Dementia Care in Primary Care

Can we do it?

Bar Harbor, June 13, 2015

First Proviso

- I have no actual or potential conflict of interest in relation to this program or presentation.
- I am not a coder so run any advice by your advisors on specifics

Resources

- State Plan for Alzheimer's Disease and related Dementias in Maine. (http://www.maine.gov/dhhs/oads/policy/documents/ALZ-State-Plan.pdf)
- Alzheimer's Association App (http://www.alz.org/health-care-professionals/health-care-clinical-medical-resources.asp)
- Lunder Dineen web site (http://www.lunderdineen.org/dementia)

Objectives

- Recognize the need for Primary Care to take leadership in the care of Older Adults.
- Recognize structural barriers to providing excellent care to Older Adults.
- Develop awareness of process indicators for Geriatric Syndromes.
- Understand how to utilize indicators to improve the care you offer.

Why

- Baby Boomer effect
  - Maine is the oldest state by median age (43)
  - Largest percentage of Baby Boomers
- Dementia is associated with aging
  - 90% of cases are >74 years of age

Why

- Complicates management of other illnesses
  - Medicare Costs of care triple with diagnosis of Dementia
  - Associated with increased LOS and Readmissions
- Under recognized and under managed
  - It is estimated that up to 50% of cases are not recognized
  - 55% of cases at diagnosis are moderate or severe

Why

- Huge impact on caregivers (70% of PWD are at home)
  - Personal burden
    - Stress
      - Behavioral manifestations will occur in 90% of PWD
      - Can occur at any stage of the disease
    - Loss
  - Financial burden
    - Loss of work hours
    - Medical Care and Medications
    - HHA $20/hr ($175,000/yr)
    - Adult Day $65/day (23,725/yr)
    - Residential Care $42,000/yr
    - LTC $77-90,000/yr
      - Estimates from AA website

Who will provide Dementia Care?

- 7,000 Boarded Geriatricians in the US
  - Maybe 40 in Maine
- 12,000 Neurologists
- 2,500 Geriatric psychiatrists
- 222,000 Primary Care Specialists
  - Provide 80% chronic care for older Americans

Xakellis GC. J Am Board Fam Pract. 2004

Grumbach JAMA 2002

Who will provide Dementia Care?

- Compounding this is that it is rare for geriatricians to do community based Primary Care of Geriatric patients.
- Geriatricians earn less than Primary Care Internists or Family Practitioner
  - Time
  - Procedureless

Who will provide Dementia Care?

- There are parts of this work that can ONLY BE DONE BY A PRIMARY CARE SPECIALIST
  - Balancing patient's needs and desires against disease specific guidelines
  - Polypharmacy

The Challenge

- Chronic illnesses
- Geriatric syndromes
- Social Issues

Health Care System

- Based on the model of acute care provided prior to 1965.
  - Payment system
  - Training
  - Office based structure

Health Care System

- Hope
  - PCMH
  - ACO/Shared risk
  - Interdisciplinary training
  - EMR????

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What does it take to get to excellent care?

- How do you know you are there?
  - Need some measures.
- How do you get there?
  - You need some reliable process
    - Team work is essential
  - The measures can help you establish a process.

Measures

- ACOVE
- PQRS
- DMQM
- NQF

  - See Table

ACOVE

- Assessing Care of the Vulnerable Elderly
  - Series of indicators of care for vulnerable elderly patients we should all meet.
    - In reality aspirational
  - 17 indicators for dementia

Wenger et al. J Am Geriat Soc 55:S247-S252,2007

DMQM

- Dementia Management Quality Measures
  - 10 measures; significant overlap with ACOVE
    - Adds Palliative Care and Advanced Care Planning

    - Neurology;2013:1545-1549

PQRS

- Physician Quality Reporting System
  - 9 indicators
  - Adds Staging

NQF

- National Quality Foundation
  - Attempt to define Dementia Capable
    - Communities
    - Practices
      - Heavily influenced by ACOVE

Measures and Process

- Let you know what you need to accomplish.
- Help you decide how to share the work amongst your team.
- Allows you do to do Q/I

ACOVE Indicators

- **IF** a VE is new to a primary care practice…, THEN there should be a documented assessment of cognitive ability and functional status
- Covers
  - Screening
  - Evaluation
  - Anticipatory guidance
  - Treatment
  - Care giver support

How do we do?

- JAGS 61:1277-85 Variation from 4-60% use of formal MSE's in patients with a of diagnosis of dementia

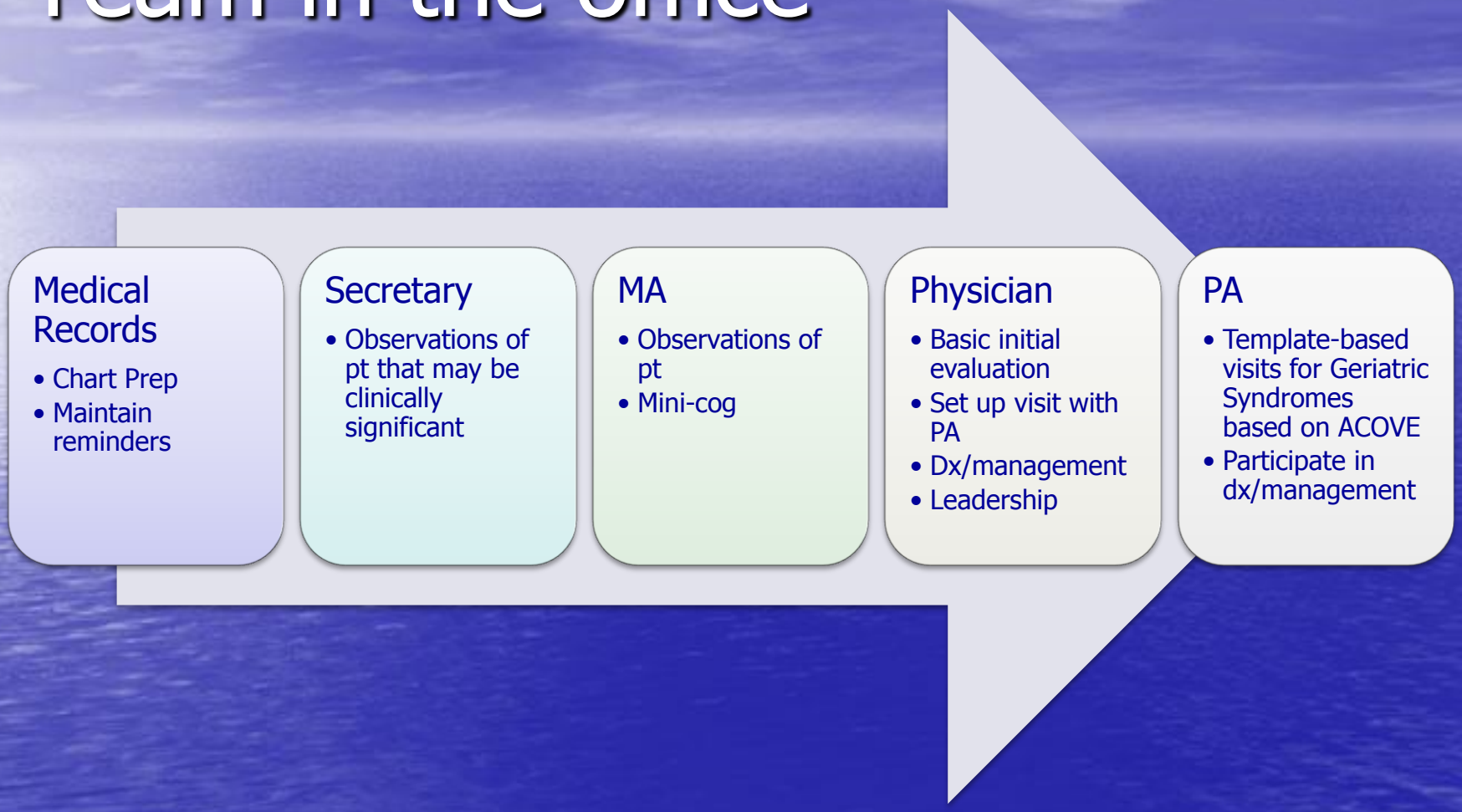
- David Reuben et al (JAGS 61:857-867,2013) 21% AB (59% vs 38%) with NP in community based care for dementia.

How might we do it?

Models in practice

- Multiple visits with a primary care provider
- Multiple visits shared with a PA or NP
- Nurse and other staff can take on enhanced roles
- Geriatrics NP as an interface between Geriatrics assessment team and Primary Care clinics with Geriatrician support
- Specially trained Primary Care provider with a practice offering clinics on a regular basis and connected to Geriatricians.

Team in the office



Team in Geriatrics

Early Recognition/Screening

- Case Finding
  - A matter of raising awareness of staff and providers to potential signs.
  - High sensitivity to concerns of others observing patient.
- Screen
  - MCI screening questions as routine part of AWV or routinely on all over 74 y/o
  - Mini Cog
    - Who to target.
    - Who to do the test
    - Training
    - Scripting

Then what?

- History
- Cognitive Evaluation
- Physical Exam
- Neurological Exam
- Depression screening
- Medication Review
- Laboratory testing
- Diagnosis

And more.

- Treatment decision
- Anticipatory Guidance
  - Legal
  - POA
  - Driving
- Caregiver support
- Connection to community resources

Approaches

- Cannot be done in one visit
- Single provider with multiple visits
- Shared work
  - MD/DO/NP and PA or NP
  - MD/DO/NP and nurse

MEDCAPS Grant

- Implement a standardized approach to Dementia Care (ACOVE) and link to a Q/I process.
  - Q/I Focus
    - Early Detection/Screening
    - Further work up
    - Referral to community resources

Pilot Approaches

- Screening
  - MCI questions built into AWV
    - If negative done
  - MCI questions to all >74 y/o without memory diagnosis by MA
    - If negative
  - MiniCog by MA
    - If negative → Repeat 1 year

Pilot Approaches

If a positive question or MiniCog <4 →Provider visit 1

- Code Memory Problem (780.93)
- Script similar to a single abnormal BP result
- Bill, captured in the original reason for visit, this will not generally raise that code unless time spent

Pilot Approaches

- Visit 1 (Designed as nurse note but could be basis for provider note)
  - EMR template
  - History
  - Specific Testing
    - MoCA (http://www.mocatest.org/)
    - PHQ 9
    - IADL's
  - Labs

Pilot Approaches

- If performed by provider can easily meet criteria for a 99214.
  - Can add elements of Visit 3.
- If performed by nurse will only be able to code as 99211
  - Loss of billing but perhaps worth the efficiency
- Will be either under ICD code of Code Memory Problem (780.93) or Dementia or a more specific diagnosis code.

Pilot Approaches

- Visit 2 (Provider. Note, if provider doing both these visits the order of tasks could be changed/mixed)
  - Medication review
  - Physical and Neurological exam
    - Consider imaging
  - Synthesize and decide on diagnostic category
  - Refer community resources
  - Manage/consult if needed

Pilot Approaches

- Again Provider should be able to bill 99214 level with this work.

Pilot Approaches

- Visit 3 (Provider/Nurse/Care manager)
  - Anticipatory Guidance
    - Legal
    - POA
    - Driving
    - Home safety
  - Care Giver Support

Pilot Approaches

- This is work that can be divided up amongst multiple team members depending on the nature of your team.
  - Some of the work can be done by others outside your practice.
- Any significant counselling visits can be billed on time up to 99215 level.

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MEDCAPS Pilot

- If interested:
  - Lunder Dineen website
    - (http://www.lunderdineen.org/dementia)
  - Contacts
    - Me Roger.Renfrew@MaineGeneral.org
    - Cliff Singer csinger@emhs.org

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Questions

Roger Include

- Indicators and Bibliography
- MiniCog
- Pamphlet
- Diagnostic codes for dementia