2014 Gage Awards

Reference #	7491631
Status	Complete
Name of hospital or health system	Eskenazi Health (formerly Wishard Health Services)
Name of project	Dissemination of the Aging Brain Care Program
CEO name	Lisa E. Harris, MD
CEO approval	Check here to confirm that your CEO approves of this project being submitted for a 2014 Gage Award
Submitter name (first and last)	Catherine Alder, JD, MSW
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Within which of the two categories does your application best align?	Population Health

1. Provide a brief description of the project. (This section should resemble an abstract for a poster presentation or an abstract for a peer reviewed journal. Include an objective, data sources, study design, findings, and conclusions.)	Objective: The goal of the Aging Brain Care (ABC) Medical Home is to provide high-quality, efficient collaborative care for older adults with late life depression or dementia. Background: More than 3 million Medicare beneficiaries suffer from dementia and 6 million are afflicted with depression. These conditions, which often co-occur, account for more than $30 billion in annual Medicare spending. Most patients with these conditions are cared for in primary care settings where suboptimal care results in excess morbidity and excess health care costs. Over the past 20 years, scientists from the Indiana University Center for Aging Research (IUCAR) used the framework of the collaborative care model to develop new systems of health care delivery for older adults affected by depression and dementia. In studies, these models have been shown to lead to improved quality, efficiency and outcomes of care; however, these models have not been widely adopted because they require an extensive redesign of the practice environment. In 2009, in collaboration with Eskenazi Health [formerly Wishard Health Services] (Eskenazi) in Indianapolis, Indiana, the scientists at IUCAR developed the Aging Brain Care (ABC) Medical Home, a collaborative dementia and depression care program serving 200 patients in one primary care site at Eskenazi. In 2012, the ABC Medical Home received funding from the Centers for Medicare and Medicaid Innovation to expand the pilot program to serve approximately 1500 older adults in Indianapolis, Indiana. Project Design and Data Sources: During our first year, we hired, trained, and deployed 20 full-time clinical staff to deliver our collaborative care intervention at Eskenazi. More than 1500 Medicare and Medicaid beneficiaries with dementia and/or late-life depression have been enrolled in our program. The clinical team has been in the field delivering the intervention for more than 12 months. Our electronic medical record tracking system automatically tabulates the major health outcomes of our enrolled patient population, allowing us to quickly gauge the health of our enrolled population. Findings: During our first year, we provided 3433 home visits to over 1500 patients enrolled in our program in Indianapolis. Among those individuals, 25% had a dementia diagnosis and 66% had a diagnosis of depression. Sixty percent of individuals with high depression scores (PHQ-9 score of 14 or greater) had at least a 50% reduction in their depressive symptoms. Fifty-eight percent of caregivers of patients with dementia had at least a 50% reduction in caregiver stress symptoms (measured by the Healthy Aging Brain Center Caregiver Monitor). Conclusion: After one year, the ABC Medical Home has demonstrated significant progress toward achieving the triple aims of better health, better care, and lower costs through improved quality. This model shows significant promise for answering the challenges posed by our nation's

	rapidly aging population.
1A. Attachment, if applicable (Applicable examples include a peer reviewed journal article, other content published in the literature, or a presentation at a national meeting)	ListofLocalNationalandInternationalPresentations.docx (16k)

2. Describe the methods use in this project. Include where, why, and how the project was accomplished.	During the first year of the expansion project, we hired, trained, and deployed three clinical teams to deliver our collaborative care intervention at Eskenazi. [A fourth team was established at a second site.] Each team is responsible for 500 patients and includes a nurse practitioner (or RN) and a social worker who serve as the care coordinators and supervise five care coordinator assistants (CCAs). One CCA from each team is provided by CICOA Aging & In-Home Solutions (CICOA), Indiana's largest Area Agency on Aging. The CCAs have at least a high school degree, have been chosen for their aptitude for working with vulnerable older adults, and have received additional training in the care of older adults with dementia and depression. The CCAs are responsible to assist the care coordinators in conducting the biopsychosocial needs assessment, delivering care protocols, monitoring medication adherence, managing data entry, scheduling patient and caregiver visits, tracking enrollment, and managing patient transportation. Each team meets once per week to discuss the plans of care being provided to their patients. The goal of the ABC Medical Home is to assist primary care clinicians in achieving the recommended standard of care in the management of older patients with dementia or depression. The success of the ABC intervention has been demonstrated in three randomized controlled trials led by or participated in by IUCAR investigators. Much of the intervention is targeted to co-manage or support the practice behavior of primary care clinicians by providing personalized care aimed at improving the self-management skills and coping behavior of both the patient and the informal caregiver. The ABC program utilizes the concept of a “mobile office” which allows clinical staff to take into account the physical, emotional, and psychological comfort of patients and caregivers when scheduling appointments. The mobile office sites may include the patient’s home, any of the primary care or specialty clinics, the hospital or ER, and any community setting. The clinical providers are supervised by a medical director with expertise in dementia and depression management. The team is also supported by the eMR-ABC care coordination software. The eMR-ABC creates a registry of all patients enrolled in the program, tracks appointments, alerts the care coordinators of any acute care visits, monitors the current symptoms of the patients and informal caregivers, recommends individualized care protocols based on current symptoms, and provides timely feedback on the performance of the ABC program in managing the health of its population. The clinical teams at Eskenazi have been in the field delivering the intervention for more than 12 months. To date, more than 1500 Medicare beneficiaries with dementia or late life depression (many of whom are dual-eligible) have been

	enrolled in the program.

3. Describe the results of the project. What data was used to support improvement results?	Assessments of patient symptoms and caregiver burden are collected by the CCAs on a regular basis (at least once every three months). The program uses standardized assessment tools including the Patient Health Questionnaire (PHQ-9) and the Healthy Aging Brain Care (HABC) Monitor. The HABC Monitor is a 30-item instrument used to monitor the cognitive, functional, behavioral and psychological symptoms of patients with dementia and the caregiver stress. While the total HABC Monitor score is helpful to measure change over time, each question also indicates a specific care area where help or coping strategies might be indicated. When these symptoms (for either the patient or the caregiver) are identified, the ABC team works with the primary care clinician and other providers to begin initial pharmacological and non-pharmacological management. Consistent with current recommendations, protocols for patient management emphasize non-pharmacologic treatment at the outset. During the first year, we provided 3433 home visits to over 1500 patients enrolled in our program. 25% of our sample had a dementia diagnosis and 66% had a diagnosis of depression. 4.5% had both diagnoses. Results to date are consistent with the foundational research demonstrating the effectiveness of the intervention. After one year: •60% of patients with high depression scores (PHQ-9 score of 14 or greater) had at least a 50% reduction in their depressive symptoms and an additional 27% had at least a 25% reduction in their depressive symptoms. •47% of patients had at least a 50% reduction in their behavioral and psychological symptoms of dementia (BPSD) and an additional 6% had at least a 25% reduction in their BPSD. •56% of caregivers of patients with dementia had at least a 50% reduction in caregiver stress symptoms while an additional 7% had at least a 25% reduction in their caregiver stress symptoms. Six months into the program, a random sample of patients and caregivers were asked to complete a satisfaction survey. Results demonstrate high satisfaction with the program and the clinical providers: •63% of patient responders rated their overall impression of the ABC Medical Home as “Excellent”. An additional 20% rated their overall impression of the program as “Very Good”. On a scale of 1 to 5 (with 5 representing the highest satisfaction), the average rating of all patient responders was 4.51. •53% of caregiver responders rated their overall impression of the ABC Medical Home as “Excellent”. An additional 33% rated their overall impression of the program as “Very Good”. On a scale of 1 to 5 (with 5 representing the highest satisfaction), the average rating of all caregiver responders was 4.40. Finally, team members were consistently rated

	high by both patients and caregivers in accessibility, helpfulness, knowledge, and communication.
3A. Attachment, if applicable (Only graphically displayed data such as charts will be accepted. Data should include baseline and improvement data)	Year1PopulationStatsReportFromtheeMR-ABC.docx (22k)

4. Describe what happened as a result of the project. Was the improvement related to the intervention? Can the project be duplicated by other organizations?	The ABC Program will be judged on its ability to deliver the triple aims of better health, better care, and lower costs through improved quality. Outcomes data for the first year (obtained from the eMR-ABC care coordination software) demonstrates improvements in all health outcomes compared to the baseline. Specifically, the depression, dementia, and caregiver stress metrics all demonstrate a reduction in problematic symptoms. A specific goal of the project is to develop a business model to sustain the activities of the ABC program and to support dissemination of the model. The project not only can be duplicated by other organizations but has, in fact, already been implemented in another health system. In the fall of 2012, the project leadership team made a decision to open a new program site at IU Health Arnett (Arnett) in Lafayette Indiana. Demonstrating the model can be implemented in a rural setting is an important step in successful nationwide dissemination. Successful implementation requires adapting the program to the needs of the local environment. The process of adapting the model for Arnett has been helpful in identifying areas where the program can be improved: •The need for rapid start-up created challenges for enrollment. Patients were identified using ICD-9 codes and administratively enrolled with the consent of the primary care physician. At Eskenazi, enrolled patients were randomly assigned to CCAs, but the process was more deliberate at Arnett. More than 500 patients have been enrolled from Arnett primary care. Because Arnett serves a much larger geographic area and a more rural patient population than Eskenazi, CCAs were assigned to particular sites by location. This process not only decreases the travel time required for home visits, but also increases opportunities for relationship building with the staff at these sites. •Because of the difficulty we encountered recruiting nurse practitioners, Arnett hired a registered nurse to serve as the Care Coordinator. We have demonstrated the effectiveness of the RN model in Eskenazi's memory care clinic, the Health Aging Brain Center (HABC), where RNs are employed in this role. The RN model will be easier to replicate in other areas of the country where nurse practitioners are not available. •The Arnett team began delivering services to patients in January of 2013. Initially, they reported that the clinical team was having difficulty finding appropriate resources for their patients' needs. In response, our partners at CICOA intervened to engage the Area Agency on Aging serving Lafayette, IN to assist in providing resources to patients enrolled in the ABC program at IU Health Arnett. This solution has been successful and highlights the value of partnering with the local AAA in any future dissemination effort.

5. Describe how patients, families, and if appropriate, community was included in the work.	The ABC program is dedicated to caring for both patients and caregivers to deliver care aimed at improving the physical and psychological health of all involved in the patient's care. The ABC team serves as the liaison between the patient and caregiver, the primary care physician, specialty care providers and community resources, all in an effort to facilitate communication and coordinate care for the benefit of the patient and caregivers. In collaboration with the Alzheimer's Association of Greater Indiana, the ABC program organizes a monthly support group specifically designed to give the ABC caregivers emotional support and tailored information to meet their needs within Eskenazi. While participation cannot be required, the clinical team encourages participation by stressing the importance of the support group for the overall health of both the patient and the caregiver. The ABC program has also partnered with CICOA Aging & In-Home Solutions, Indiana's largest Area Agency on Aging. Four employees of CICOA are embedded within the ABC clinical team serving as one of the program social workers and three CCAs. These employees have received specialized training as options counselors and serve as liaisons between the ABC team and the resources facilitated by the CICOA. Finally, the project team established a supporting consumer advisory board comprised of patients, families, and their advocates. The board is convened every six months to review the progress of the project and to provide valuable feedback and suggestions to improve the experience of patients and caregivers.
5A. Attachment, if applicable (Applicable attachments include documents created for patients, families, or community members or by them as a result of the project)	CaregiverManual.pdf (5693k)
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