Opportunities to Champion Dementia Healthcare

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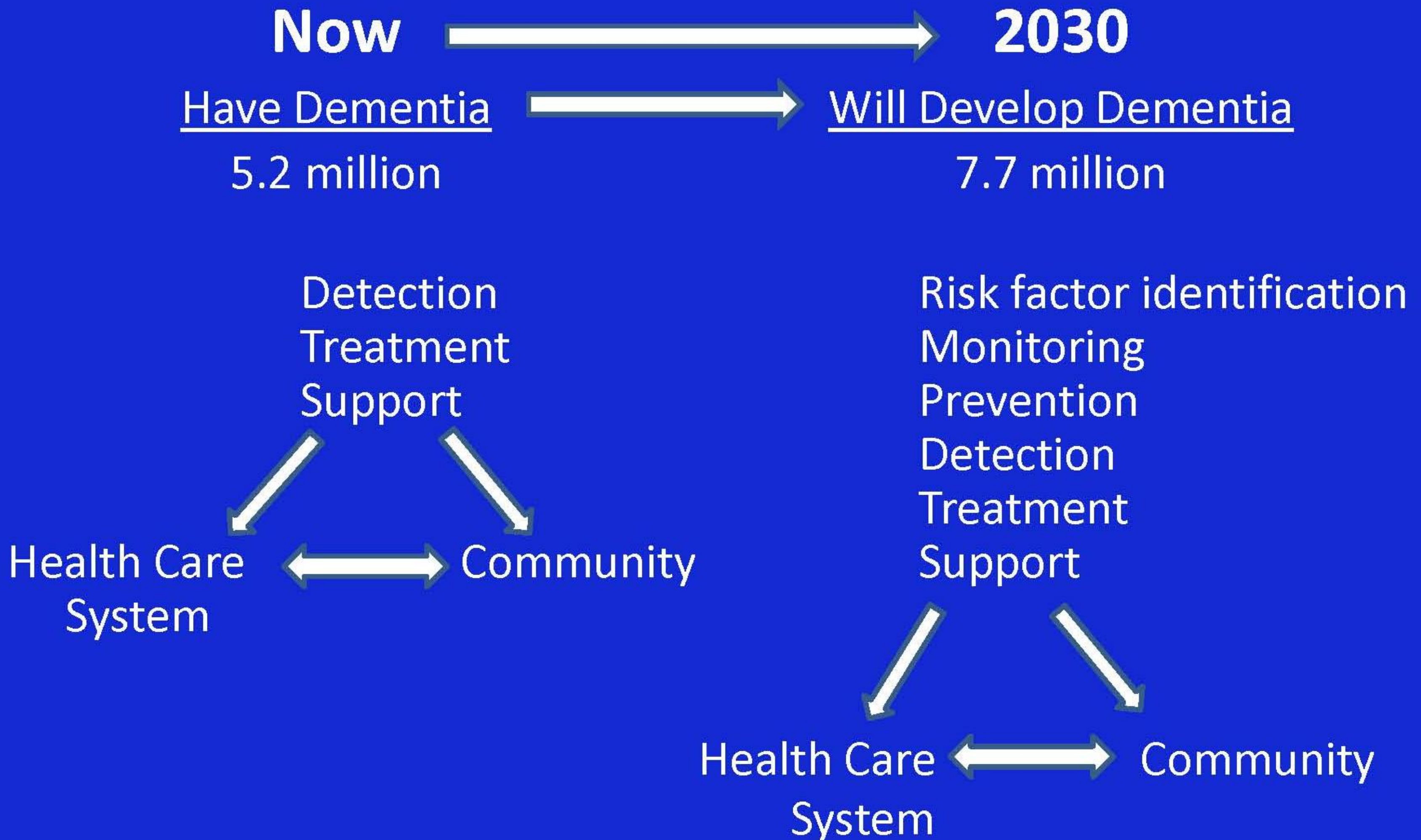
Overview

- The “Why”
  - The burden and unmet needs
- Successful dementia management strategies
- Being a champion
  - Selling the program
  - Thinking broadly: a population approach

Alzheimer's Disease:
A Two-Phase Strategy



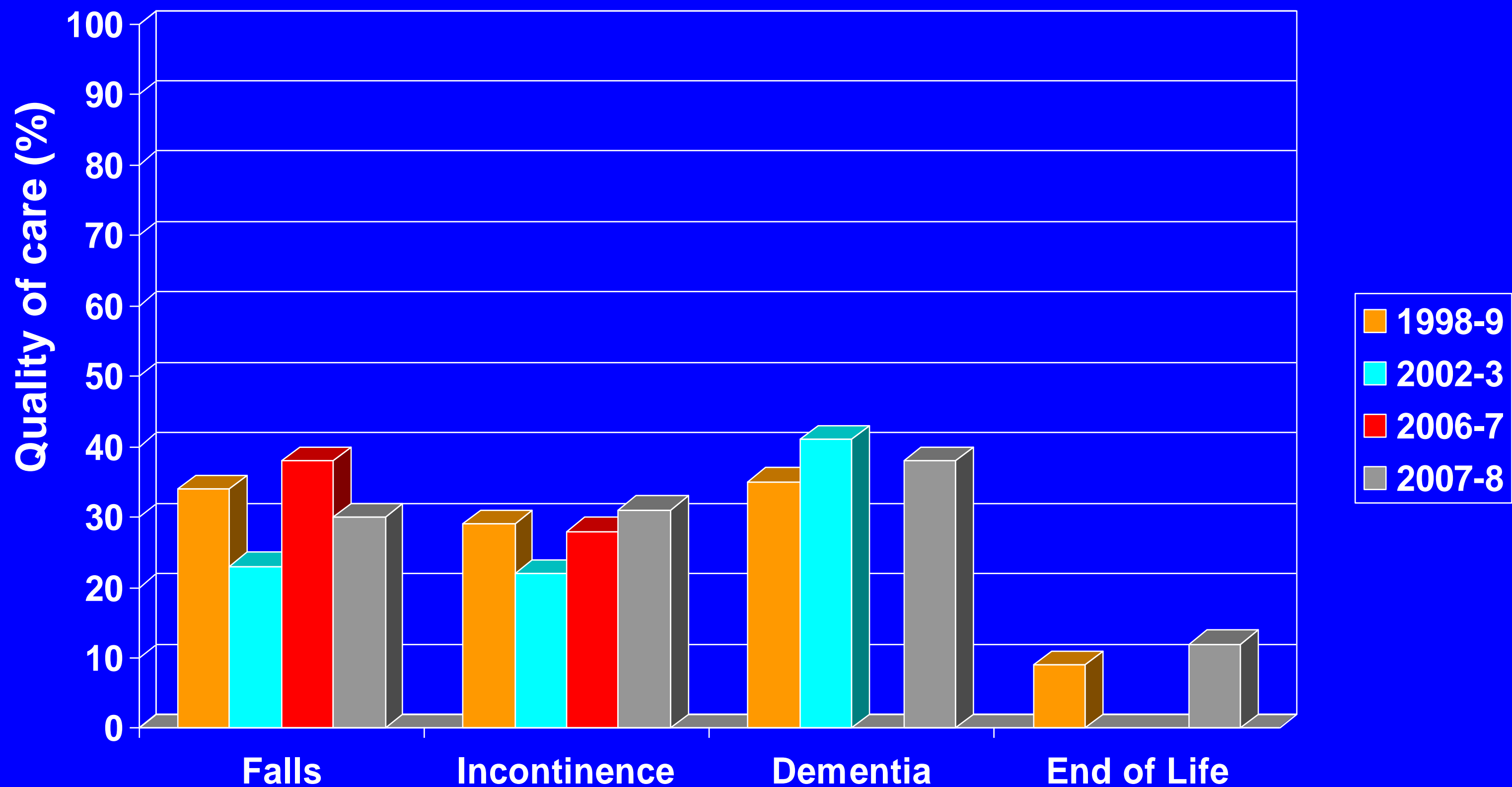
The Burden in 2018

- 5.7 million with Alzheimer’s disease
- Costs $277 billion, $186 billion to Medicare and Medicaid
- Family caregivers provide 18.4 billion hours of care valued at $232 billion

Caregivers

- Depression & strain
  - 14% mod/sev depressive sx
  - 36% high stress
- Low self-efficacy
  - 21% knew how to access services
  - 36% confident handling dementia problems
  - 26% have healthcare professional who helps work through dementia issues

Quality of care:
4 Cohorts of Vulnerable Elders



Management

- Manage the disease
  - Cholinesterase inhibitors
  - Memantine
- Manage the patient
  - This is a lifelong disease
  - Play the ball where it lies
    - If disease is early, include patient
    - If late, rely on family and caregiver
  - Aim for the highest level of independence that works for everyone

Manage the Patient

- Manage hot-button issues (e.g., driving)
- Manage symptoms
  - Behavioral therapies
    - https://www.uclahealth.org/dementia/caregiver-education-videos
  - Drug management of complications
- Advanced care planning
- Manage co-morbidities
- Caregiver support

Caregiver Support

- Caregivers are the most important resource a demented patient has
- Over 50% develop depression
- The more knowledgeable and more empowered the caregiver is, the better care the patient will receive
- Caregiver resources are available
  - Local Alzheimer's organizations and other community resources
  - Specific programs (e.g., REACH, NYU CI, Savvy Caregiver, Partnering With Your Doctor)

Evidence Behind Caregiver Support

- 200 interventions tested in RCTs
  - Behavioral management
  - Skills training
  - Counseling/psychotherapy
- Various interventions improve (small-med):
  - Knowledge
  - Well being
  - Confidence/self-efficacy
  - Time to institutionalization
  - Behavioral symptoms

Caregiver Support

- Barriers and limitations
  - Focus only on the caregiver
  - Tested using traditional research not pragmatic designs
  - Cost ($2.50-$5/day for 6 months) and reimbursement
  - Poor integration with health care systems

New Models of Comprehensive Care for Dementia

- Focus on patient and caregiver
- Community-based
  - BRI Care Consultation
  - MIND at Home
- Health System-based
  - Indiana University Healthy Aging Brain Center (HABC)
  - The UCLA Alzheimer's and Dementia Care Program (UCLA ADC)

Community-based

- Implemented at CBOs by SWs, RNs, MFTs
  - Systematic assessment
  - Care planning
  - Delivery or referral care, services, and support
  - May or may not have in-person visits, home visits
- Reduced caregiver burden/strain/depression
- Better guideline care, QoL, behaviors
- Reduced NH placement
- No effect on health care use or costs

Health-system Based

- Implemented in health systems by nurse practitioner or physician-led staff
  - Face-to-face annual visits
  - Coordination within health system and EHR
  - Order writing
  - May or may not have home visits
- Better quality of care
- Reduced caregiver burden/strain/depression
- Reduced NH placement
- Lower health care costs

Championing Dementia Care

- Frame the problem

Framing the Problem

- UCLA Top 3 diagnoses with higher than expected utilization
  - Chronic Kidney Disease
  - Dementia
  - Cancer
- Why is this important?
  - Increasingly payment is value based (MA, ACO's, MSSP, bundled payments)

Championing Dementia Care

- Frame the problem
- Identify solutions

The UCLA Alzheimer's and Dementia Care Program

- Approaches the patient and caregiver as a dyad; both need support
- Recognizes that this care is a long journey
- Provides comprehensive care based in the health system that reaches into the community
- Uses a co-management model with Nurse Practitioner Dementia Care Manager (DCM) who does not assume primary care of patient

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
- Partners with Community-based organizations to provide direct services (eg, adult day care) and caregiver training

Championing Dementia Care

- Frame the problem
- Identify solutions
- Provide data

Data that Make the Case for Dementia Care Programs

- Quality
- Cost
- ROI

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 of first 797 patients

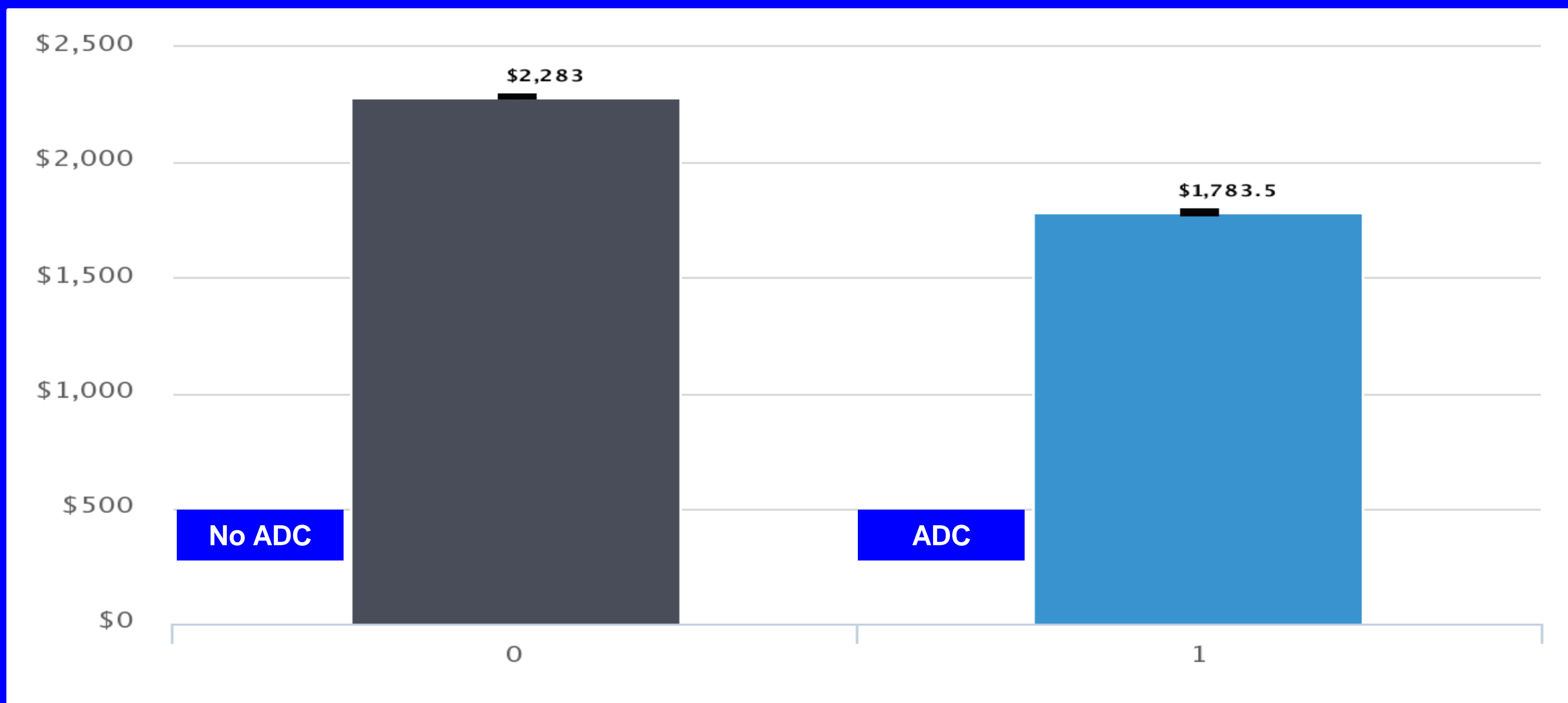
Jennings LA, et al. J Am Geriatr Soc, Jun 2016. PMID: 27355394

Examples of Quality

Annual assessment of cognition	94%
Staging of dementia	92%
Annual assessment of function	97%
Depression screening	99%
Annual screen for behavioral symptoms	99%
Annual medication review	99%
Caregiver counseling	99%
Counseling about advanced care/palliative care	98%
Counseling about driving	93%
Treatment with behavioral interventions first or concurrently	68%

Cost: ADC Participation Linked to Lower Health Care Spend

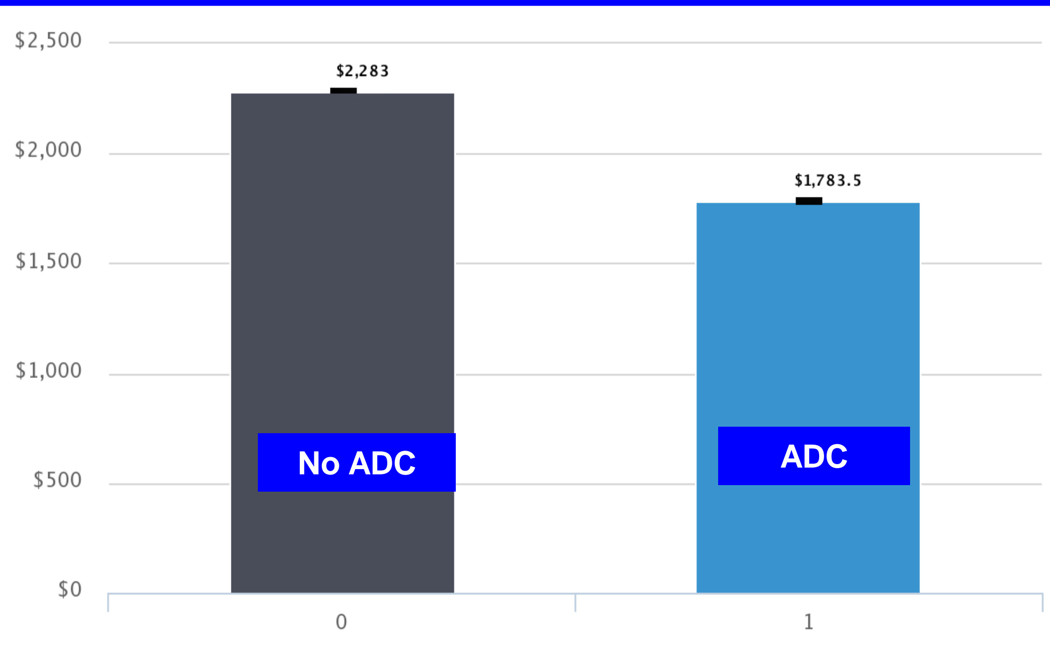
$500 per month spend reduction between ADC Participation & No ADC Participation

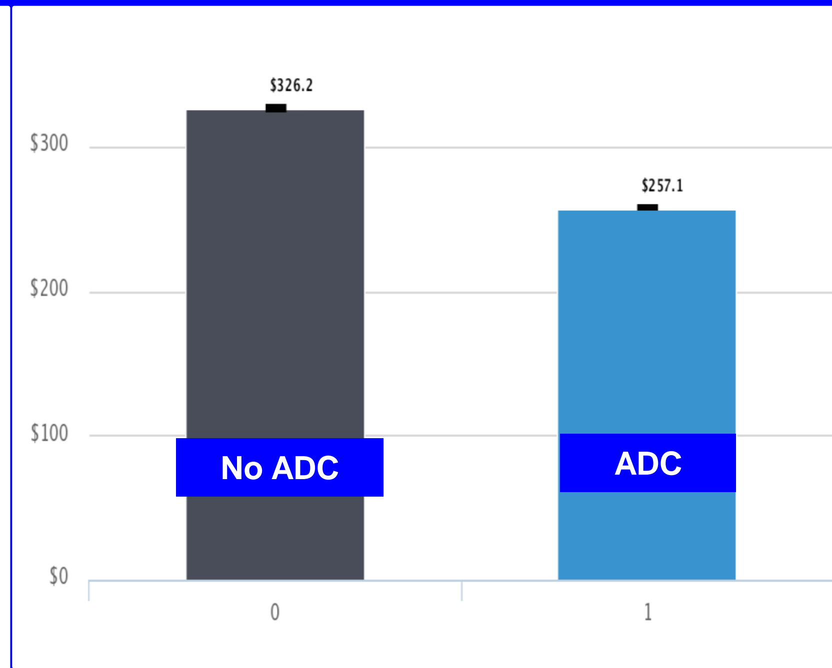


Time Frame: May 2015-May 2017
Source: ACO Claims

ADC Participation Linked to Lower Inpatient & Post-Acute Spend

Inpatient Monthly Spend/Patient **SNF Monthly Spend/Patient**





Time Frame: May 2015-May 2017
Source: ACO Claims

Comparison of Dementia Patients by ADC Participation

Measure	Not Managed Currently by ADC	Managed by ADC Program
UCLA dementia patients	2,994	1,358
Avg. unplanned admissions per patient	0.96	0.91
30-day all-cause readmission	23%	17%
Average length of stay	6.6 days	5.9 days
Any ICU days	67%	27%
Bed Days per 1000 patient years	3,558	2,501

*September 2015- September 2017

Costs of Program (per 1250 participants)

- 5 FTE Nurse Practitioner DCMs
- 2 FTE DCM Assistants
- 0.5 FTE Medical Director
- 1 FTE Program Administrator
- 0.15 FTE Psychologist Support Group Leader
- Software maintenance and supplies
- Vouchers for community-based organizations

Comparative Costs of Program

• UCLA ADC	$1460/y	$4.00/d
• Rivastigmine (generic)	$1261/y	$3.45/d
• Rivastigmine transdermal	$4474/y	$12.30/d
• Memantine/donepezil	$4630/y	$12.68/d

Potential Revenue: Fee for Service

- Medicare billing
  - Cognition and Functional Assessment (99483)
    - $190-$260/per assessment)
  - Chronic Care Management (CCM) Codes
    - $34-$104/month
  - E & M Codes
- Enough? Depends upon local labor costs
  - Nurse practitioners receive 85% payment rate
  - Annual FFS revenue assuming: non-hospital setting, 1 G0505, 1/3 Complex and 2/3 standard CCM, 1 F/U E & M code=$906/year

ROI

- Net Revenue “Savings”
- Total Incremental Operating Costs
- Contribution Margins (investment)
- Payback Periods
- Investment Return Ratios
- UCLA ADC program doesn’t completely cover its costs but saves the system a lot
- Depending upon local labor costs, the model may be cost saving

Thinking Broadly: Population-based Dementia Care

- Defined population (e.g., MA, ACO, MSSP)
- Analytics to characterize the population
- Tailored interventions to different strata
- Providing appropriate resources efficiently
- Monitoring for transitions in strata and changes in needs

A Model for Dementia Risk Stratification

Risk Stratification

1st Tier (1%) ***45 pts***

- Severe behavioral problems, functional impairment, few resources, comorbidities
- Frequent ED and hospital admissions

2nd Tier (2-5%) ***180 pts***

- Frequent behavioral problems, functional impairment, few resources, comorbidities
- Multiple ED and hospital admissions

3rd Tier (6-20%) ***673 pts***

- May have behavioral problems and/or severe functional impairment, comorbidities

4th Tier (21-60%) ***1796 pts***

- Mild dementia
- Getting routine health care

5th Tier (61-100%) ***1796 pts***

- Mild dementia
- Getting no health care

Dementia population as of Jan 2018
Utilization: Feb 2017-Jan 2018

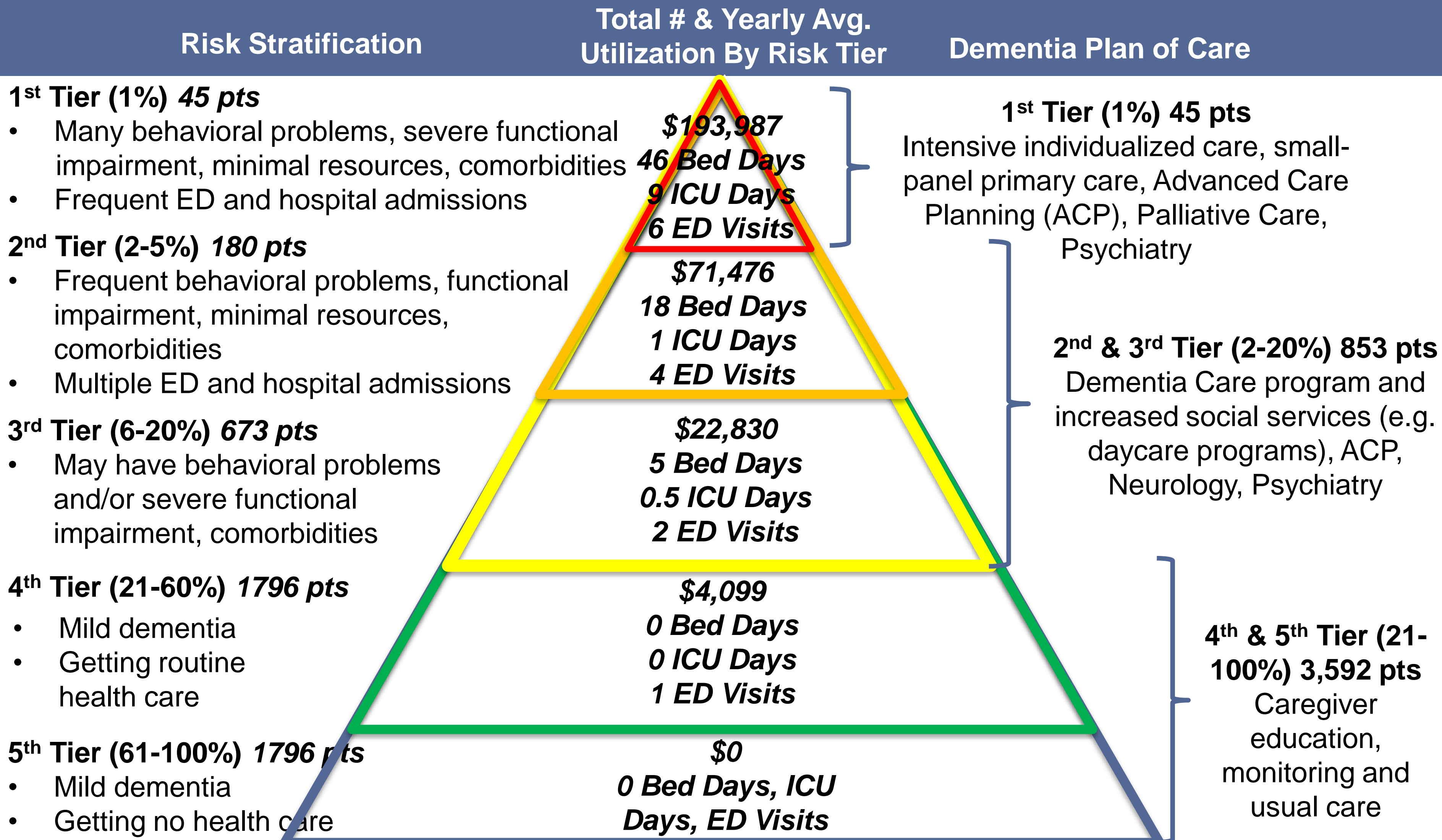
UCLA Health

A Model for Dementia Risk Stratification

Risk Stratification	Total # & Yearly Avg. Utilization By Risk Tier
1st Tier (1%) ***45 pts*** • Many behavioral problems, severe functional impairment, minimal resources, comorbidities • Frequent ED and hospital admissions	***$193,987*** ***46 Bed Days*** ***9 ICU Days*** ***6 ED Visits***
2nd Tier (2-5%) ***180 pts*** • Frequent behavioral problems, functional impairment, minimal resources, comorbidities • Multiple ED and hospital admissions	***$71,476*** ***18 Bed Days*** ***1 ICU Days*** ***4 ED Visits***
3rd Tier (6-20%) ***673 pts*** • May have behavioral problems and/or severe functional impairment, comorbidities	***$22,830*** ***5 Bed Days*** ***0.5 ICU Days*** ***2 ED Visits***
4th Tier (21-60%) ***1796 pts*** • Mild dementia • Getting routine health care	***$4,099*** ***0 Bed Days*** ***0 ICU Days*** ***1 ED Visits***
5th Tier (61-100%) ***1796 pts*** • Mild dementia • Getting no health care	***$0*** ***0 Bed Days, ICU Days, ED Visits***

Dementia population as of Jan 2018
Utilization: Feb 2017-Jan 2018

A Model for Dementia Risk Stratification



Dementia population as of Jan 2018
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Championing Dementia Care

- Frame the problem
- Identify solutions
- Provide data
- Persevere

Championing Dementia Care

- Frame the problem
- Identify solutions
- Provide data
- Persevere
- Bring passion