Dementia Care in Primary Care: Meeting the Needs of Patients and Caregivers in an Aging World

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Disclosures

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• Board Member, Vermont Chapter of Alzheimer’s Association
Overview

• Dementia in Vermont and its challenges
• Lessons from Indiana: one possible solution to the challenge
• Vermont’s Emerging Approach
• Questions and Comments
“Grow old along with me! The best is yet to be.”

• Robert Browning (1812-1889)
Life Expectancy Changes

- 1900-1902: 49 years
- 1939-1941: 64 years
- 1969-1971: 71 years
- 2003: 77.4 years
- 2015: 78.7 years

Source: CDC
In 2000, Vermont ranked 26th among states in the percent of population ≥ 65. Where do you think we will rank in 2030?

- 8th
- 18th
- 28th
- 38th
- 48th
Ranking of States by projected population age 65 and over: 2000, 2010, and 2030


<table>
<thead>
<tr>
<th>State</th>
<th>2000 Projected Age 65 and Over</th>
<th>2010 Projected Age 65 and Over</th>
<th>2030 Projected Age 65 and Over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida</td>
<td>18.6%</td>
<td>17.6%</td>
<td>16.4%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>16.0%</td>
<td>15.6%</td>
<td>15.2%</td>
</tr>
<tr>
<td>West Virginia</td>
<td>15.6%</td>
<td>15.1%</td>
<td>14.8%</td>
</tr>
<tr>
<td>Wyoming</td>
<td>15.3%</td>
<td>14.9%</td>
<td>14.6%</td>
</tr>
<tr>
<td>Idaho</td>
<td>14.4%</td>
<td>14.0%</td>
<td>13.7%</td>
</tr>
<tr>
<td>North Dakota</td>
<td>14.2%</td>
<td>13.9%</td>
<td>13.6%</td>
</tr>
<tr>
<td>Iowa</td>
<td>14.4%</td>
<td>14.2%</td>
<td>14.0%</td>
</tr>
<tr>
<td>Maine</td>
<td>14.4%</td>
<td>14.2%</td>
<td>14.0%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>13.6%</td>
<td>13.4%</td>
<td>13.2%</td>
</tr>
<tr>
<td>Montana</td>
<td>13.6%</td>
<td>13.4%</td>
<td>13.2%</td>
</tr>
<tr>
<td>Dakota</td>
<td>12.8%</td>
<td>12.6%</td>
<td>12.4%</td>
</tr>
</tbody>
</table>

Notes:
- The data reflects projections for the years 2000, 2010, and 2030.
- The percentages indicate the proportion of the population aged 65 and over.

What do the numbers look like for Alzheimer’s in Vermont?

• 42% increase in number of persons with AD in 10 years
  • 12,000 people in 2016 and 17,000 people in 2025
• 5th leading cause of death in Vermont
• 4th highest Alzheimer’s death rate in America

• 30,000 caregivers providing 34 million hours of unpaid care
• Value of unpaid care = $417,000,000
• Higher health care costs of caregivers = $21,000,000
Fork in the Road
Poetic Version...

Two roads diverged in a yellow wood,
And sorry I could not travel both…

-Robert Frost
“When you come to a fork in the road, take it.”

-Yogi Berra
Lessons Learned from Indiana
Case Study

- Mr. B, 68 yo man with depression and hx of blindness since age 18 months
- Referred by his psychiatrist
- At initial home visit (January 29th):
  - PHQ-9: 18
  - MMSE: 27
  - HABC self-report monitor: 35
- But....
Case Study

• During our visit we discovered:
  • Patient was going to be evicted February 1st
  • No family/friends

• Weather that weekend ---- freezing rain and snow

• Our team identified temporary housing at hotel

• Working with community resources, we then identified permanent senior apartment for patient
Case Study

• Return visit (March 14th):
  • PHQ-9 score of 3 (previously 18)
  • HABC self-report monitor score of 9 (previously 35)
• Over 3 million Medicare beneficiaries with dementia and 6 million with depression
• Conditions frequently co-occur
• Medicare costs: >$30 billion annually
• Providers report inadequate time resources to manage these complex patients
• Patients with dementia have 20% higher rate of ED use than older adults w/o dementia
The Collaborative Dementia Care PREVENT Model 2000-2006

**Primary Care Clinician:**
- Detect and treat delirium
- Detect and treat BPSD
- Enhance cholinergic system by
  - Prescribe ChEIs
  - Discontinue Anticholinergic

**Caregiver Focus:**
- Problem solving skills
- Counseling
- Respite care
- Support group

**Expert Team:**
- Geriatrician
- Social Psychologist
- GeroPsychiatrist

**General Environmental Modification:**
- Medication adherence support
- Home safety assessment

Callahan et al, JAMA 2006; Austrom et al, Gerontologist 2004; Boustani et al, JCIA 2006
The Impact of CCDM

- NNT = 3.7
- Each 1 point decline in NPI = $250-$400 in health care expenses
- CCDM led to 7 NPI point improvement
- CCDM saved 1750-$2800 per patient
- Improvement in family stress

Callahan, Boustani et al, JAMA 2006
Having Community Based Colleagues who Push Us is a Good Thing!
Healthy Aging Brain Center

• Memory Care Center:
  • Staffed by geriatricians, neurologists, and geriatric psychiatrists
  • Provide evidence-based evaluations of patient’s cognition
  • Support patients and caregivers with dementia diagnoses

• Positive Results
  • Improved patient and provider satisfaction
  • Cost Savings (95% CI: $2,855 ± $4,227) for enrolled patients in 2008-2009 compared to non-enrolled patients
Healthy Aging Brain Center

• **Downsides**
  - Dependent on having memory care physicians so not scalable
    - Example: Treating Alzheimer’s Disease in Vermont
  - Dependent on patients coming to clinic
  - Provides no insight into what is going on in the home
Aging Brain Care (ABC) Medical Home

➢ Grew out of Healthy Aging Brain Center
➢ Started October 2009
➢ Incredible Growth:
  • July-December 2011: Add new medical director and SW
  • January-June 2012: Add 2nd NP
  • July 2012: Begin CMS Innovation Grant to expand our services to 2000 patients with dementia or depression served by Wishard Health System and IU Health Arnett
ABC Med Home Organizational Structure

Medical Director (0.4 FTE)

1 FTE Care Coordinator

5 FTE Care Coordinator Assistants

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1 FTE Care Coordinator

5 FTE Care Coordinator Assistants

Social Worker

Social Worker
Who are our team members?

1. CCAs:
   a. High school and 2 year college degrees
   b. Selected for their experience and desire to work with older adults
2. Nurses/NPs
3. Social Workers
4. Medical Director
Care Team Development

• **Selection:**
  • Multiple mini-interview scenarios
  • Emphasis on demonstrated ability to connect and communicate with older adults and caregivers
  • Input from many evaluators

• **Training:**
  • Intense 2 week orientation
    • Dementia care
    • Team building exercises, home visits, simulations
Care Team Development

• Training (cont’d):
  • Depression care training (via UW’s AIMS Center)
  • Weekly case conferences

• Deployment:
  • Outreach to primary care doctors
  • Outreach to practice staff
  • Recurring visits to PCP’s offices for patient appointments
Standardized ABC Minimum Care

1. Check Hospital & ER Alerts every day

2. Coordinate with Inpatient services
   a) Alert hospital team of presence of CI/ Depression
   b) Medications conciliation
   c) Connect with family caregiver
   d) Request ACE consult
   e) Coordinate post discharge transition

3. Post discharge care
   a) Home visit within 72 hours of discharge
   b) Mediation reconciliation
   c) Coordinate Home Care visit
   d) Coordinate post hospital orders
   e) Deliver Delirium protocol and handout

4. Ongoing Aging Brain Care
   a) Manage Depression
      i. PST
      ii. SSRI
      iii. CBT
   b) Manage Cognitive Impairment
      i. ChEIS (if needed)
      ii. D/c Anticholinergics
      iii. Caregiver counseling and education
      iv. Medication adherence support

Callahan et al, Aging & Mental Health 2011; Boustani et al, Aging & Mental Health 2011
# 18 Month Results

<table>
<thead>
<tr>
<th>Variable</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Active Patients</td>
<td>1650</td>
</tr>
<tr>
<td>Coordination of Care Visits – mean</td>
<td>4.8 (6.5)</td>
</tr>
<tr>
<td>Home Visit – mean</td>
<td>3.2 (4.3)</td>
</tr>
<tr>
<td>Phone Visit – mean</td>
<td>3.5 (4.6)</td>
</tr>
<tr>
<td>Clinic visit – mean</td>
<td>0.5 (1.3)</td>
</tr>
<tr>
<td>Mean Age</td>
<td>74.6</td>
</tr>
<tr>
<td>Female %</td>
<td>77.7%</td>
</tr>
<tr>
<td>Number of comorbidities per person – mean</td>
<td>3.3 (1.8)</td>
</tr>
</tbody>
</table>
## 18 Month Results

<table>
<thead>
<tr>
<th>Variable</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnoses</strong></td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td>22.9%</td>
</tr>
<tr>
<td>Depression</td>
<td>70.0%</td>
</tr>
<tr>
<td>Dementia and Depression</td>
<td>7.1%</td>
</tr>
<tr>
<td>Rate of Behavioral/Mood Problems</td>
<td>57.4%</td>
</tr>
<tr>
<td>Rate Major Depression</td>
<td>11.9%</td>
</tr>
<tr>
<td><strong>Response</strong></td>
<td></td>
</tr>
<tr>
<td>Dementia Responders</td>
<td>51%</td>
</tr>
<tr>
<td>Major Depression Full Responders</td>
<td>66%</td>
</tr>
</tbody>
</table>
Secrets to Success

1. Use Community Health Workers
   • Staff from the community know the community and can be very enthusiastic about helping our older adults
   • They can build strong relationships

2. Work with Patients and their Current Providers
   • Building upon pre-existing relationships between our patients and their providers facilitated our outreach

3. Partner with existing service organizations in the community
   • Avoids the need to recreate the wheel
   • Keeps costs down

4. Build a community advisory board to provide feedback and direction
A Way Forward...
George Santayana (1863-1952)

- Philosopher, Novelist, Poet
- “Those who cannot remember the past are condemned to repeat it.”
How can we learn from our shared past?

• Opioid Care
  • Hub and Spokes
  • Extremely Successful
  • Potential model that can be applied to other conditions
Hub and Spokes Applied to Dementia Care

• Old idea --- first proposed by Dr. Pendlebury circa 2000

• Two Domains:
  • Diagnosis
  • Patient and Caregiver Support

• Hubs: UVMMC and DHMC

• Spokes:
  • Regional “experts” in dementia from primary care practices
  • Local practices who will screen for cognitive impairment using the Medicare Annual Wellness Visit
Questions/Comments

• Thank you!
• Email: michael.lamantia@uvm.edu