The UCLA Alzheimer's and Dementia Care program

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The UCLA Alzheimer's and Dementia Care Program

- Clinical program with goals:
  - Maximize patient function, independence, & dignity
  - Minimize caregiver strain
  - Reduce unnecessary costs
- Began in 2011 with philanthropic funds
  - Planned 250 patients
- Round 1 CMMI Award July 2012—Dec 2015
  - To expand the program to 1,000 patients
- Today, over 1800 patients enrolled

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

Patients

- Must have diagnosis of dementia
- Live outside nursing home
- Must have a referring/partnering UCLA physician

Community-based Organization (CBO) Services

- Direct services to patients and families
  - Adult day care
  - Counseling
  - Case management
  - Legal and financial advice
- Workforce development focusing on training family and caregivers
- Paid for using voucher system

Enrollment to Date (7/20/16)

- Patients enrolled: 1,825
- Referrals waiting to be seen: 125
- 1-year follow-ups conducted: 722
- 2-year follow-ups conducted: 309
- 3-year follow-ups conducted: 52

Patients in the Program

- Mean age 82; 66% female
- Diagnosis
  - Alzheimer's disease: 35%
  - Lewy-Body: 4%
  - Vascular: 4%
  - Other, mixed or unknown: 53%
- Mean MMSE score 17.4
- Caregiver: 34% spouse, 54% child
- Dually insured 18%

Caregivers at Baseline

- 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

Services Provided

- Support group referral: 84%
- Caregiver training: 75%
- Refer to CBO: 56%
- Recommend additional evaluation: 25%
- Adjust medication: 16%
- POLST: 20%

Caregiver Satisfaction

- 90% felt the intake visit was time well spent

- 91% felt concerns listened to and addressed

- 92% would recommend the program to others

Physician Satisfaction

- Valuable medical recommendations: 61%

- Valuable behavioral recommendations: 85%

- Enhanced MD relationship with patient: 68%

- Saved MD time: 56%

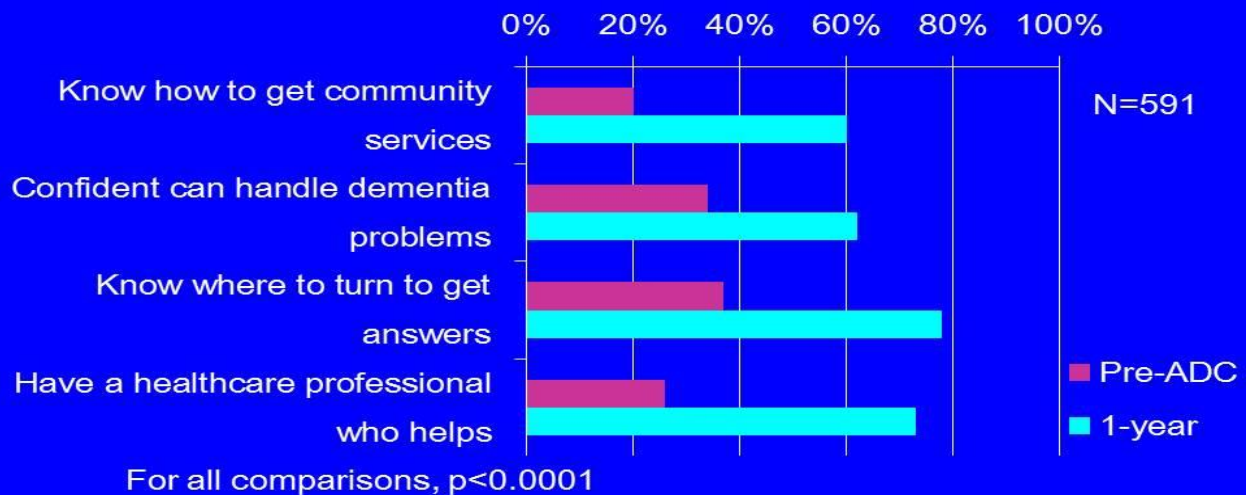- Would recommend for other patients: 90%
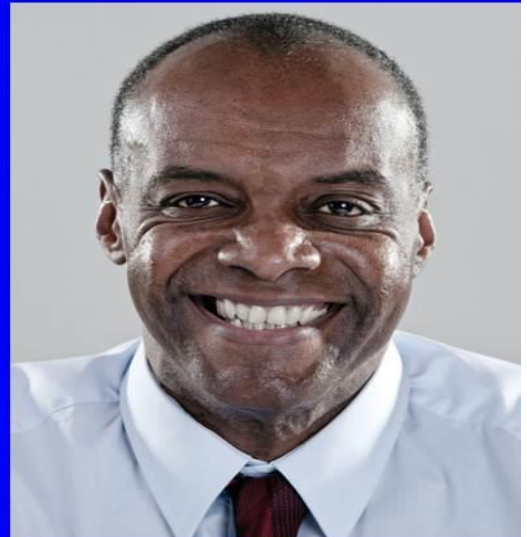
Overall Dementia Quality of Care (ACOVE-3 and PCPI QIs)*

- Community-based physicians   38%
- Community-based physicians & NP   60%
- UCLA Alzheimer's and Dementia Care 92%
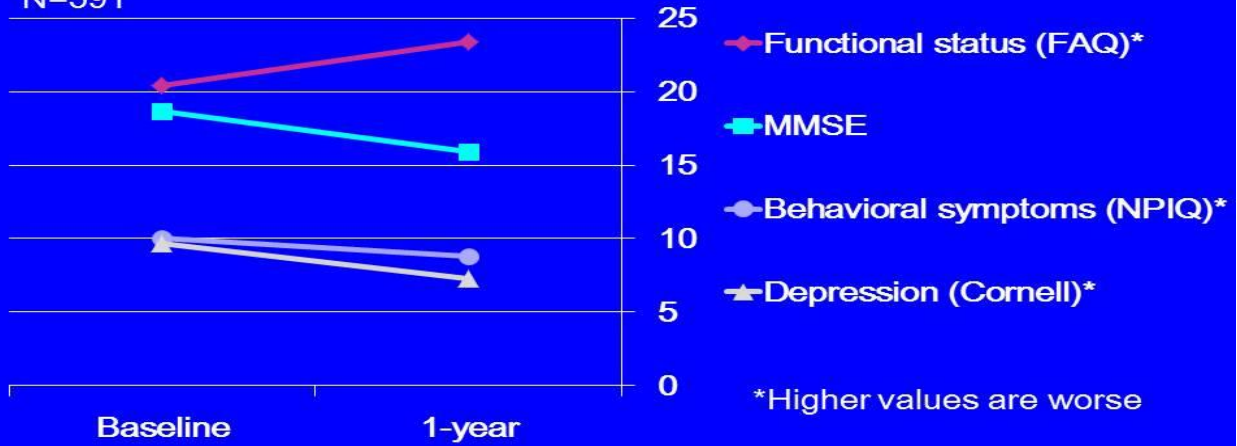
- * Based on medical record abstraction

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

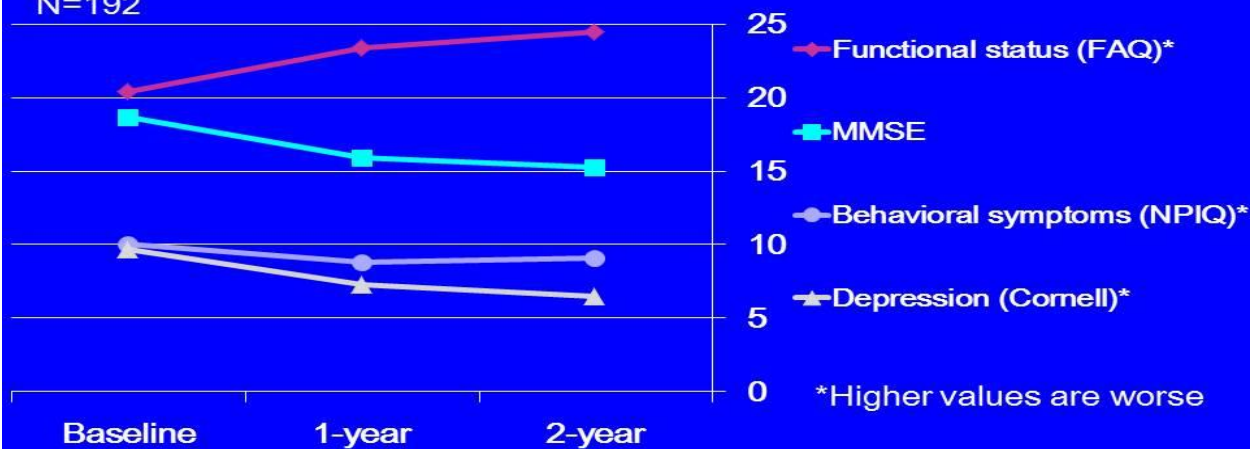# 1-year Changes in Caregiver Experience and Self-efficacy

N=591

Know how to get community services

Confident can handle dementia problems

Know where to turn to get answers

Have a healthcare professional who helps

Pre-ADC
1-year

For all comparisons, p<0.0001

1-year Outcomes: Patients

N=591

- Functional status (FAQ)*
- MMSE
- Behavioral symptoms (NPIQ)*
- Depression (Cornell)*

*Higher values are worse

For all baseline and year 1 comparisons, p<0.001.

2-year Outcomes: Patients

N=192

- Functional status (FAQ)*
- MMSE
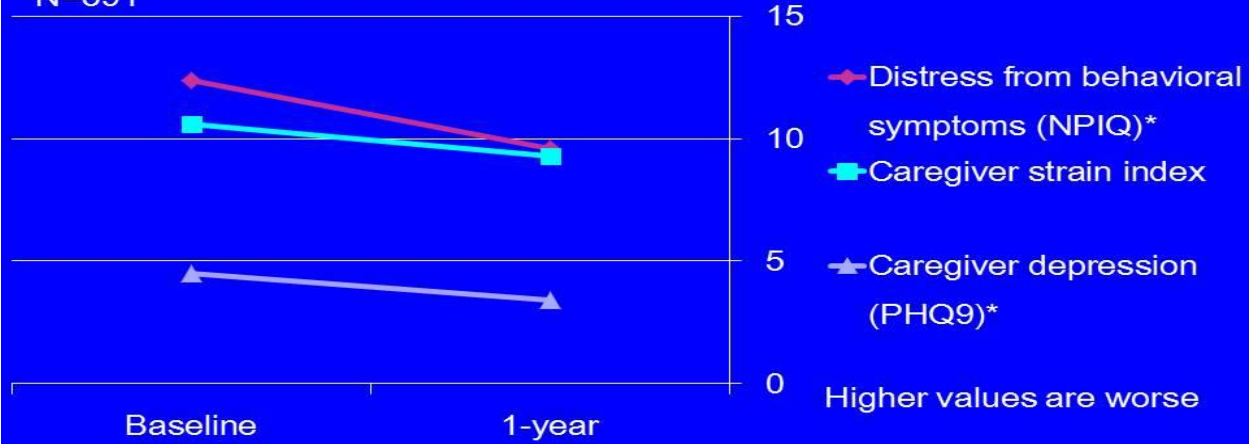- Behavioral symptoms (NPIQ)*
- Depression (Cornell)*

*Higher values are worse

For all baseline and year 2 comparisons, p<0.001, except behavioral symptoms, p=0.07.

1-year Outcomes: Caregivers

N=591

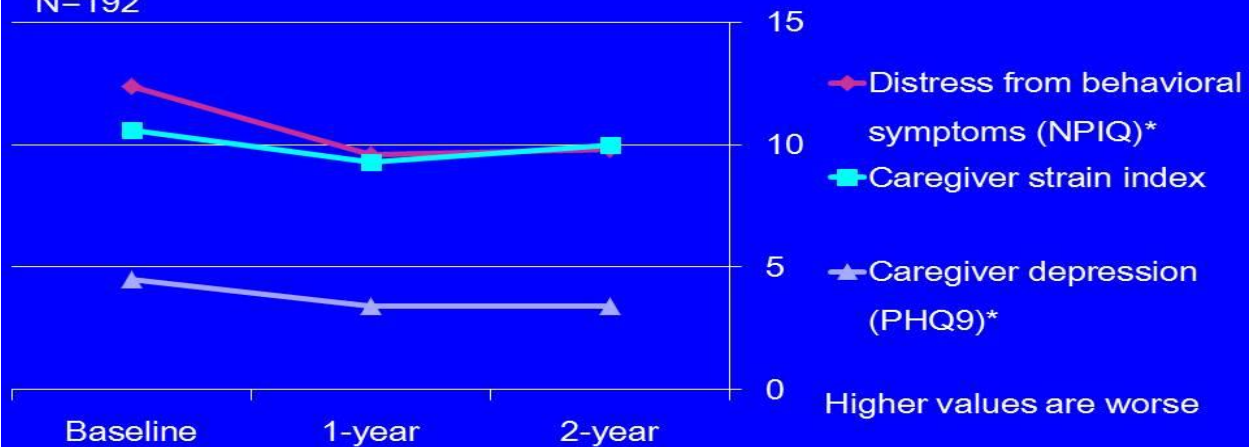Distress from behavioral symptoms (NPIQ)*
Caregiver strain index
Caregiver depression (PHQ9)*

Higher values are worse

For all baseline and year 1 comparisons, p<0.001.

2-year Outcomes: Caregivers

N=192

Distress from behavioral symptoms (NPIQ)*
Caregiver strain index
Caregiver depression (PHQ9)*

Higher values are worse

*Baseline and year 2 comparisons, p<0.01.

Spinoffs

Infrastructure
- Dementia Care Management Software
- Website with caregiver training videos and webinars
  (http://dementia.uclahealth.org)

Enhanced support for caregivers
- I-CareD (personalized caregiver training program)
- TIMEOUT@UCLA (student respite program)
- Support Groups (English, Spanish, Early Onset, FTD, and Lewy Body)

Goals for the Future

- Sustaining the program
- Increasing the number served
- Enhancing services
- Disseminating the model

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 $1400/y   ($4/d)
- Donepezil (generic) $2190/y   ($6/d)
- Memantine $2880/y   ($8/d)
- Donepezil & Memantine $5070/y   ($14/d)

Current Business Model

- Bill for Medicare-allowed services (3%)
- All other services free of charge
  - Care coordination with PCPs and CBOs
  - Telephone follow-up
  - Support groups
  - Education
- Some institutional support, both in-kind and short-term funds (29%)
- Ongoing grants and philanthropy (68%)

Barriers to Dissemination

- Current Medicare coverage for program
  - For in-person visits, nurse practitioners are reimbursed 85% of what physicians are paid
  - For all clinical work that is not in-person, there is no reimbursement
  - No coverage for CBO services
- Shortage of qualified nurse practitioners

In Summary

- UCLA ADC Program proof of concept
  - Bringing program to scale
  - Longitudinal, co-management model
  - Patients and doctors like it
  - Filling a gap in care
- Improving outcomes for patients and caregivers
- But no current economic model under Medicare