The UCLA Alzheimer's and Dementia Care Program:
An innovative nurse practitioner led health system based clinic

David B. Reuben, MD; Leslie C. Evertson, GNP; Michelle Panlilio, GNP; Mihae Kim, AGNP; Kelsey Stander, AGNP; Zaldy S. Tan, MD, MPH
Division of Geriatrics, University of California, Los Angeles

UCLA Health
David Geffen School of Medicine

BACKGROUND

5.2 million Americans currently diagnosed with dementia

Annual U.S. costs of dementia care exceed $150 billion

Dementia patients incur 3x as many hospital stays

Several dementia care programs been developed but have not been disseminated widely

UCLA PROGRAM HISTORY

→ **2011:** UCLA Alzheimer's and Dementia Care (ADC) program launched in November, begin patient enrollment

→ **2018**: 1050 active patients, over 2500 patients enrolled

THE UCLA ALZHEIMER'S AND DEMENTIA CARE PROGRAM

GOALS: | **Maximize patient function, independence, and dignity** | **Minimize caregiver strain** | **Reduce unnecessary costs** |

STAFF:
Dementia Care Managers

- 4 Nurse Practitioner Dementia Care Managers
- Certification in Adult/Geriatric, Geriatric or Family Practice

PATIENTS:
Must meet required criteria

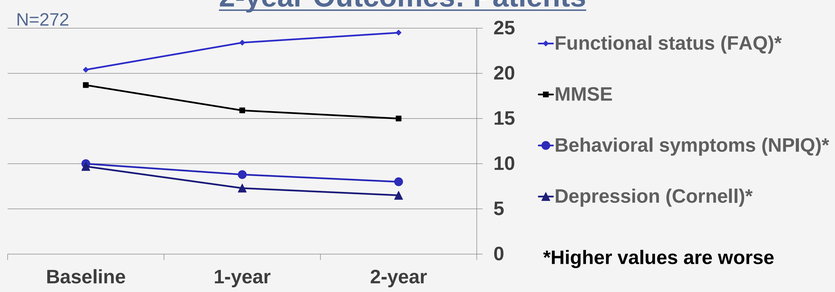
- Diagnosis of dementia
- Live outside nursing home
- Have referring UCLA physician willing to co-manage
- Have family member/caregiver willing to attend visits and assist with carrying out care plan

PROGRAM: Key Characteristics and Approach to Care

- Co-management model: physician partners with NP Dementia Care Manager (DCM), NP does not assume primary care
- Approach patient and caregiver as a dyad: both need support
- Structured 90-minute, in-person needs assessments of patients and their caregivers
  - Review dementia history and concerns (meds, behaviors, safety)
  - Focused physical and mental status exam
  - Advance Care Planning
  - Education and Support
- Create and implement individualized dementia care plans
- Facilitate transitions of care (to/from ED, hospital, SNF, ALF, home)
- Community-based Organization Partnership: provide services
  - Adult day care
  - Counseling
  - Case management
  - Legal and financial advice
- Ongoing Care
  - Follow up phone calls every 3-4 months
  - Additional calls as indicated based on acuity, needs, caregiver stress
  - Follow up in-person visits if needed or desired
  - Follow-up calls after ED visits and hospitalizations
  - Annual visit with patient and caregiver
  - Can be contacted by phone, email, or through patient portal anytime
- Accessible 24/7, 365 days a year for assistance and advice

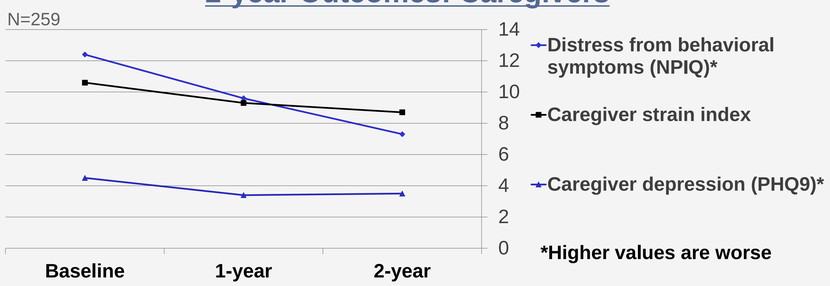
RESULTS

2-year Outcomes: Patients



For all baseline and year 2 comparisons, p<0.001, except behavioral symptoms, p=0.09.

2-year Outcomes: Caregivers



For all baseline and year 2 comparisons, p<0.01.

Satisfaction with ADC Program

Physicians:

Valuable medical recommendations: 61%

Valuable behavioral recommendations: 85%

Enhanced MD relationship with patient: 68%

Saved MD time: 56%

Would recommend for other patients: 90%

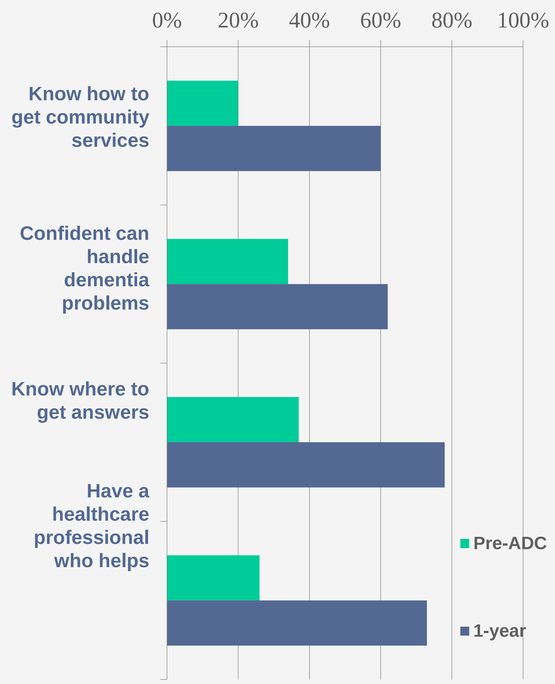
Caregivers:

90% felt intake visit time well spent

91% felt concerns were listened to and addressed

92% would recommend program to others

1-year Changes in Caregiver Experience and Self-Efficacy



Outcomes

- Currently providing care to 1000+ patients with dementia
- >90% on dementia quality indicators; meets all 5 dementia MIPS measures
- Outcomes data indicate:
  - ✓ Improved caregiver self-efficacy and less depression
  - ✓ Fewer patient behavioral symptoms despite worsening dementia
- Utilization/Cost Results:
  - ✓ Reduced hospital length of stay by 0.7d
  - ✓ ICU days reduced by over 50%
  - ✓ Hospital Bed days/1000, reduced by 30%
  - ✓ Total cost of care $2404 less per year
  - ✓ Nursing home placement reduced by 40%

Conclusions

- NP co-management of dementia results in:
  - ✓ High satisfaction
  - ✓ Improved clinical outcomes
  - ✓ Cost savings
- Dissemination is needed to demonstrate generalizability
- Medicare reimbursement needed for long-term sustainability