Clinical Services Update

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Health Resources and Services Administration

- Geriatric Education Centers (GECs) are continuing to provide interprofessional continuing education to the healthcare workforce
- GECs are currently in the process of reporting their January 1 – June 30, 2014 activities
- As of May 29, 2014, over 37,300 healthcare providers have participated in the Medscape training on "Case Challenges in Early Alzheimer's Disease"

National Quality Forum Project: Alzheimer's Disease and Related Disorders

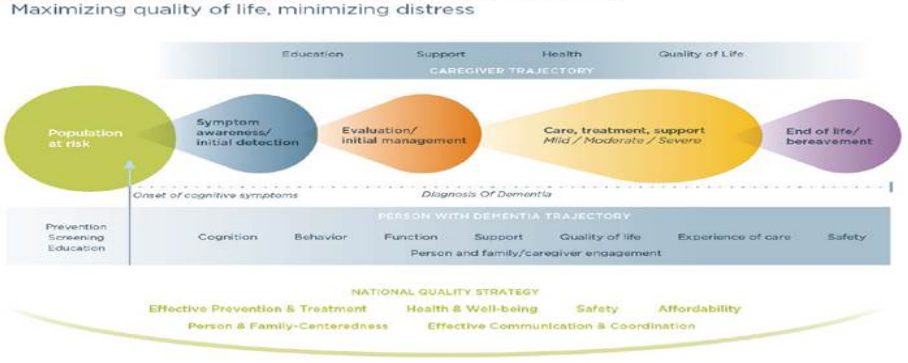
- "Prioritizing Quality Measure Gaps"
- Conceptual framework for measurement
- Environmental scan of measures
- Multi-stakeholder consensus process
  - Identify quality measure gaps
  - Provide recommendations to HHS for measure development efforts
  - In person meeting, June 2-3, 2014
  - Draft report released for public comment, Aug. 22, 2014

Conceptual Model for Performance Measure Development for Dementia (Presented at the June 2-3 NQF Meeting)

NATIONAL QUALITY FORUM

Meeting Materials

Conceptual Framework - Latest Version



In Person Meeting at NQF on June 2-3

- NQF project presented within context of the National Plan to Address Alzheimer's Disease
- Setting the stage for quality measurement opportunities - short vignettes
- Prioritizing measure gaps -
  - Summary recommendations on following slides

Measure Priorities Focusing on the Person with Dementia

- Detection should lead to diagnostic evaluation
- Diagnostic evaluation is intentional and results in a diagnosis, occurs in a reasonable time, and is documented
- Core dementia work-up ("initial dementia assessment")
- Hospitalization/transitions of care (including long-term care facilities)

Measure Priorities Focusing on the Family/Caregiver

- Measures caregiver support, a composite measure that includes:
  - Assessment
  - Communication with family
  - Training
  - Responsive to needs of the caregivers
  - Advocacy, due to unresponsiveness of system

Measure Priorities Focusing on Both the Person w/ Dementia & the Family/Caregiver

- Dementia-capable health care and community care system (broader than just LTC)
- Shared decision-making
  - With advanced care planning – composite that includes prognosis, treatment options, education
  - Caregiver participatory decision-making
  - For person with dementia assessing for personal treatment goals

Opportunity for Public Comment

- Draft report released: Aug. 22, 2014
- Public webinar: Aug. 27, 1:30-3pm ET
- Public comment period on draft: Aug. 22 – Sept. 13, 2014
- Webinar registration (and eventual draft report) available at:

  http://www.qualityforum.org/Prioritizing_Measure_Gaps_-_Alzheimers_Disease_and_Related_Dementias.aspx

Innovative Models of Care

- The Innovation Center, established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act).
- Congress created the Innovation Center for the purpose of testing "innovative payment and service delivery models to reduce program expenditures …while preserving or enhancing the quality of care" for those individuals who receive Medicare, Medicaid, or Children's Health Insurance Program (CHIP) benefits.
- Authority to expand the scope and duration of a model being tested through rulemaking, including the option of testing on a nationwide basis.
  - A model must either reduce spending without reducing the quality of care, or improve the quality of care without increasing spending, and must not deny or limit the coverage or provision of any benefits.
  - These determinations are made based on evaluations performed by the Centers for Medicare & Medicaid Services (CMS) and the certification of CMS's Chief Actuary with respect to spending.

Health Care Innovations Awards (HCIA)

Goal: To identify and support a broad range of innovative service delivery and payment models that achieve better care, better health and lower costs through improvement in communities across the nation.

- Project started in July 2012
- Most projects launched first quarter, CY 2013.
- Ongoing self-monitoring and rapid cycle improvement at each site
- Programs developed measures of success and use those measures to identify operating issues and make improvements
- Program close June 2015

HCIA Projects Serving People with Dementia

Awardee	Brief Description
Regents of the University of California, Los Angeles	Coordinated, comprehensive, patient and family-centered program. Five key components: (1) patient recruitment and a dementia registry; (2) structured needs assessments of patients and their caregivers; (3) creation and implementation of individualized dementia care plans; (4) monitoring and revising care plans as needed; and (5) providing access 24/7, 365 days a year for assistance and advice.
Trustees of Indiana University	The Aging Brain Care program incorporates the common features of several evidence-based collaborative care models into one program designed to deliver high quality, efficient medical care to older adults suffering from dementia and or depression.
University of Rhode Island	The Living Rite Innovations project is delivering holistic coordinated care through the project's two Living Rite Centers. The Centers provide comprehensive chronic care management in order to coordinate services between multiple community providers, improve health and decrease unnecessary hospitalizations and ER visits.
University of Arkansas for Medical Sciences	Project is providing enhanced training of both family caregivers and the direct-care workforce in order to improve care for elderly patients requiring long-term care services, including Medicare beneficiaries qualifying for home healthcare services and Medicaid beneficiaries who receive homemaker and personal care assistant services.
Suttercare Corporation	Project is expanding the pilot of Sutter Health's Advanced Illness Management program (AIM) across the entire Sutter Health (Sutter) system. AIM is essentially a complex medical home model that deploys interdisciplinary teams to deliver care that adheres to patient goals and preferences, improves patient self management of chronic illness and provides concurrent disease modifying and palliative care.
University of North Texas Health Science Center	The awardee in partnership with Brookdale Senior Living (BSL), is developing and testing the Brookdale Senior Living Transitions of Care Program, which is based on an evidenced-based assessment tool called Interventions to Reduce Acute Care Transfers (INTERACT) for residents living in independent living, assisted living and skilled nursing facilities. The goal of the program is to prevent the progress of disease, thereby reducing complications, improving care, and reducing the rate of avoidable hospital admissions for older adults.

HCIA Projects Serving People with Dementia

Awardee	Project Launch	Cumulative Direct Program Participants (July 2012 – March 2014)	Indirect Program Participants (January- March 2014)	Cumulative Trainees *(Individual may have participated in more than one training course, and thus can be counted more than once)*
Regents of the University of California, Los Angeles	7/1/2012	658	672	14
Trustees of Indiana University	10/1/2012	2,647	-	211
University of Rhode Island	5/1/2013	236	-	86
University of Arkansas for Medical Sciences	3/25/2013	-	1,852	869
Suttercare Corporation	7/1/2012	4,233	-	1,554
University of North Texas Health Science Center	11/30/2012	-	4,421	3,984

Health Care Innovation Awards Round 2

- In May 2013, the Innovation Center announced a 2nd round of *Health Care Innovation Awards*, specifically soliciting proposals in 4 specific categories of care:
  - One of the four categories, "improve care for populations with specialized needs," designates proposals that target care for persons with AD as a priority population for funding.
  - Prospective recipients have been announced and will receive Notice of Awards in the summer of 2014.

Healthcare Innovation Awards Round 2

Awardee	Brief Description
Regents of the University of California San Francisco	"The UCSF and UNMC Dementia Care Ecosystem: Using Innovative Technologies to Personalize and Deliver Coordinated Dementia Care" Project to implement a clinical program to offer dementia care while providing specialized expertise in functional monitoring and rural dementia care. Target population is Medicare-Medicaid dual eligibles. By supporting family caregivers, keeping patients healthy, and helping them prepare for advancing illness, model aims to improve care satisfaction and prevent emergency-related health care costs.
Johns Hopkins University	"Comprehensive home-based dementia care coordination for Medicare-Medicaid Dual Eligibles in Maryland" Project will test implementation of an Alzheimer's disease/ Dementia (AD) – targeted care coordination model that addresses critical barriers to adults with AD in home. Model creates link between community health agencies, medical providers and community resources.
CareChoice Cooperative	"Person Centered Care Connections" This project will use tests to reduce unnecessary hospitalizations and total cost of care to address problems in nursing home post-acute and long term care. Aim to create an efficient system for nursing home staff to do comprehensive education and prep to promote successful patient transition to home.
Avera Health	"Avera Virtual Care Center: Improving Care & Reducing Costs for the Vulnerable Elderly Population" Project will test virtual wrapping of comprehensive set of resident-centered, geriatric care services around long term care population. Project will operate in SD, MN, IA, and NE.
Yale University	"Paramedic Referrals for Increased Independence and Decreased Disability in the Elderly (PRIDE)" Test model for elders and those with impaired mobility. Project to expand paramedic workforce as a community-based resource to improve care coordination and health outcomes for elders staying at home.

http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Round-2.html

National Partnership to Improve Dementia Care

...and **reduce unnecessary antipsychotic medication use** in nursing homes

The Partnership to Improve Dementia Care promotes a multi-dimensional approach that includes the 3 Rs:

Rethink our approach to dementia care
Reconnect with residents via person-centered care practices
Restore good health and quality of life

16

National Target Met

- Progress of the National Partnership by publicly reported measures of antipsychotic medication usage among long-stay nursing home residents.
- In 2011Q4, 23.9% of long-stay nursing home residents were receiving an antipsychotic medication
- Since then there has been a decrease of 17.1% to 19.8% in 2014Q1.
- Just refined this goal to 25% reduction next goal