Person Centered Care Planning: 
A View from the Clinic

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April 29, 2019

Person Centered Care for Dementia: Principles and Process

• Person > disease(s)
• Key friends and family
• Clinician roles = consultant, technician, container of uncertainty
  • Eliciting concerns, understanding, priorities
  • Advising from evidence + judgment
  • Integrating complexity
  • Negotiating goals
  • Evaluating goal attainment
  • Adjusting and revising
  • Anticipating and counseling
  • Mitigating risk
Person-Centered Dementia Care: 5 Domains

CMS Cognitive Impairment Care Planning Code 1.0 – Alzheimer’s Association Workgroup

- Interprofessional collaboration
- Goals
  - Explain in plain language - purpose and elements of CPT 99483
  - Encourage uptake in primary care
    - Illustrate simple ways to meet required 9 elements
  - Identify gaps – the evidence of collective experience
  - Anticipate potential barriers to use

Key innovations

- Acknowledges complexity (9 elements)
- Explicitly includes caregivers
- Requires written, shared care plan
- Offers good value for providers and health systems
- Allows combination with other select codes – reflects realities of ‘care on the ground’...and the phone...and when patient is not present...and...

CPT 99483 vs. Person-Centered Care Planning

- History, objective measure, staging, impact on function
  - Ability to make own decisions?
- Neuropsychiatric symptoms
  - Potential causes/care?
- 1. Mental and emotional health
- Physical health, risks
  - Safety
  - Med reconciliation
  - Advance care plan
  - Treatment and prognosis?
- 1. Social determinants
  - Resources, access, continuity of care?
- 1. Key friends and family
- Cognition / function
  - Willingness/ability to care
  - Stress, depression, cognitive impairment, frailty, knowledge and skills?
Person-Centered Care Planning 2.0: Putting It into Practice

- What providers need in order to change their practice
- Person-centered measures, e.g. Managing Your Loved One’s Health
- Payment incentives for comprehensive dementia care (already in CPC+ models of primary care)
- Systems of care
  - Dementia care teams - adapting local resources
  - Standardized documentation and care plan templates
  - Electronic accountability and referral tools
  - Population and outcome research management