Integrating the Care Ecosystem into Dementia Care at Allina Health

Kate Possin, PhD
Associate Professor of Neurology, UCSF

Kim Radel
Operations Director, Allina Health

ACT on AD Leadership Summit
September 29, 2016
The UCSF (left) and UNMC (right) Care Ecosystem teams
Current dementia care is often reactive, intermittent, generic, and expensive

- More than 25% of patients are prescribed unsafe drugs
- Unwanted emergency-related care is common
- The high cost of care does not equate to improved quality of life or other patient-centered outcomes
- Caregivers feel unsupported by the healthcare system, and experience high rates of burden and depression
Dementia is the most costly health condition

- Cancer: $77 billion (2011 direct health care expense)
- Heart Disease: $102 billion
- Dementia: $109 billion

Hurd et al., NEJM, 2013
Where Persons with Dementia Spend Their Days Compared to Where they Spend CMS Dollars

Days Spent in Each Site of Care over 5 years

Money Spent in Each Site Of Care over 5 Years

Each Small Box Equals 5 days

Each Box Equals $250

Figures derived from Callahan CM et al. JAGS 2012; Callahan CM et al. JAGS 2015
Why must dementia care programs rely on family caregivers?

- They are comforting and familiar and loved
- They are the only workforce of sufficient size and distribution
- There is no practical alternative

*By QUOC TRINH LUU and CLAIRE CAIN MILLER: DEC. 29, 2015*

*The Typical American Lives Only 18 Miles From Mom*

*Source: The Health and Retirement Study, 2008*

*Slide courtesy of Chris Callahan, MD.*
The Care Ecosystem: proactive, continuous, and personalized care that supports the caregiver

**Goals:**

- To build an alliance between the care team and the patient and caregiver
- To provide the right care at the right time
- To personalize care to diverse care recipients
  - ethnic, SES, rural/urban, all types of dementia
- To support the caregiver to keep the patient at home
- To avoid unnecessary or unwanted emergency related care
The Care Ecosystem Model. The CTN is at the Center.
Who is a Care Team Navigator or CTN?

- A friendly, empathic, and organized person who loves working with people
- Health care background not required
- CTN is trained, supervised, and supported by a clinical team
- CTN provides telephone-based care coordination, education, and support
**Modules of Care Ecosystem**

**Medications**
Review and monitor your medicines to make sure they are safe and effective for you.

**Functional Monitoring**
Detect and respond to changes in the patient’s activity level that could be an early sign of illness using smartphones, wearable devices, and in-home sensors.

**Caregiver Support**
Offer suggestions and advice about caring for the patient and provide caregiver education, support, and community resources just for you.

**Decision-Making**
Provide guidance for decision-making around medical, financial and safety issues.
The Dashboard: A workflow management tool

The Caregiver Portal: Information for the family
Healthcare Innovations Award Round Two: A Randomized Controlled Trial

- Target enrollment by February: 700 randomized to the intervention and 350 to the usual care group
- Patient, caregiver, and cost outcomes are compared between groups
- Sample is diverse
  - A large rural cohort from NE and IA
  - Monolingual Chinese and Spanish cohorts
  - Range of SES
Care Ecosystem Satisfaction
4 months post-enrollment

- 92% would recommend the Care Ecosystem to other caregivers
- 77% said they needed help from the CTN at some point since enrollment
  - 96% of these said the CTN was available when needed.
- 92% said the amount of contact they had with their CTN was about right
- 59% recalled that the CTN had referred them to resources in their community
  - 87% of these said the referrals had been helpful.
- 49% said that the patient has problematic behavioral changes
  - 65% of these said that the CTN helped them manage those behaviors.
- 11% thought the Care Ecosystem helped the patient avoid an unnecessary emergency room or hospital visit.
Payment Models: Factors to consider when selecting a sustainable dementia care program

The program should be:

- **Built with cost efficiencies:**
  - Non-clinical CTN role, leverages technology

- **Project cost savings:**
  - Decrease emergency department utilization, delay long-term care placement

- **Demonstrate quality outcomes for patients and caregivers:**
  - Patient quality of life, Pt/cg satisfaction, caregiver burden and depression

- **Support increased primary care billing using new and potential codes**
  - Chronic care management code, potential high severity code
  - Advanced care planning codes
  - Hope Act for Alzheimer’s disease comprehensive care planning
The project described was supported by Grant Number 1C1CMS331346 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.