Care; Silverado Dementia Assisted Living; Optum Rx
- Advisor: F. Hoffman LaRoche/Genentech
- Associate Editor, Journal of the American Geriatrics Society
- Mentor: Hartford Foundation and Robert Wood Johnson Nursing Scholars; NIMH K23 Scholars
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DEMENTIA: A WORLDWIDE PRIORITY

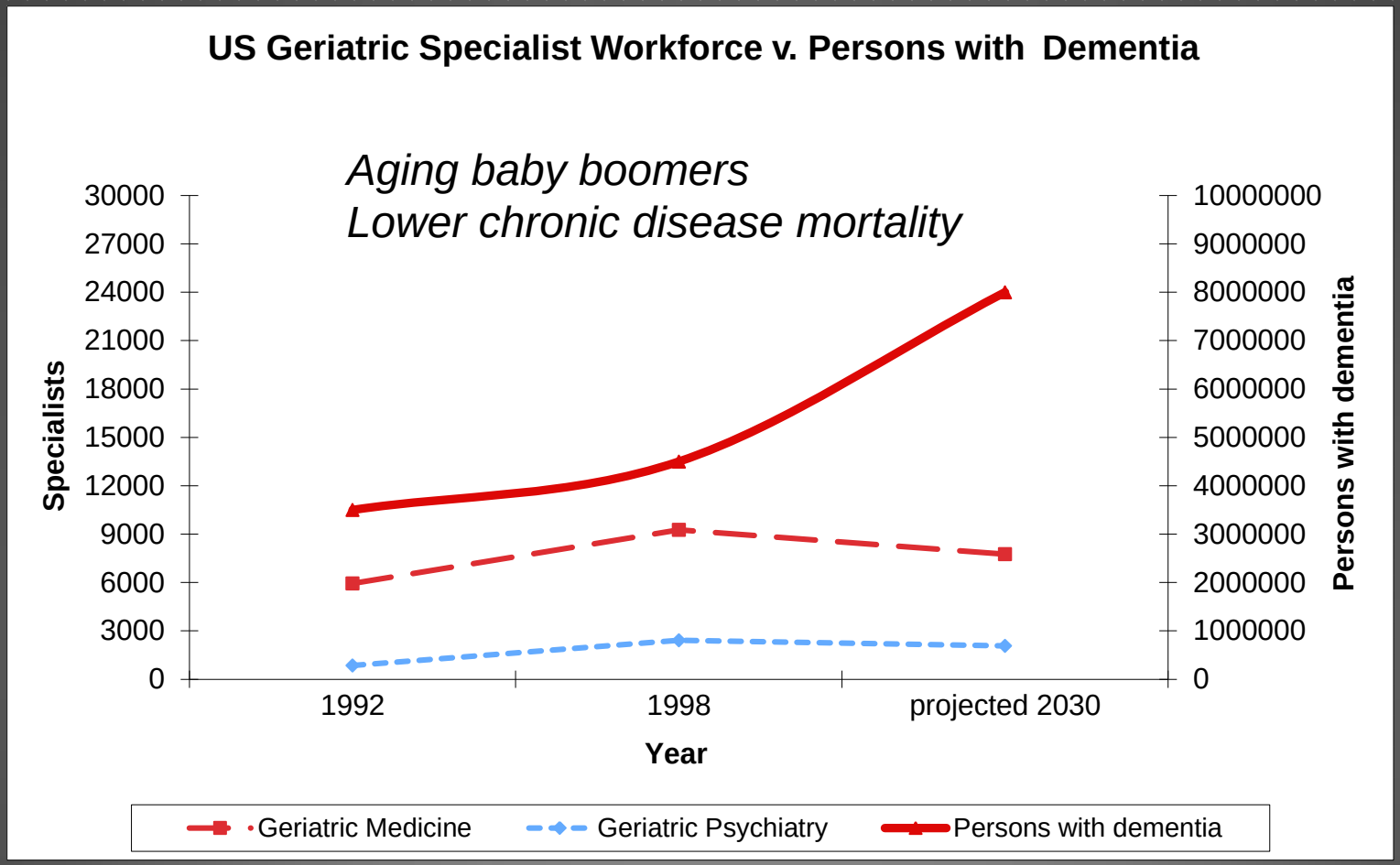
RESEARCH INVESTMENT, EARLIER DIAGNOSIS, BETTER CARE

- G7 Alzheimer's Summit
- US National Alzheimer's Plan; UK Dementia Strategy
- Professional and advocacy organizations
  - AMA, ACP, AAFP, ACS, AAN, Alzheimer's Association, Alzheimer's Foundation, Alzheimer's Drug Discovery Foundation, Dementia Action Alliance…
- CMS

ARE HEALTH CARE SYSTEMS READY FOR DEMENTIA?

- Low recognition/diagnosis rates (~ 50%)
- Care partners not identified
- Care approach unsystematic, uncoordinated
- Poor clinician support for complex care
- Lack of consensus around quality metrics

DEMENTIA: *A JOB FOR PRIMARY CARE*



Borson S, Chodosh J. Clin Geri Med 2014; 30: 395-420.

Late/missed diagnosis

Medication mismanagement

Unnecessary crises

Caregiver stress, poor health

Safety risks

Family breakdown

Dementia Care Quality: Targets for Improvement

Poor chronic disease control

Inappropriate Rx

Discontinuity of care

Preventable hospitalizations, readmissions, and complications

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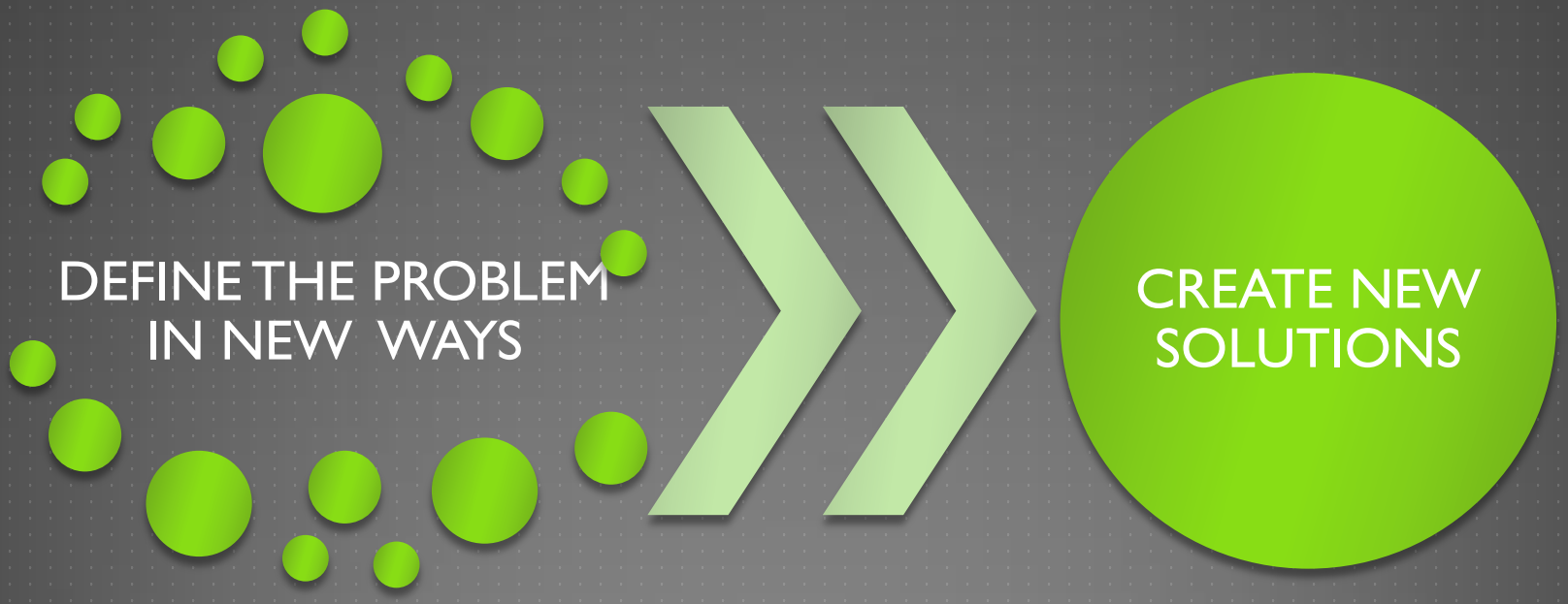
AN INVITATION TO PRIMARY CARE



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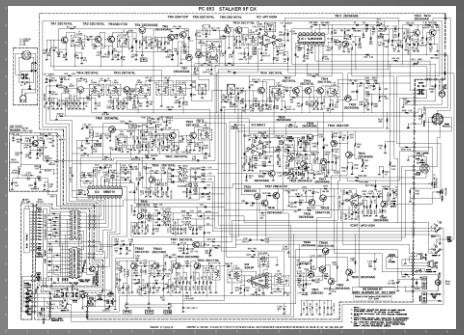

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WHERE TO START?

Routine screening for cognitive impairment in primary care

Everyday disability

Low health literacy

Risk of medication mismanagement at home

Delirium

Screen (Mini-Cog) Failure

Elective surgery complications

Post-op nursing home placement

Long-term post-op mortality

Length of stay

ED visits, hospitalizations and 30-day readmissions

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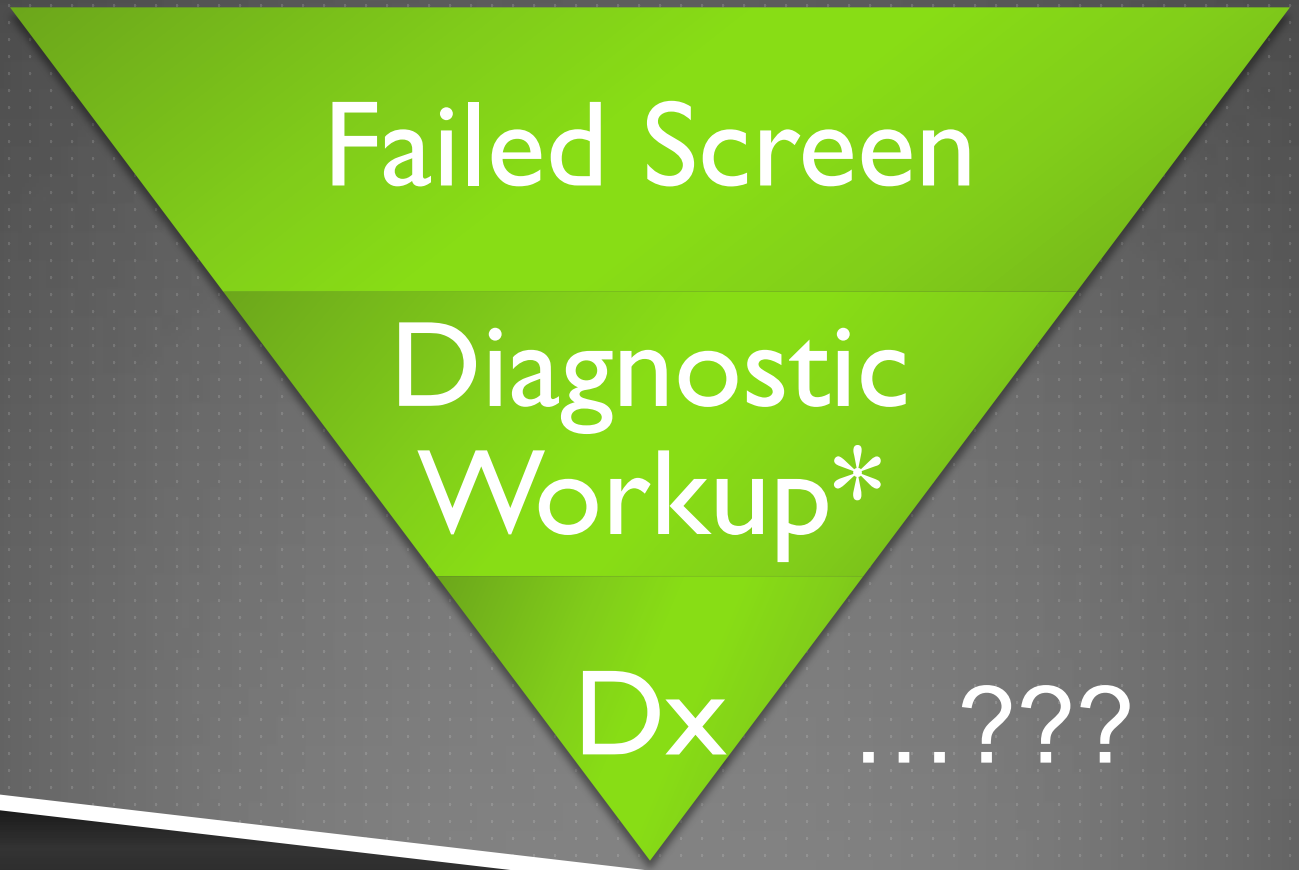
COGNITIVE SCREEN: WHAT NEXT?

DEMENTIA SPECIALIST APPROACH



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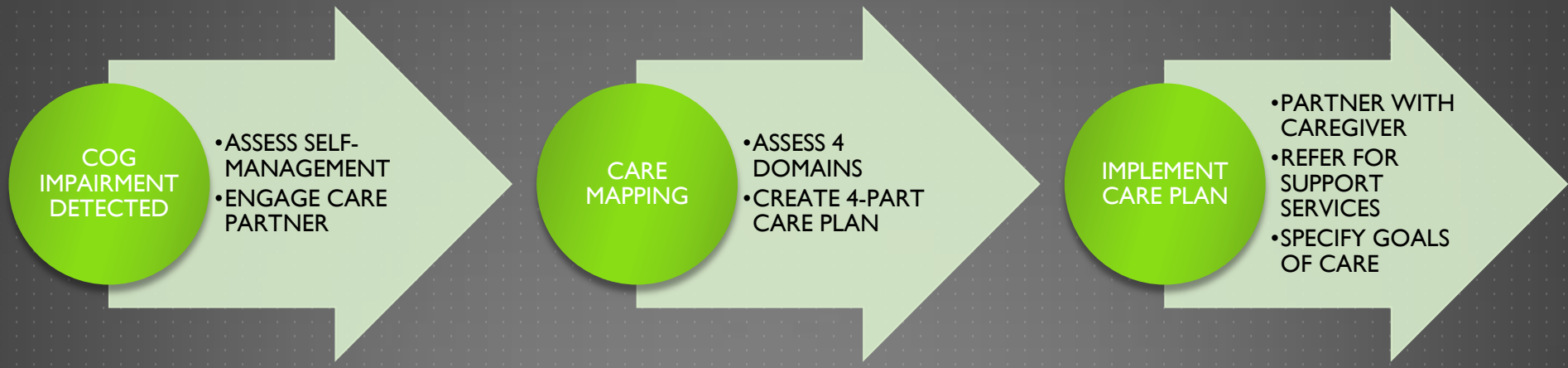
COGNITIVE SCREEN: WHAT NEXT?

A PATH FOR PRIMARY CARE



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A COHERENT FRAMEWORK FOR DEMENTIA CARE

Dementia

Use objective cognitive assessments

Gather history on physical function/self care

Identify/remove cognitively impairing meds

Assess for other cognitively impairing conditions

Discuss cognitive enhancing medications

Neuropsychiatric problems

Screen for depression (PHQ-9)

Ask about delusions, hallucinations

Structured behavioral assessment - refer for behavioral strategies as needed

Patient/Care Partner Dyad

General medical status and safety risks

Identify/manage cognition-impacting comorbidities (diabetes, hypertension, heart disease)

Assess for orthostatic hypotension

Address home and medication safety, driving

Care partner status and needs

Use structured caregiver assessment tools

Ask about additional support at home

Encourage attention to personal and healthcare needs

Lessig M et al. JAGS 2006; 52: 1937;
Borson S, Chodosh J. Clin Geri Med 2014; 30: 395-420.

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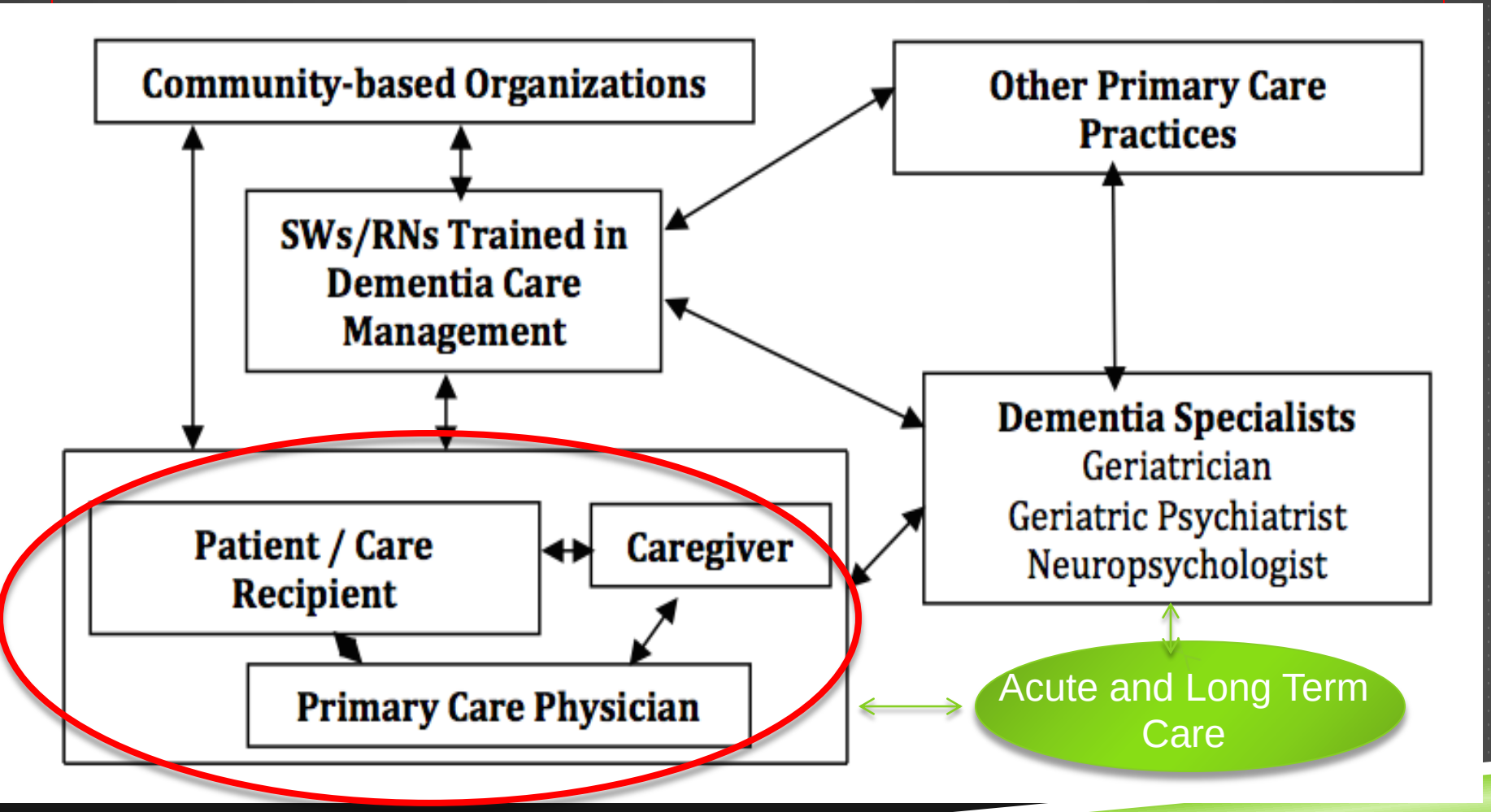
SUPPORTING CLINICIANS: THE DEMENTIA CAPABLE HEALTH CARE SYSTEM



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POLICIES THAT PROMOTE IMPROVEMENT IN HEALTH CARE FOR DEMENTIA (1)

- Medicare Annual Wellness Visit
  - Objective cognitive assessment required (screening)
  - Once a year; includes snapshot of patient's health risks and current health care arrangement
  - No patient co-pay
  - Elements can be done by non-physicians

POLICIES (2)

- Complex care management (CCM)codes
  - One clinician takes overall responsibility for care
  - Billed monthly; improved reimbursement rates
  - Most patients with dementia have multiple chronic conditions
- Advance care planning codes
  - Now reportable (but not payable yet)

POLICIES (3)

- Physician quality reporting system (PQRS)
  - Includes 9 of 10 AMA dementia care quality measures
  - Incentive payment when annual quality indicators met

POLICIES (4)

- Advanced team-based health care models
  - Accountable care organizations
  - Medical homes
- Value-based frameworks
  - Outcome (not guideline) driven

PUTTING IT INTO PRACTICE (1)

- Several specialty models tested
- Some significant outcomes, ~small effect sizes
  - Caregiver burden, proxy-reported behavior problems, medication profiles
  - Inconsistent effects on acute care
  - No risk stratification

PUTTING IT INTO PRACTICE (2)

- Dementia Medical Home
  - Primary care
  - Essentia Health, Northern Minnesota

Dementia Grant Process

Essentia Health

Patient/ Care Partner

RN Care Coord. & Comm. HC Worker

PCP

Specialty Care

Senior LinkAge Line®

Alzheimers Assoc.

Northwoods Partners

1. Patient identified by failed MiniCog at AWV or reg PC visit as suspected memory concerns

2. A referral for MOCA testing is ordered for patient by PCP

3. Patient comes in for MOCA

4. RN administers MOCA

5. RN scores MOCA with patient or advocate. May review with them or tell them provider will review with them. Provides list of patient instructions for brain health.

NOTE: Ideally, patient sees provider same day as MOCA

6. Dementia focused visit w/PCP using MOCA Smart Set.

7A. Dementia Dx?

Yes or Uncertain

No

7B. F/U as usual. Annual MiniCog screening. END

7C. Further evaluation as needed (lab, imaging, referral).

Either PCP or Specialist gives order

8. Diagnostic Specialist visit

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9. Dementia Dx?

Yes

No

Yes

10. Team Care

RN Coordinator

PCP

Specialist

11. Tell patient to see PCP in 3 weeks.

12. Patient makes 3 week appointment

13A. Refer to Community Services or additional services as needed.

Either PCP or Specialist gives order

Go to Box 13B on Page 2

DATE	DESCRIPTION	DEVELOPED BY
7/22/2014	DEMENTIA GRANT WORK FLOW	DEMENTIA GRANT TEAM (DRAWN BY NANCY TARIO, PROCESS EXCELLENCE DEPT)

FULL FILENAME

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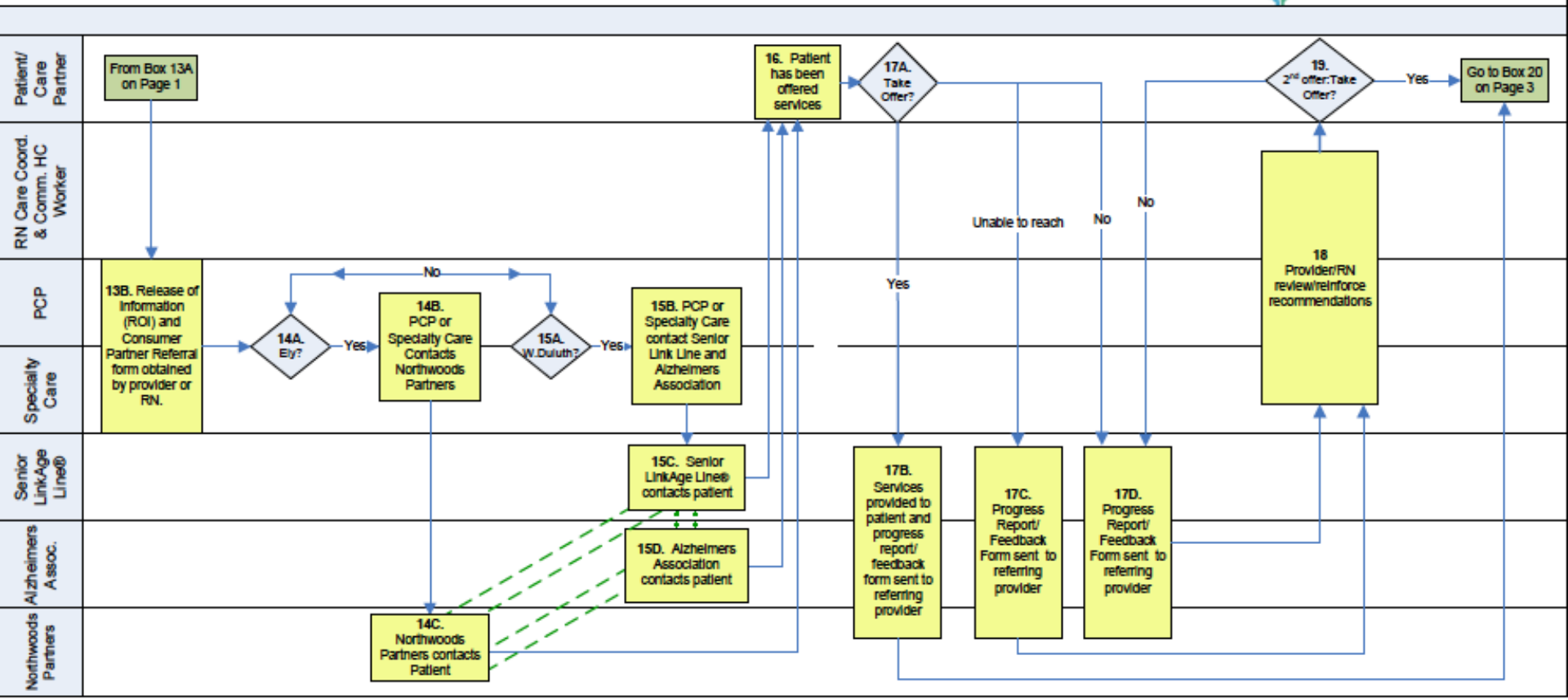
1 OF 3

REVISIONS

REV BY	DESCRIPTION	DATE REV	APPROVED

Dementia Grant Process

Essentia Health



Dementia Grant Process

Essentia Health

Patient/ Care Partner

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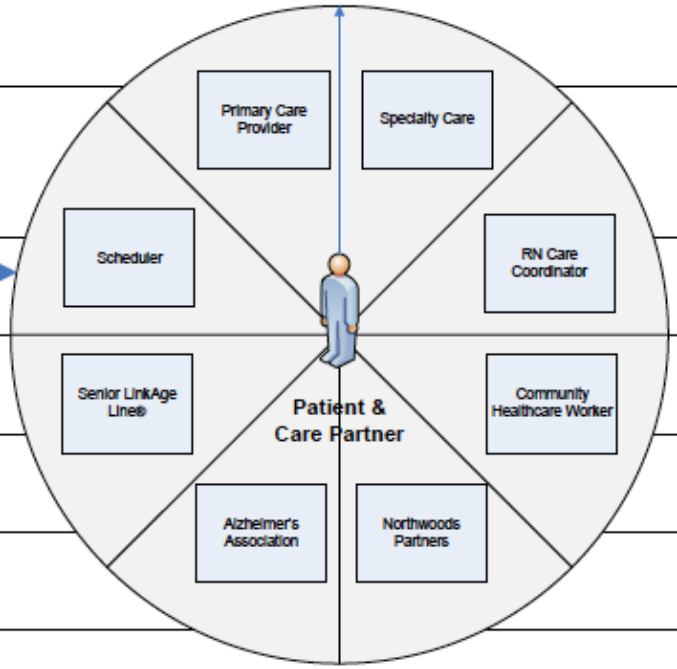
From Box 19 on Page 2

20 Incorporates feedback sent from Community Partner into Plan of Care

21. On-going Process and Evaluation