

Case Study: Baylor Scott & White Health's Geriatrics Program for Dementia Care

A Model for Comprehensive Care Management in the Home

"Our leadership realized that patients with dementia are high utilizers of health care, at risk for adverse events and medical complications. They recognized the connection between good medical directorship in nursing homes and rates of emergency room use and hospitalization. We are committed to providing the highest quality of care to improve outcomes and reduce the cost of health care for this group of patients."

Dr. Aval-Na'Ree S.Green, Division Director for Geriatric Medicine at Baylor Scott & White Health, Medical Director for BSW Hospice

BACKGROUND

Baylor Scott & White Health (BSWH) provides home-based primary and post-acute care for people living with dementia and other frail elderly in more than a dozen nursing homes and assisted living facilities in Central Texas. Launched a decade ago by BSWH's Geriatric Medicine Department, the program was designed to improve health care outcomes for vulnerable patients with a new model for medical directorship in area nursing homes, providing more comprehensive case management and expanding the use of advanced practice providers.

BSWH is an integrated health care system that dominates the continuum of care in Central Texas, providing a strong systemic incentive to manage these patients well and to invest in a new approach to comprehensive care management. Beginning in skilled nursing and long-term care facilities, the program soon expanded to assisted living facilities, and more recently, added a small but growing house calls service for patients still living in their own homes. The program is funded through fee-for-service billing and medical director fees from skilled nursing facilities.

IN BRIEF: DEMENTIA CARE AT BAYLOR SCOTT & WHITE HEALTH

Program Name: Dementia care is provided by the Baylor Scott & White Division of Geriatric Medicine.

Institutional Home: BSWH is the largest not-for-profit health care system in Texas, resulting from the 2013 merger of Baylor Health System and Scott & White Healthcare.

Location: Multiple cities in Bell County, TX (Temple, Belton, Harker Heights, Killeen and Copperas Cove)

Patient Population: Patients at any stage of dementia and in any site of care. Most patients are seen in skilled nursing facilities and assisted living facilities; the program is beginning to make private house calls.

Caregiver support: The program provides informal caregiver education at bedside, partners with the Area Agency on Aging which can offer needed services, and refers caregivers to community support groups.

Staffing Model: MD/APP dyads with the support of LVNs, RNs and CMAs

Funding Model: Fee-for-service billing for provider services; medical director fees in skilled nursing facilities

APPROACH

Baylor Scott & White Health describes its program for dementia patients as "comprehensive care management in the home," a model in which BSWH assumes full primary care of the patient and coordinates all their needs. The program currently serves a total of eight hundred residents of seven nursing homes and seven assisted living facilities—at least half of whom are living with dementia, and many more with mild cognitive impairment. The program deploys 12 billable providers, equivalent to 10 full-time employees: 6 doctors and 6 nurse practitioners. The team is supported by 2 registered nurses, 2 licensed vocational nurses, a certified medical assistant, 2 patient service specialists (administrative staff who provide patients and families with scheduling, information and billing support), an administrative assistant, and a division manager. Dr. Green hopes to add a social worker to the program in the next year. Physicians are either certified medical directors through the Society for Post-Acute and Long-Term Care¹, or working to complete certification requirements. The APP Manager has a PhD in Palliative Nursing and Dr. Green has attended a two-day certificate program at the Dementia Training Academy offered by the Texas Department of Aging and Disability Services.² Providers also engage in communication skills training using Ariadne Labs' Serious Illness Conversation Guide.³

New patients receive a comprehensive assessment to establish their level of cognitive and functional impairment and psycho-social well-being using standardized instruments, such as the Saint Louis University Mental Status Exam (SLUMS). Registered nurses, licensed vocational nurses or certified medical assistants are responsible for initial assessments such as gathering vital signs, performing screenings such as the SLUMS, and compiling complete medication lists. Physicians or nurse practitioners complete medication reconciliation by reviewing all medications with the patient and making necessary updates. Physicians or NPs engage in advance care planning with patients and caregivers. If the patient has dementia, the program has a follow-up conversation with the surrogate decision maker (by telephone if necessary). Providers use documents from the Serious Illness Conversation Project and Medical Order for Scope of Treatment (MOST) forms to

document these conversations in the EHR. MOST completion is one of the program's quality metrics tied to provider compensation.

After the initial assessment, the providers work with the patient and family to design a plan for the patient's future care, and schedule follow-up visits based on patient need and acuity. Nurses and CMAs ensure that the care plan is communicated to everyone involved in patient care: facility staff, home health, and hospice, if they are involved. For patients with low-level need, the Geriatrics team plans follow-up visits every two to three months, unless otherwise mandated by regulatory requirements for the facility. Patients receiving skilled nursing are seen weekly, for example, while long-term care residents are seen every sixty days, or more often if there is an acute need. Staff at the skilled nursing, long-term care, and assisted living facilities have 24/7 access to the physician or nurse practitioner on call.

“In many facilities around the country, it’s common to have multiple providers, but under our model, we are the only provider. This creates a tremendous opportunity to improve quality because we are both directing and providing the care,”

Dr. Green, Division Director of Geriatric Medicine, Baylor Scott & White Health

People living in long-term care or receiving care in skilled nursing facilities under BSWH medical directorship automatically become patients of the program. BSWH is the sole provider in most of the nursing facilities it administers. In assisted-living facilities, enrollment is entirely patient-driven—new residents are made aware of the house calls program and can choose whether to use the service, which people living with dementia tend to do. BSWH providers make weekly and sometimes bi-weekly rounds at the assisted living facilities, depending on the volume and acuity of patients at a given location.

In November 2017, BSWH also began a small house calls service for patients living in their own homes, currently serving around thirty patients. The service is not limited to people living with dementia, but most have at least some degree of cognitive impairment. The initiative was initially intended as a way to reduce readmissions for patients recently discharged from nursing facilities, but it is also an effective strategy to partner with patients and their caregivers to develop care plans before they experience a crisis. The BSWH house calls program is a way to help people age in place for as long as possible and support their caregivers as they coordinate needed services.

“More often than not, these patients languish at home because they have trouble getting to clinic visits, and then they show up in the ER when they are really ill. That cascade often progresses to an inpatient hospitalization and skilled nursing stay from which some of them never really recover. Providing the care in patients’ homes, alongside allied health providers and family caregivers, gives us a deeper understanding of how to meet the needs of each patient and an opportunity to respond early to clinical changes in condition.”

Dr. Green, Division Director of Geriatric Medicine, Baylor Scott & White Health

BSWH is also in the preliminary stages of a partnership with the Central Texas Housing Consortium, which provides low-income housing for dual-eligible Medicare-Medicaid beneficiaries living with disabilities. Under the partnership, the housing board will identify people who are homebound and could benefit from home-based medical care, and the BSWH program will build efficiency by visiting apartment buildings in which they can see multiple patients at a time. The program does not yet have the infrastructure to manage a 24/7 phone line for these house call patients but hopes to provide it in the future.

Funding the program through fee-for-service billing requires careful coding practices. The basic building blocks are evaluation and management (E/M) codes, which differ for skilled nursing, assisted living, and house calls services. The program also makes use of the Medicare advance care planning codes, and the annual Medicare Wellness Visit code, though this code cannot be used in skilled nursing facilities. The program’s medical director fees are separate from, and in addition to, service-related billing.

RESULTS TO DATE

In its work with skilled nursing facilities, BSWH’s performance is tracked using the CMS-mandated minimum data set (MDS), a clinical assessment that must be performed for all residents in Medicare- and Medicaid-certified nursing homes. The MDS tracks metrics such as rates of readmissions, falls, infections, and pressure ulcers. Assessments are required for all residents on admission to

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the nursing facilities, periodically and on discharge. BSWH has monthly meetings to discuss the results of these assessments by facility. The program has helped to keep readmissions for the skilled nursing facilities between 12-17 percent, well below the current 21 percent average readmission rate for the state. All SNFs served by the program have either a four- or five-star rating.

Data tracking has not occurred in the assisted living facilities in which BSWH's program is active—in part because the BSWH team lacks analytics support—but this is a goal for the future, in order to make the case to grow the program.

TOOLS

- Katz Index of Independence in Activities of Daily Living^{4,5}
- Lawton Brody Instrumental Activities of Daily Living Scale^{6,7}
- Saint Louis University Mental Status Examination⁸
- Geriatric Depression Scale⁹
- Self Mini Nutritional Assessment¹⁰
- For patients who are still driving, the program administers the Trail Making Test Parts A&B¹¹
- EPIC EHR
- Medical Order for Scope of Treatment (MOST)
- Serious Illness Conversation Guide³

One challenging aspect of BSWH's work with multiple facilities is managing the different record-keeping practices each facility employs, from paper charges to EHRs. BSWH approaches the problem by doing all its documentation in EPIC and using the auto-fax function to route notes directly from the EHR to the facility's fax machine. Each facility can then transfer the notes into the paper chart or scan it into their own EHR, so that documentation resides in both facility's records.

BSWH hopes to expand the functionality of its medical record, which currently lacks the EPIC geriatrics module and its suite of standard geriatrics assessments. At the moment, information such as the psycho-social assessment does not live in a discrete field, but in the text-entry note, making the data more variable and difficult to track over time.

LESSONS LEARNED

- **Build and maintain facility relationships carefully:** Dr. Green cautions that relationships are not with buildings, but with people. Turnover in leadership can severely disrupt your practice. It is important to be very intentional about relationship building with staff across the organizations you are working with.
- **Prepare your elevator pitch for system leadership:** Make sure that those in leadership positions know about your program and its impact.

- 1 For more information on The Society for Post-Acute and Long-Term Care Medicine, and its core curriculum on Medical Direction in Post-Acute and Long-Term Care, visit <https://paltc.org/core-curriculum-medical-direction-post-acute-and-long-term-care>.
- 2 For more information about the Texas Department of Aging and Disability Services' Dementia Training Academy and other Texas-based training opportunities, visit <https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/nursing-facilities-nf/quality-monitoring-program-qmp/evidence-based-best-practices-qmp/alzheimers-disease-dementia-care>.
- 3 For more information about Ariadne Labs' Serious Illness Conversation Guide, see <https://www.ariadnelabs.org/areas-of-work/serious-illness-care/resources/#Downloads&%20Tools>.
- 4 Katz, S. "Assessing Self-maintenance: Activities of Daily Living, Mobility, and Instrumental Activities of Daily Living," *J Am Geriatr Soc*, 1983; 31(12): 721–727. Web access: <http://doi.org/10.1111/j.1532-5415.1983.tb03391.x>.
- 5 For more information on the Katz ADL scale see <https://consultgeri.org/try-this/general-assessment/issue-2.pdf>.
- 6 Lawton, M., Brody, E. "Assessment of Older People: Self-maintaining and Instrumental Activities of Daily Living," *Gerontologist*, 1969; 9: 179-186. Web access: http://doi.org/10.1093/geront/9.3_Part_1.179.
- 7 For more information on the Lawton-Brody IADL Scale, see <https://consultgeri.org/try-this/general-assessment/issue-23.pdf>.
- 8 For the SLUMS Exam, visit <http://aging.slu.edu/pdfsurveys/mentalstatus.pdf>.
- 9 For more information on the Geriatric Depression Scale, see <https://consultgeri.org/try-this/general-assessment/issue-4.pdf>.
- 10 For more information on the Self Mini Nutritional Assessment, see <https://www.mna-elderly.com>.
- 11 For more information on the Trail Making Test, see <http://apps.usd.edu/coglab/schieber/psyc423/pdf/IowaTrailMaking.pdf>.

June 2018

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