WORKING TOWARD VALUE BASED PRIMARY CARE FOR DEMENTIA

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CO-LEAD, BOLD PUBLIC HEALTH CENTER OF EXCELLENCE ON EARLY DETECTION OF DEMENTIA

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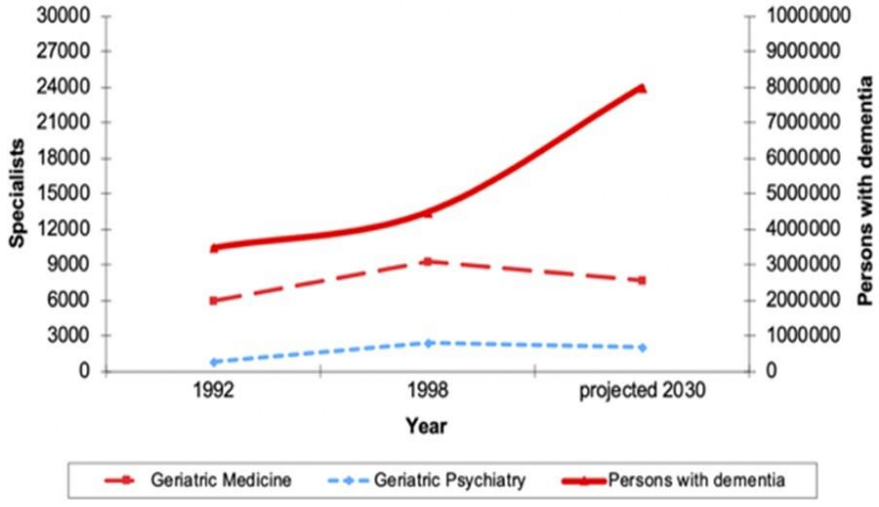
Figure 1. US Geriatric Specialist Workforce v. Persons with Dementia



Borson S, Chodosh J. Clin Geri Med 2014; 30: 395-420.

No reliable figures for cognitive neurologists

THE SCOPE OF PRIMARY CARE

- Health promotion
- Prevention – primary, secondary, tertiary
- Health maintenance
- Counseling and patient education
- Provider is a personal physician/advanced practitioner (ARNP, PA)
- Patient advocacy with health care system: coordination, cost-effectiveness
- Sustained relationship – long-term patient-provider partnership

https://www.aafp.org/about/policies/all/primary-care.html

PRIMARY CARE PROVIDERS

85% of first diagnoses, 80% of care

- Under-detection
- Late diagnosis
- Inequities in detection
- Dx often 'NOS'
- Broad care model
- Low uptake of CMS dementia care benefits

MEMORY DISORDER SPECIALISTS

(neurology, geriatrics, psychiatry)

15% of first diagnoses, <10% of care

- More standardized assessment
- Mainly earlier stages
- Larger health disparities
- Narrow disease-focused care model
- No specific role or relationship with primary care
- More 99483 coding

Yang et al. *J Am Med Dir Assoc* 2016; Drabo et al. *Alzheimer's Dement* 2019

TO IMPROVE DEMENTIA OUTCOMES, LEVERAGE THE POWER OF PRIMARY CARE

DEMENTIA AS A BRAIN DISEASE *VS* DEMENTIA AS A CHRONIC CONDITION

- Focus on etiology
- Biological mechanisms
- Pharmacotherapy
- Address presenting problem
- "Diagnose and adios"

- Focus on the person and the total mix
  - Multidomain assessment, what matters most, managing uncertainty, staying the course
- Organizing principle of care
  - Psychosocial and functional impact
  - Health outcomes
  - Health systems

UPTAKE OF MEDICARE BENEFITS THAT CAN ENABLE BETTER DEMENTIA CARE

VISIT TYPE	FIRST DATA YEAR	MOST RECENT DATA YEAR
Annual Wellness Visit (older adults)	8% (2011)	32% (2018)
Cognitive Assessment and Care Planning (PLWD)	<0.05% (2017)	0.96% (2019)
Chronic Care Management (PLWD)	n/a	6.7% (2019)

2021 MEDICARE ADVANTAGE 'DEMENTIA INCENTIVE' – HCC adjustment

Jacobson et al, *Health Aff* 2020; Hargraves, *Health Care Cost Institute*; Zissimopoulos et al *in prep*; Reddy et al. *Ann Fam Med* 2020

IMPACT OF PRIMARY CARE CONTINUITY ON ACUTE CARE UTILIZATION IN DEMENTIA

OUTCOME	RISK RATIO	p value	NNT TO PREVENT ONE EVENT
Hospitalization 1+	0.90	< .001	29
30-day readmission 1+	0.81	<.001	97
ACSC hospitalization 1+	0.87	<.002	87
Emergency dept visit 1+	0.92	<.001	23

Godard-Sebillotte et al, JAGS 2021. N=22,033 people living with dementia and 2+ primary care visits; Quebec primary care administrative data. Year 1 baseline (high vs low PC continuity), Year 2 outcome.

PRIMARY CARE PROVIDERS WANT TO CARE FOR PEOPLE LIVING WITH DEMENTIA AND THEIR FAMILIES

"I think that we are it… When it comes to dementia specifically…we are there from the beginning to the end, or we *can* be, or when it comes to someone's life, we are there from the beginning to the end. I have the training to deliver babies. I can be there when someone takes their first breath as a human being, and I have the training to take care of someone at the end of life, too, and then for every breath in between, we are here. I think when it comes to people's family systems and the life course that someone takes, I think that we are uniquely positioned to take care of people with dementia, to be the medical provider. Who else is better suited to do that? At the same time, we definitely don't have the resources, the culture, societally, or the systems and structures in place with reimbursement and funding to do it well."

With thanks and credit to Dr. Alissa Bernstein Sideman for sharing her work [supported in part by the National Institute on Aging (K01AG059840) and the California State Alzheimer's Disease program (19-10615)].

PRIMARY CARE PRACTICES: EMBRACE STRENGTHS, FIX WEAKNESSES

- Strengths: relationship-based, located in patients' own communities, prioritize access to health care, and maintain a range of specialty and institutional consultative and referral relationships for specific care needs
- Targets for improvement
  - Team-based care: Physicians/advanced practice providers + other health professionals
  - More face-to-face/personal contact, more continuity, lower documentation burden/screen time,
  - Safe simplification of assessments and management interventions
  - Incentives to implement existing CMS benefits – traditional Medicare vs Medicare Advantage plans
  - Relevant education/training that demystifies dementia, builds on unique strengths of primary care

MANAGING DEMENTIA IN PRIMARY CARE: FIVE DOMAINS OF HEALTH

CAN WE IMAGINE 'NO-CRISIS' CARE?

PRIMARY CARE OF DEMENTIA: GAPS IN RESEARCH AND POLICY

RESEARCH

1. Define outcome goals and value for primary vs specialty care of dementia
2. Test prevailing assumptions: e.g. do all patients really need neuroimaging?
3. How can specialty providers best support primary care?
4. What payment models best address critical barriers to implementing better care?

POLICY

1. Engage primary care leaders as co-designers of dementia care goals/content/benefits
2. Expand the value discussion beyond dollars: solve the dementia care quality measure problem
3. Invest in practice-based dementia research network
4. Sponsor collaboration between Alzheimer's Disease Research Centers and Geriatric Workforce Enhancement Programs