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
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

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

Short-Term Goals

- Reduce Unmet Needs
- Maximize Quality of Life (QOL)
- Reduce Behavior Problems
- Appropriate Use of Health Services
- Reduce CG Burden

Long-Term Goals

- Stay Well at Home
- Better Care, Better Quality, Lower Cost
MIND at Home Care Team

MIND at Home Model
(Streamlined, PLUS)
MIND at Home Development

Observational study (Phase I) (The Associated)
- Needs Assessment development and piloting
- Prevalence and types of unmet care needs

MIND Pilot Trial (Phase II) (The Associated)
- Feasibility acceptability, preliminary efficacy
  (n=303)

IT health record enhancement
(The Hoffberger Foundation, Arnold Richman)
- Enhancement of DCMS

MIND 12-month extension
(The Hoffman Foundation)
- 12 month extension of MIND services families

MIND-Plus Innovation Award (CMS HCIA)
- Effect on Medicare and Medicaid costs,
  Develop certification program, Develop payment model

MIND-Streamlined RCT (NIA R01AG046274)
- Definitive efficacy on time to long term care (LTC), cost savings, durability, moderators/mediators
Research Findings

Compared to a similar group...

Persons with cognitive disorders 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

Caregivers receiving the MIND program had:

- Time savings (i.e. fewer average hours per week with PT)
- Reduced perceived caregiver burden
Superior HealthPlan & Alignment with MIND at Home
An Overview of Superior HealthPlan

1. Multiline leading healthcare organization
2. Whole health focus, fully integrated care model
3. Local, community-based partners throughout TX
MIND at Home Alignment with Superior’s Broader LTSS Initiative

- Timely access to care, stabilization of chronic conditions
- Reduction in PPEs / Prevent further complications
- Appropriate level of care / Waiver upgrade
- Keep member in the least restrictive environment

HopkinsMedicine.org SuperiorHealthPlan.com
Superior’s MIND at Home Care Model
MIND at Home Member Experience

1. Member Identification
2. Initial Phone Screen With Member/CG/Family
3. In-Home Assessment (Joint visit MCC and MCM)
4. Initial Care Plan (CP) Development
5. CP Review Visit/Discussion with Member/CG
6. MIND Care Plan Implementation/Collaboration
7. Ongoing follow up/monitoring
8. CP Review/Revisions/Reassessment
Comprehensive Dementia Care Needs Assessment

Tailored dementia care planning process

Integration of LTSS benefits

MIND at Home Staff Training / Simulation Room
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
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 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
Outcomes of MIND at Home at Superior HealthPlan
## Participant Demographics

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<th>Sample Size</th>
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<td>≤ 3 months of post-intervention data</td>
<td>170</td>
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<tr>
<td>&gt; 3 months of post-intervention data</td>
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<tr>
<th>Sex</th>
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<tr>
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<td>33.53%</td>
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<tr>
<td>Female</td>
<td>66.47%</td>
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<table>
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<tr>
<th>Age</th>
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<tbody>
<tr>
<td>Average Age</td>
<td>61.38  (S.D. = 8.87)</td>
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<tr>
<td>Minimum Age</td>
<td>16</td>
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<tr>
<td>Maximum Age</td>
<td>92</td>
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<table>
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<tr>
<th>Ethnicity</th>
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<td>Asian or Pacific Islander</td>
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<tr>
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<tr>
<td>Unknown</td>
<td>1.18%</td>
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<tr>
<td>White (Non-Hispanic)</td>
<td>24.71%</td>
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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

How satisfied are you with the MIND at Home program?

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
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.