Not All Who Wander Are Lost

How a Health Plan Translated an Academic Care Model for Dementia

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An Overview of MIND at Home

Impact of Dementia

10-16% of persons 65+ have Alzheimer's Disease/Related Dementias (ADRD)

50% of ADRD is undiagnosed

70% of persons living with ADRD live in community

Dementia is more costly than Heart Disease and Cancer

Healthcare costs for persons with dementia vs. those without:

- Medicare 3:1 ($43,847 PBPY vs. $13,879 PBPY)
- Medicaid 19:1 ($10,120 PBPY vs. $527 PBPY)

ADRD is associated with:

- High risk of nursing home placement
- Poorer quality of life
- Serious behavioral symptoms
- Medical complications (UTI, infections, falls)
- Preventable hospitalizations, longer stays, risk of readmissions
- Physical, emotional, social, financial impact on family/caregiver

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Treating Dementia

There is no cure for Alzheimer's Disease; disease-altering treatment likely decades away

Dementia undermines person's ability to manage own care

Increasing reliance on caregivers for all needs as dementia progresses

Caregivers become overwhelmed, nowhere to turn

ADRD care delivery is often fragmented, inefficient, and uncoordinated

MIND at Home mobilizes effective care strategies that are available now:

- Manage co-morbidities
- Medication management/simplification
- Prevent delirium
- Treat cognitive symptoms
- Treat neuropsychiatric and behavioral symptoms
- Support member: home safety, meaningful activities, etc.

Support caregiver: disease education, empowerment, care skills, respite, connect to resources

MIND at Home Model of Care

Care Needs	Short-Term Goals	Long-Term Goals
Patient ○ Cognitive ○ Behavioral ○ Home Safety ○ Medical Care ○ Activity / Daily Living ○ Legal / Adv. Care ○ Care Financing **Caregiver** ○ Education ○ Skills Training ○ Medical Care ○ Mental Health Care ○ Informal Supports ○ Legal	Reduce Unmet Needs Maximize Quality of Life (QOL) Reduce Behavior Problems Appropriate Use of Health Services Reduce CG Burden	Stay Well at Home Better Care, Better Quality, Lower Cost

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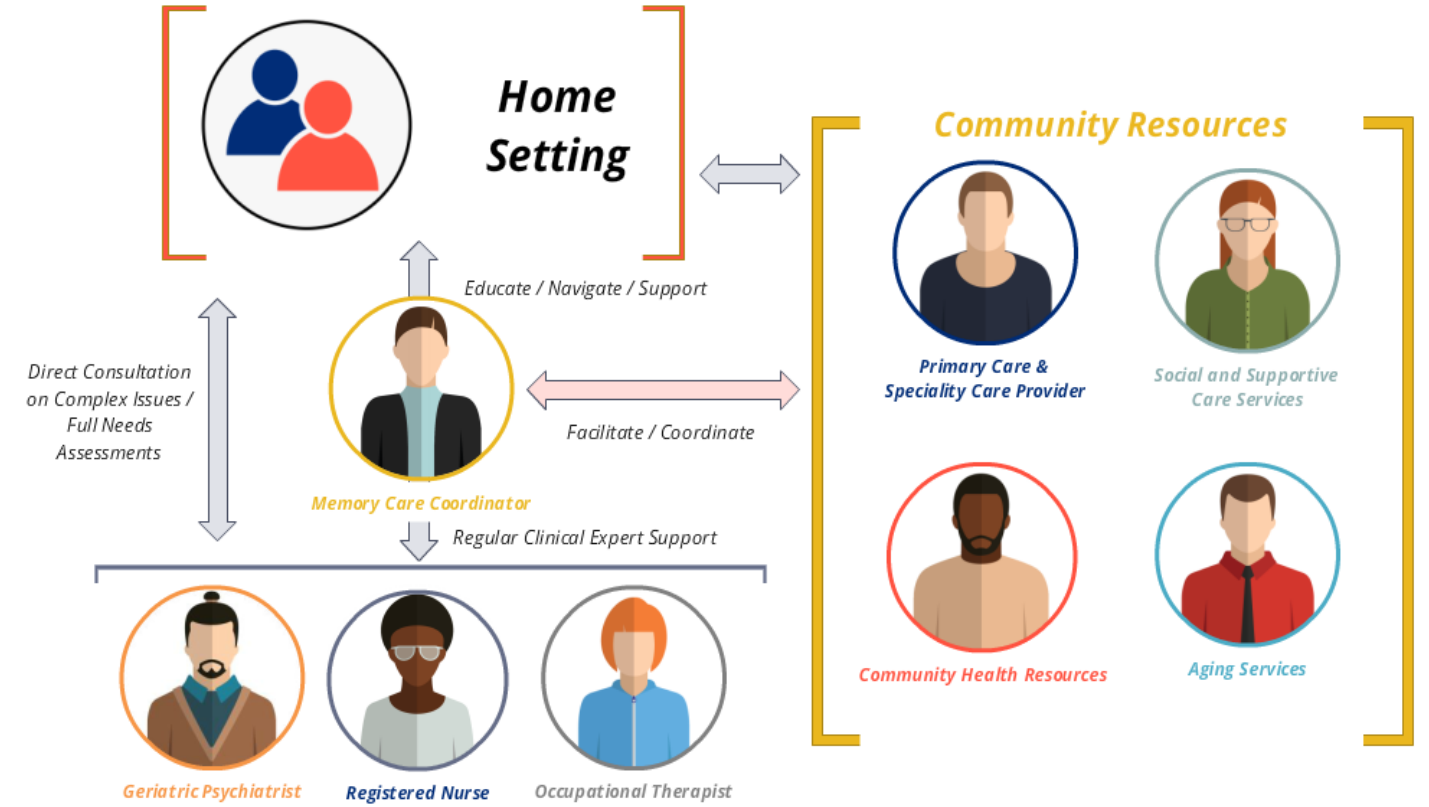
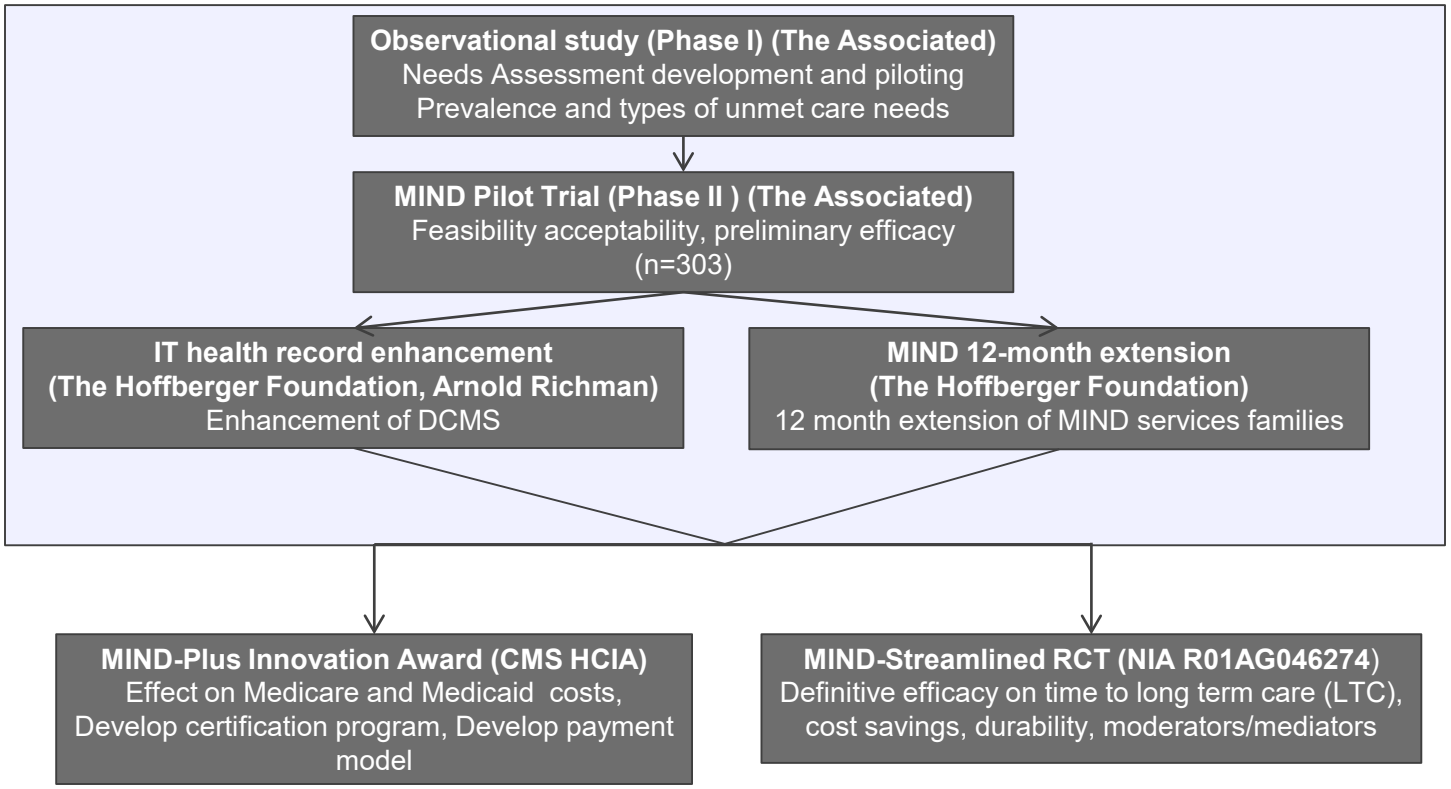
MIND at Home Care Team

MIND at Home Model (Streamlined, PLUS)



MIND at Home Development



Research Findings

Compared to a similar group…

Persons with cognitive disorders receiving the MIND program had:	Caregivers receiving the MIND program had:
• Delay in time to transition from home or death • Reduced risk of transition • Improved quality of life • Reduced unmet patient care needs	• Time savings (i.e. fewer average hours per week with PT) • Reduced perceived caregiver burden

Superior HealthPlan & Alignment with MIND at Home

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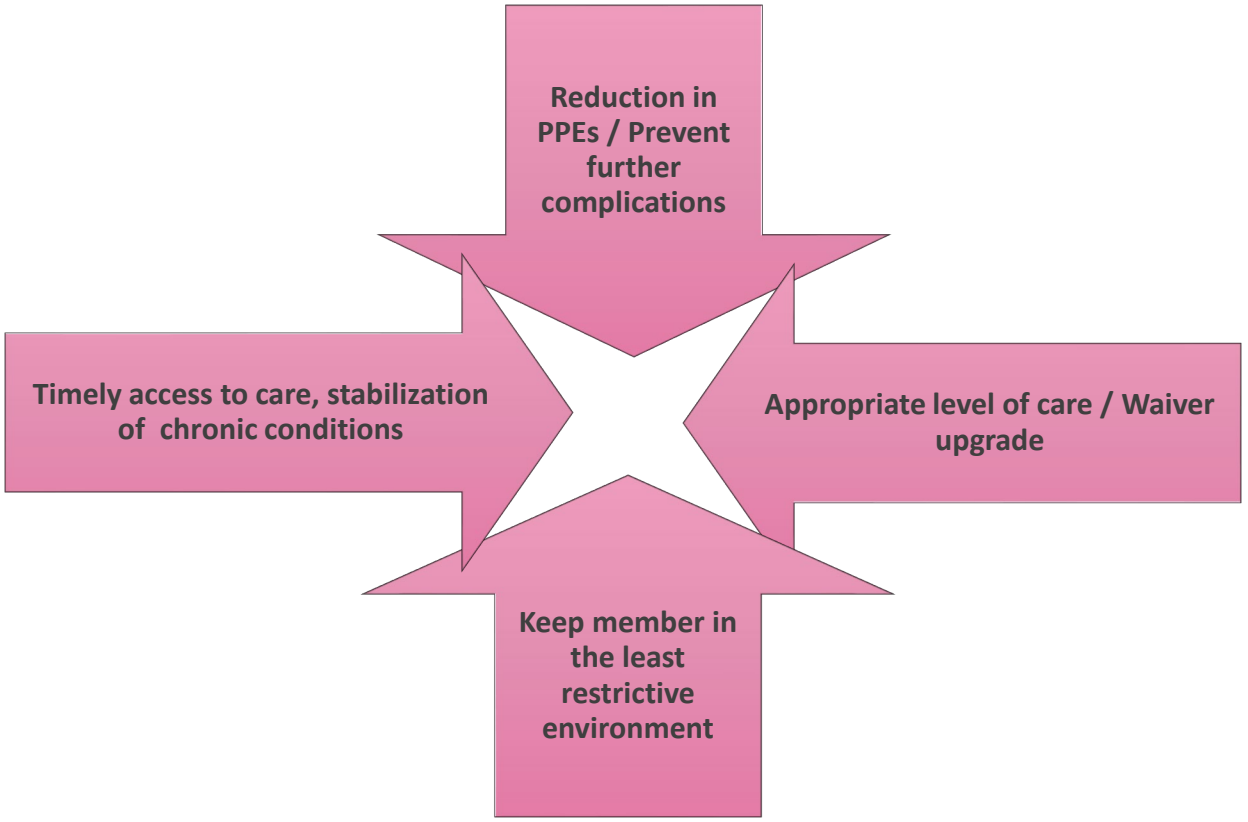
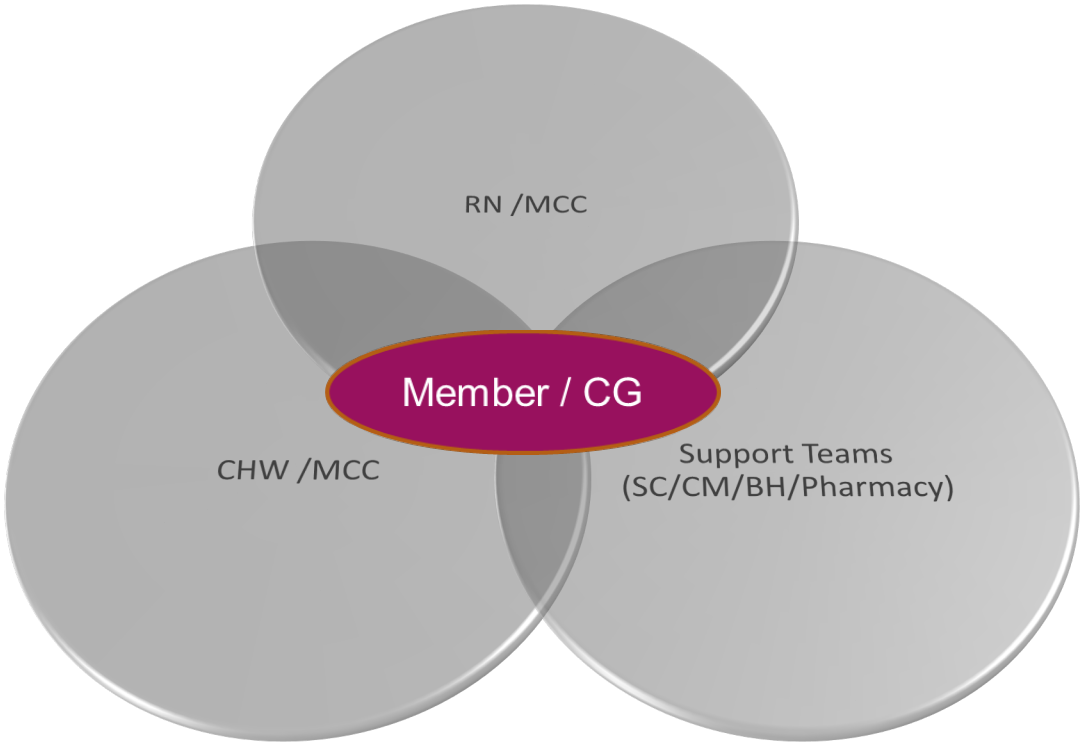
An Overview of Superior HealthPlan

- Multiline leading healthcare organization
- Whole health focus, fully integrated care model
- Local, community-based partners throughout TX

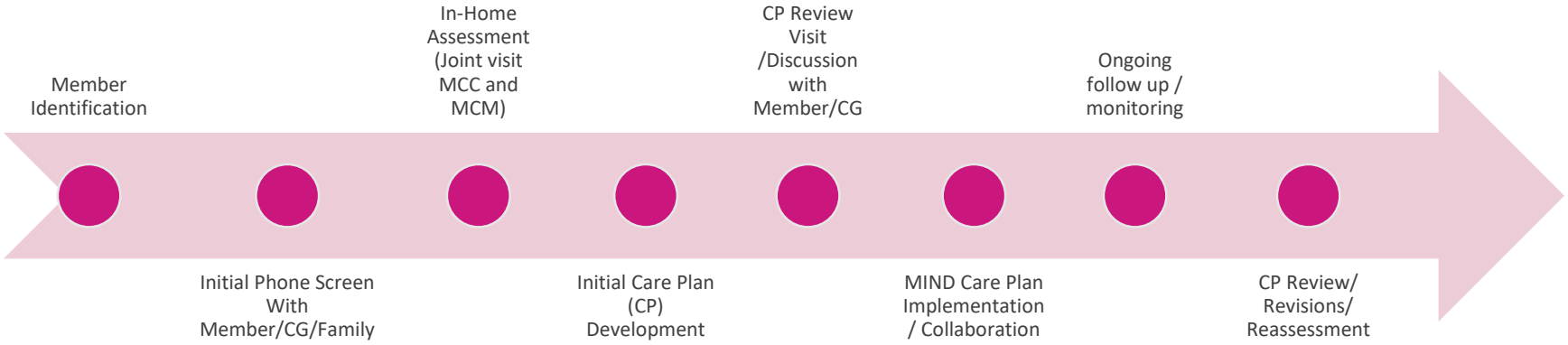
MIND at Home Alignment with Superior's Broader LTSS Initiative



Superior's MIND at Home Care Model



MIND at Home Member Experience



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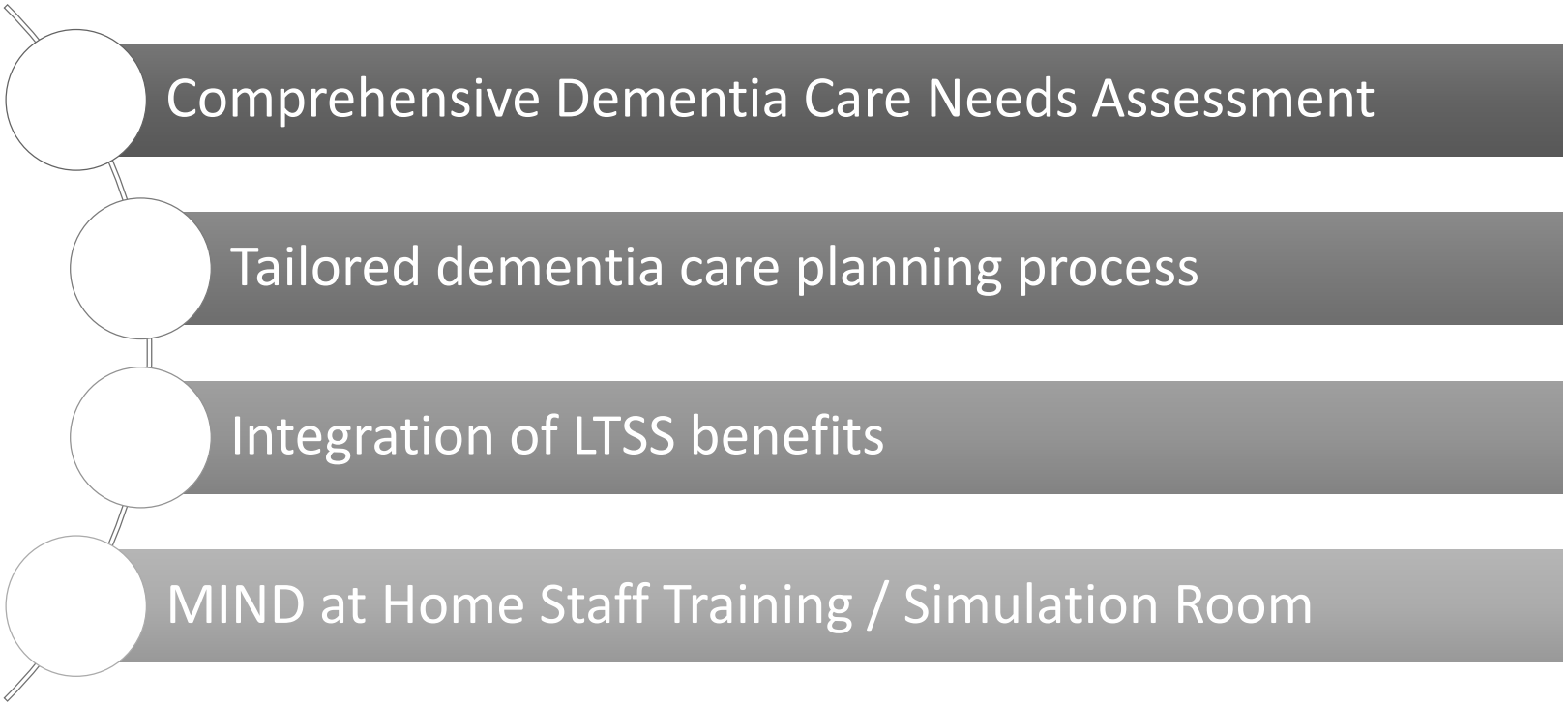
Johns Hopkins & Superior Partnership



Operationalizing MIND at Home at Superior HealthPlan

MIND at Home Training

- Superior MIND at Home teams-in-training completed 7 CME/CEU-accredited online interactive case-based modules on:
  - Dementia basics
  - Purpose and function of MIND at Home
  - Memory Care Coordinator and other team member roles
  - MIND at Home domains (A-M) and the intervention as applied to the example case

MIND at Home Training

2 days intensive in-person training:
• Review of dementia basics and its impact on the member and family caregiver(s) • Orientation to MIND at Home protocol, administration of instruments, associated materials, implementation, and workflow • Member and provider outreach, referral and enrollment process • Review online modules • Roleplay demos by trainers • Small group practice cases using Module 8—assessment, care plan building, and follow up • Orientation to weekly telecollaborative case discussion

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Simulation Training: Home Safety and Virtual Dementia Tour (VDT)

Implementation of MIND at Home: Telecollaboratives

Case Rounds – Team discusses solutions for complex and/or challenging cases

Didactics – Educational topics relevant to ADRD

- Some topics include:
  - Managing caregiver denial
  - Building effective relationships
  - Using the DICE Method (Describe, Investigate, Create, Evaluate)
  - Medications, memory and aging
  - Keeping personal health record
  - Grief and loss
  - Meaningful activities during COVID-19

Average Attendance:

- 20 staff and leaders
- 6 MCCs
- 4 RNs

Implementation of MIND at Home: Operationalization

Fidelity of MIND at Home – Ride-alongs with Superior HealthPlan

JHU MIND at Home team joined SHP field staff on member visits

Observations of MCCs and RNs indicated effective implementation of the MIND at Home model of care by the SHP team

Member Demographics

MIND at Home participants (non-dual Medicaid members) were, on average, younger than participants in previous research studies conducted by JHU team

Participants tended to have complex medical and non-medical needs

Case Studies from MIND at Home Pilot Program at Superior HealthPlan

Case Summary # 1 - Joy

- 59 year old female with diagnosis of unspecified dementia with behavioral health (BH) disturbance, anxiety disorder, major depression, hypertension, Type 2 diabetes
- Member lives with brother and sister-in-law, who act as caregivers, but with limited knowledge on dementia disease process and progression
- Family works full time and member is left unattended for about 4-8 hours per day during the week

Problem List:

- Cultural and language barrier; does not speak English
- Very frail, poor appetite, underweight, and lethargic
- Unsteady gait, history of falls with frequent ER visits and IP admissions
- Multiple serious and unsafe BH issues:
  - Likes to have multiple items surrounding her and likes to collect things
  - Wandering regularly to a nearby Goodwill station, harassing and spitting at the staff, hiding under the semi-truck trailers, stealing items from donations, and had to be removed from the property by police on several occasions
  - Opening the valve on the outside propane tank, scratching the family cars with keys and sharp objects, smearing feces on the floors as she was incontinent of both bladder and bowels
- Family believes behavioral issues were done on purpose and did not understand the extent of member's dementia disease process
- Family/caregiver burnout and overwhelmed, wanting assistance for LTC/NF placement
- Inadequate support system

Case #1: Joy

Approach & Interventions

- Comprehensive Dementia Care Needs Assessment and home safety evaluation
- Multiple family/caregiver educational sessions on dementia care and disease process/progression (on-site and telephonic)
- Intensive follow-up calls to answer questions, address barriers, provide assistance in accessing necessary services/support to keep member stable and safe at home
- Medication reconciliation and medication management education
- Access to appropriate services and supplies, such as diabetic testing supplies, physical therapy, Rollator to aid in ambulation, and blood pressure monitor
- HCBS waiver program evaluation/upgrade to access additional services/support, such as respite services to relieve caregiver, protective supervision while caregiver is at work, and minor home modification to address fall risk and home safety issues
- Assist family/caregiver to navigate the healthcare and support system (financial and social support) as well as linkage to community resources

Case #1: Joy

Post-Intervention Outcomes

- Member's health status has improved, member has gained weight, and has improved gait/ambulation
- Family/caregivers have taken steps to make the home safer, including adding locks to cabinets and installing grab bars to address safety risks
- Adequate support in place, attendant care is able to provide supervision while family/CG is at work, and member is no longer wandering
- Since completing physical therapy and receiving Rollator, member has had no more falls and member has not been to ER or IP for the last 7 months
- Family began to trust the MIND at Home staff and was much more open to additional support and education from the memory care team
- Family has better understanding of the extent of member's disease process and progression, states they feel much more confident in caring for the member and are happier and less stressed
- Family has agreed to keep the member at home as long as possible with MIND at Home program and LTSS services/support in place

Case Summary # 2, Johnny

- 71 year old male with diagnosis of dementia with night time behavior and other medical issues such as tremors, insomnia, cerebral infarction, major depression, Type 2 diabetes with diabetic neuropathy, GERD, and HTN
- Member has significant cognitive impairment; lives with disabled wife and daughter
- Daughter is the primary caregiver, but is also having health issues and limited time to care for the member due to work schedule
- Member/family speaks very little English, has a close family friend that advocates and translates for them

Problem List

- Language barrier
- Hiccups and reflux episodes, resulting in exacerbation of night time behaviors and lack of sleep for both member and caregiver
- Limited mobility with abnormal gait and lethargy (rarely got up from the sofa)
- Unsteady gait with multiple falls that resulted in frequent ED visits
- Daughter is overwhelmed trying to manage and juggle care for the member and recent job schedule change, as well as managing her own health issues (finishing treatment for breast cancer, in remission)
- Multiple medications
- Inadequate support in place
- Lack of knowledge regarding dementia disease process and progression
- Requires personal care/assistance with ADLs
- Caregiver burnout

Case # 2: Johnny

Approach & Interventions

- Comprehensive Dementia Care Needs Assessment and home safety evaluation
- Access to necessary services and support to promote health and safety at home, as well as improving quality of care for both member and caregiver, including:
  - Durable medical equipment and supplies such as a walker, hospital bed, incontinence supplies, and nutritional supplements
  - Increased hours for personal assistance services (PAS) to support member's functional mobility deficits and activities of daily living
  - HCBS waiver program evaluation/upgrade to access additional services/support, such as respite care to relieve caregiver, protective supervision to assist member while daughter is at work, and minor home modifications such as adding grab bars to the restroom to address safety/fall risks
  - Medication reconciliation and medication management education
  - Assist family/caregiver to navigate the healthcare and support system (financial and social support) as well as linkage to community resources

Case # 2: Johnny

Post-Intervention Outcomes

- Improved health status, decreased member's hiccups, reflux, and night time behaviors resulting in member, wife, and daughter having better rest at night
- Improved gait/ambulation; member has had no falls since using the walker and incontinence supplies, preventing ED visits
- Cognitive function improved after provider added medication to help improve memory/cognition
- Caregiver feels less stress and is more comfortable managing member's care
- Adequate support system now in place
- Daughter/caregiver is coping better and is able to better care for herself, seeing her doctor and getting exercise on a regular basis, able to spend quality time with family and friends, and becoming more involved in member's care

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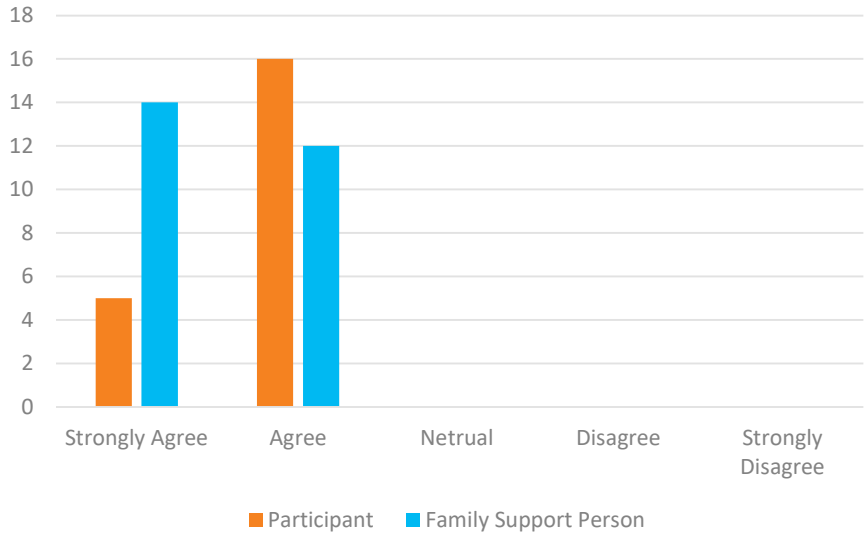
Outcomes of MIND at Home at Superior HealthPlan

Participant Demographics

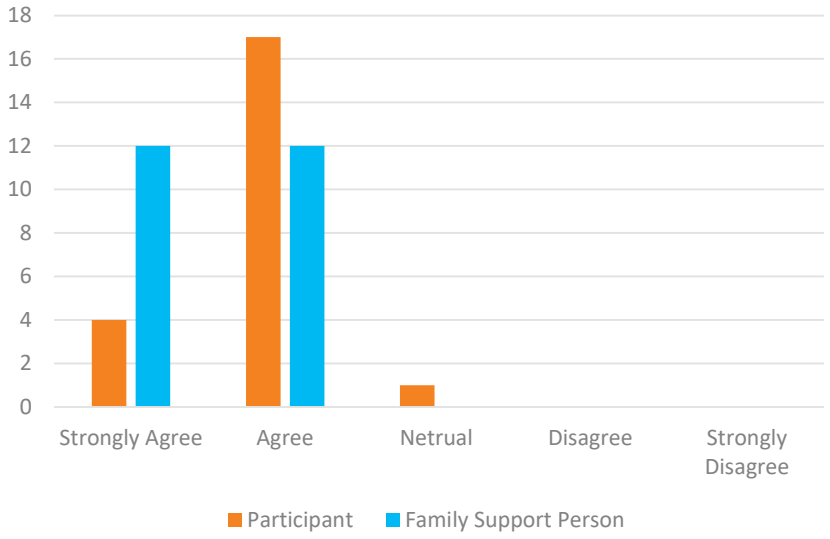
Sample Size	
≤ 3 months of post-intervention data	170
> 3 months of post-intervention data	98
Sex	
Male	33.53%
Female	66.47%
Age	
Average Age	61.38 (S.D. = 8.87)
Minimum Age	16
Maximum Age	92
Ethnicity	
Asian or Pacific Islander	1.76%
Black (Non-Hispanic)	4.12%
Hispanic	50.59%
Not Provided	17.65%
Unknown	1.18%
White (Non-Hispanic)	24.71%

Consumer Survey Results

Overall, I am satisfied with the job my Memory Care Coordinator is doing.

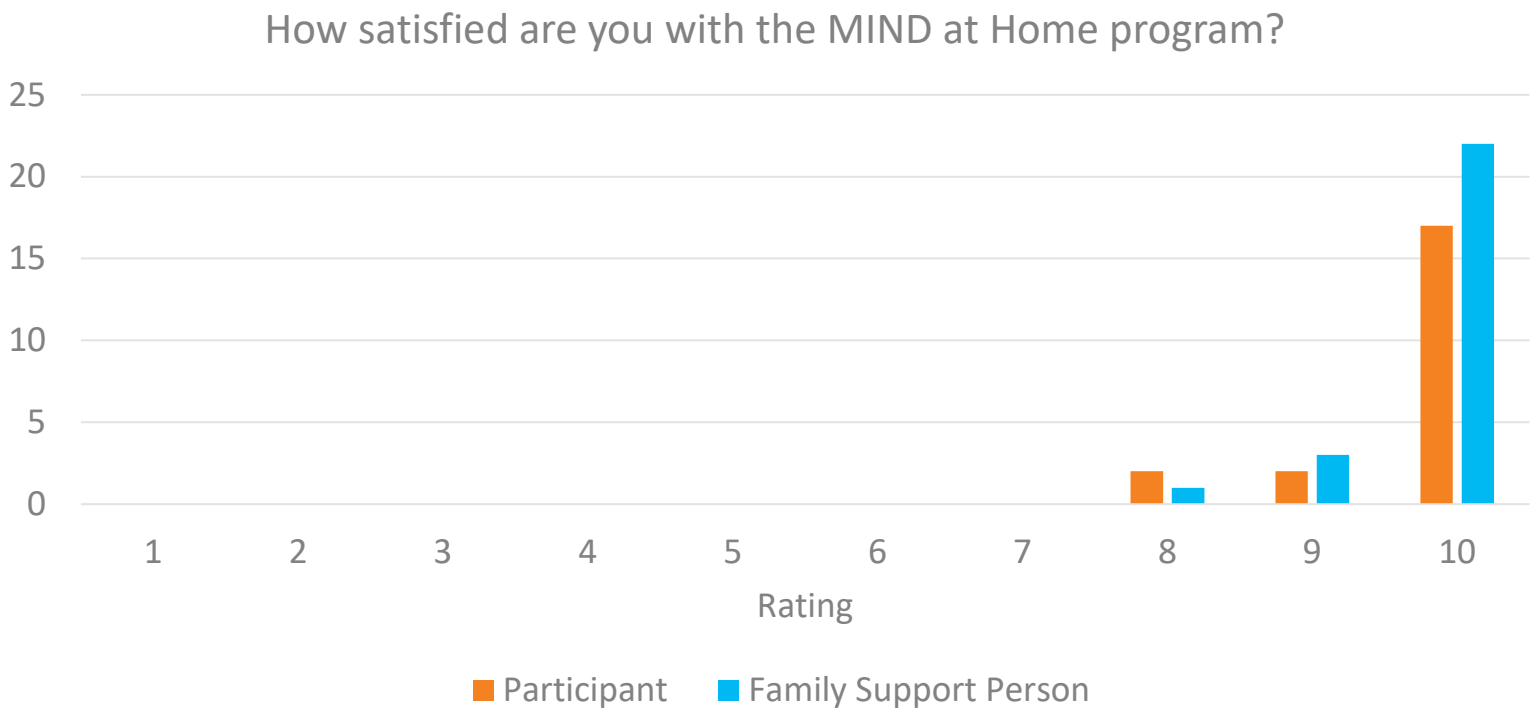


I would recommend the MIND at Home program to family and friends.



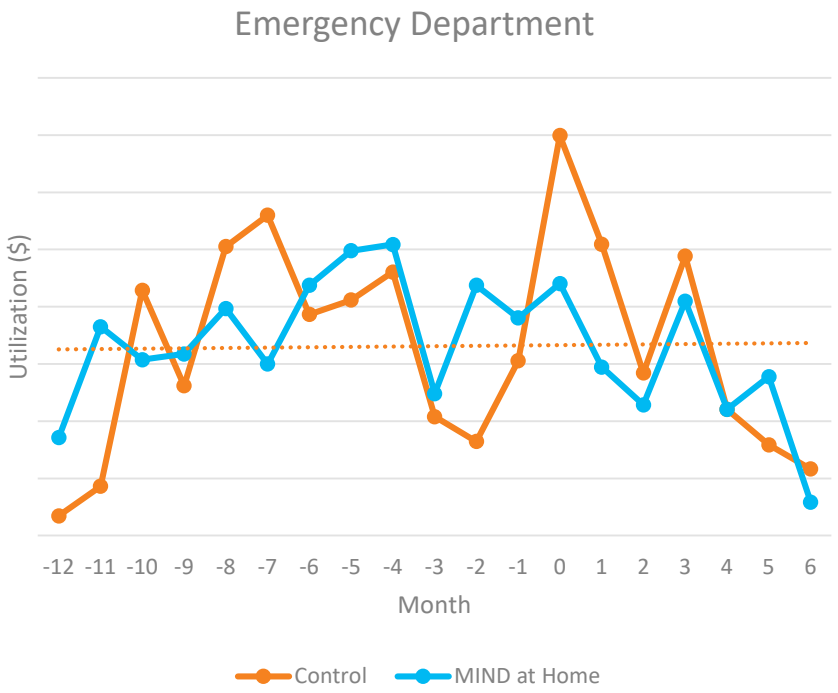
Consumer survey administered in June 2020
Participant responses n=22
Family support responses n=25

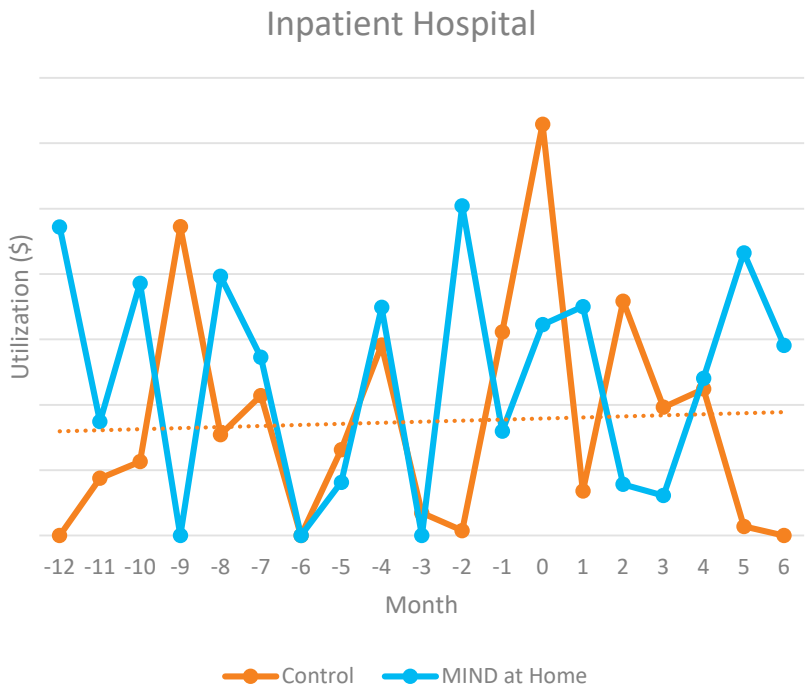
Consumer Survey Results



Consumer survey administered in June 2020
Participant responses n=22
Family support responses n=25

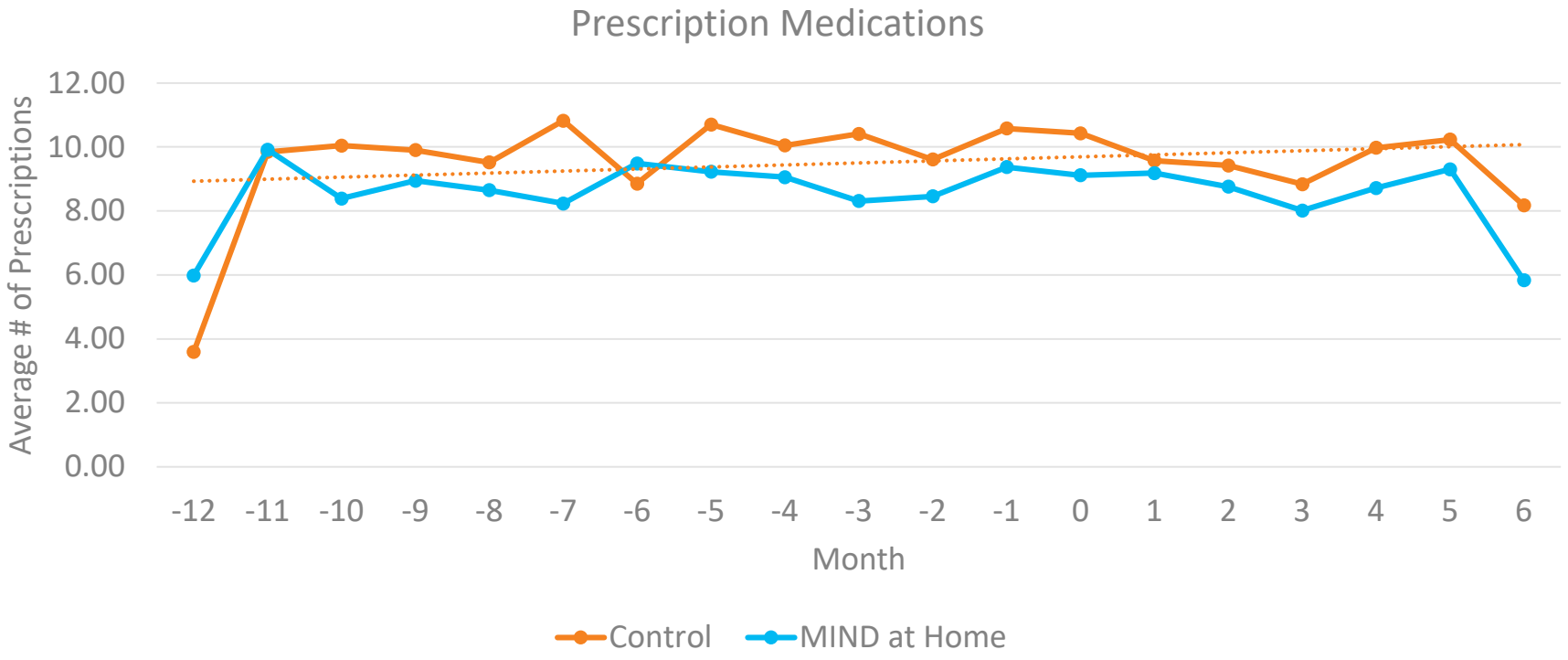
Outcomes of MIND at Home Pilot: Acute Care





MIND at Home participants vs propensity score matched control group
n=170 with ≤3 months of post-intervention data
n=98 with >3 months of post-intervention data

Outcomes of MIND at Home Pilot: Medications



MIND at Home participants vs propensity score matched control group
n=170 with ≤3 months of post-intervention data
n=98 with >3 months of post-intervention data

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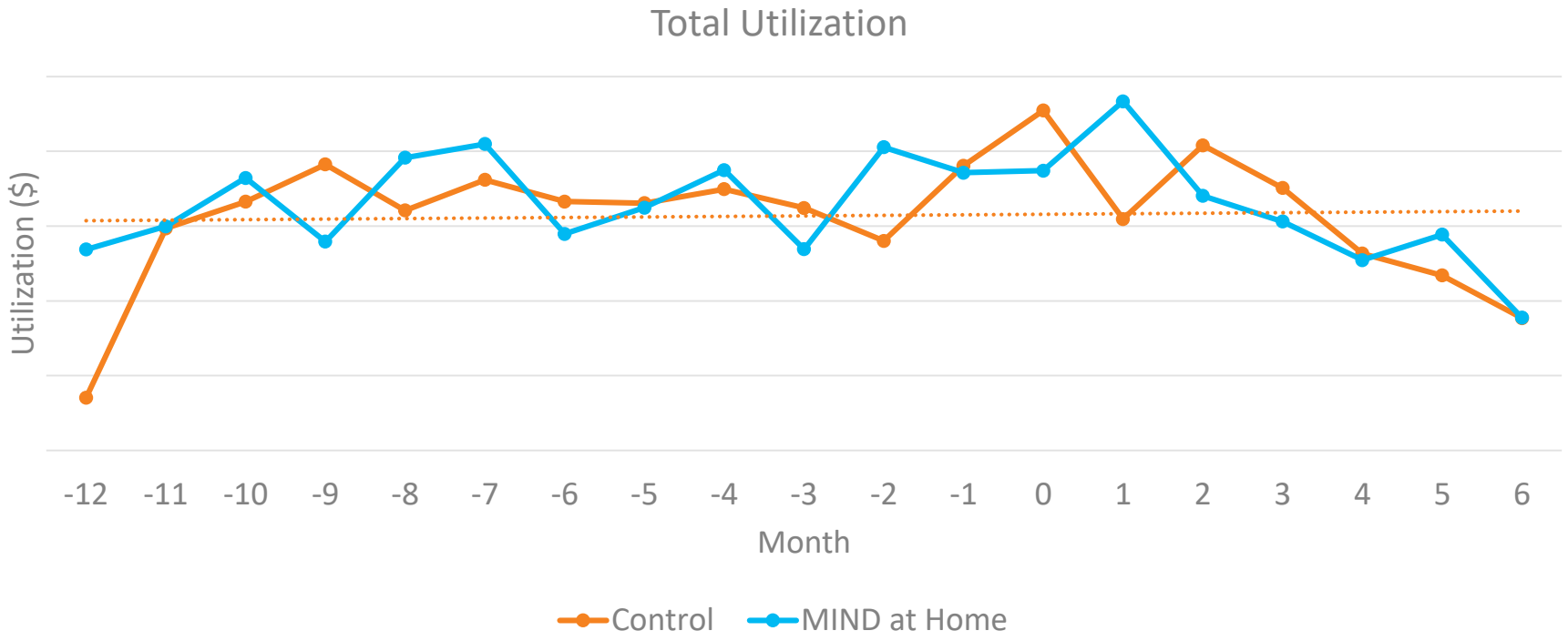
Outcomes of MIND at Home Pilot: Total Utilization



MIND at Home participants vs propensity score matched control group
n=170 with ≤3 months of post-intervention data
n=98 with >3 months of post-intervention data

Conclusions & Lessons Learned

Conclusions

- Operationalization of the Johns Hopkins University MIND at Home model of care at Superior HealthPlan was successful and effective
- Preliminary outcomes data indicate the MIND at Home model of care is reducing high cost healthcare utilization – particularly ED and polypharmacy – and overall member costs
- Need to gather additional data to verify these trends are “real” and statistically significant
- Consumer surveys indicate members are highly satisfied with the MIND at Home program
- Anecdotal evidence illustrates dramatic increase in member quality of life

Lessons Learned

The MIND at Home model of care is well suited for implementation to HCBS managed care and MLTSS

The STAR+Plus non-dual member population is younger and has more complex clinical and non-clinical needs than that of past research studies conducted by Johns Hopkins University

- Both teams have had to adapt to address these challenging and complex cases

A comprehensive training program, followed by field staff ride-alongs, was critical to ensure successful implementation of MIND at Home at Superior HealthPlan

Proprietary MIND at Home assessment and care planning tools had to be adapted to meet state requirements and fit with existing processes and IT tools within the health plan

Next Steps

MIND at Home pilot is ongoing through Feb 2021

- Participants continue to be added to the program
- Data is extracted and analyzed quarterly

Additional data to be gathered in future analyses:

- Degree of cognitive impairment
- Caregiver respite utilization
- Change caregiver support burden
- Change in unmet needs (overall and by domain)
- Transition to long-term institution

Once data has been analyzed, expansion/scaling of the program into other products and/or health plans will be considered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