National Dementia Care Collaborative

My Memory Clinic Patient Journey and Operating Principles

My Memory Clinic

Agenda

- Introduction and practice philosophy
- Recruitment
- Pre-visit and preparation
- Initial Assessment
- Referral Management
- Billing/Claims
- Additional visits and Monthly Check-Ins
- Lessons Learned
- Summary

INTRODUCING MY MEMORY CLINIC

- Florida-based telehealth clinic established in 2022
  - Convenient telehealth access to specialized memory care providers for residents and their family caregivers
  - 2 Practitioners
- Dr. Rosemary Laird has over 25 years of experience of working with patients and families with cognitive diseases.
- Established GUIDE Program
  - First patient seen under GUIDE was July 2, 2024

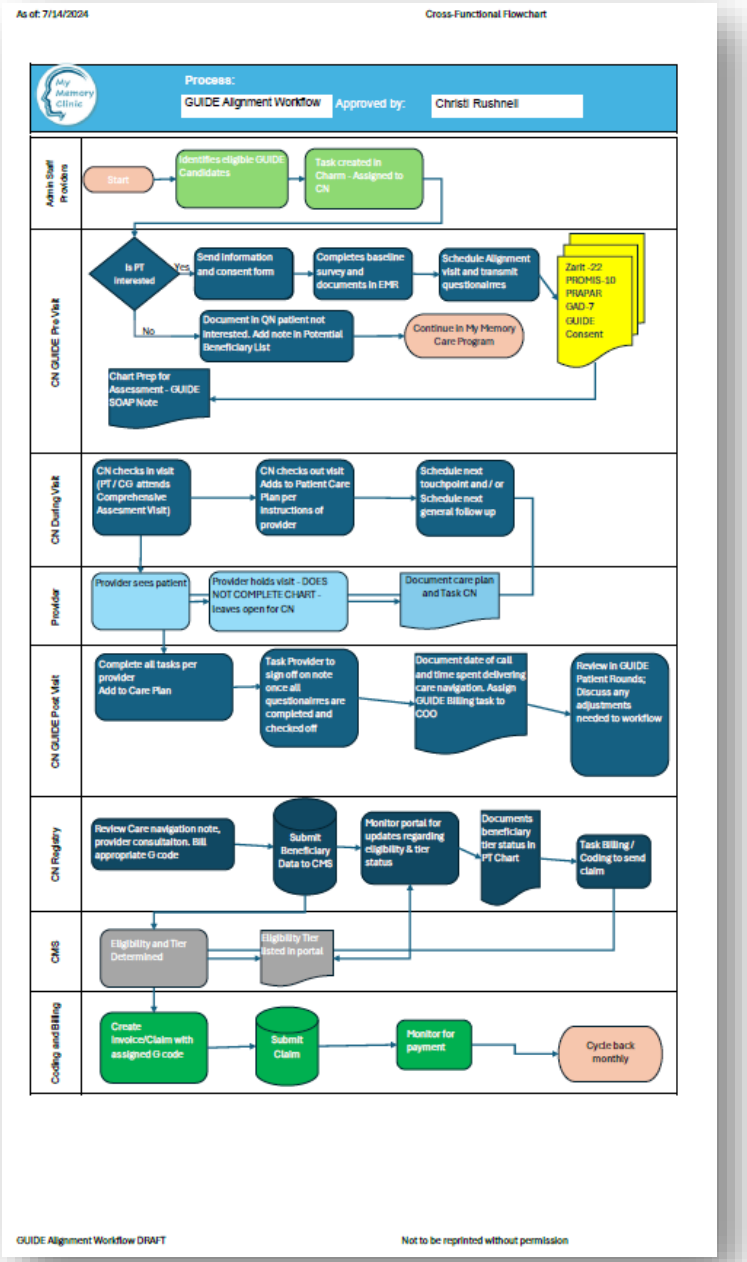
My Memory Clinic

Electronic Tool Set

- CharmHealth Electronic Health Record
- CharmHealth Personal Health Record
- Phone System
- Productivity Software
  - SharePoint
  - Lists
  - Excel
  - Loop
  - TEAMS
  - PowerBI
- Supporting Tools
  - Florida HIE Portal
  - Adobe

Cross-Functional Flow Chart

- Started with current workflow and added in the additional items for GUIDE
- All patients benefit from improvements in MMC workflow



Function:
Recruitment and Pre-Visit Prep

Tools used: EHR, PHR, MS Lists, Excel

Beneficiary Add Form

- Pulled report of traditional Medicare patients meeting DX requirements
- Loaded to Beneficiary Planning List – Add new patients via LISTS Form
- Forms in MS Lists – “Beneficiary Add Form”
  - allows staff to add to the list without having to open and navigate the MS List

Created GUIDE Specific Visit Types

Visit Type	When used	Team Member
GUIDE CN PreScreen	For detailed phone screening prior to scheduling assessment appointment	Care Navigator
GUIDE CN Touchbase	Monthly or Bi-Monthly touch base appointment between CN and Beneficiary and/or Caregiver	Care Navigator
GUIDE Comprehensive Assessment	For initial assessment and re-assessments (no more than 1 every 6 months)	Provider
GUIDE Advanced Care Planning	For GUIDE aligned patients/CG for their ACP visit	Provider
GUIDE Assessment and Care Plan	For GUIDE-aligned patients, a CPA visit with an MD	Provider
GUIDE Respite	For tracking and claims specific to Respite	Care Navigator

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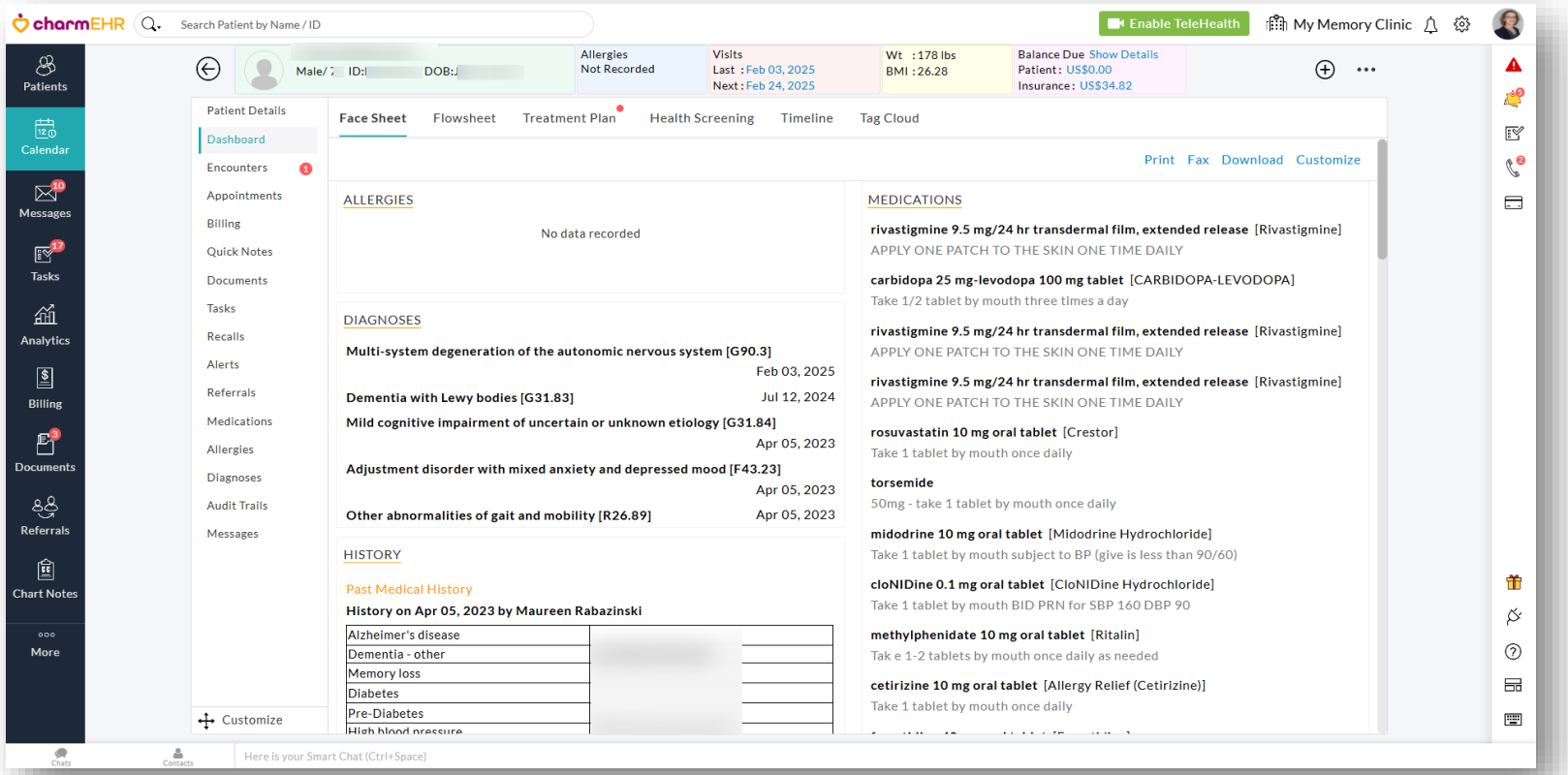
Added Additional Patient Categories

Visit Type	When used
GUIDE LCDyad	Added when GUIDE Beneficiary is identified by CMS as a member of the MMC Participant Roster; Low complexity with a caregiver
GUIDE MCDyad	Added when GUIDE Beneficiary is identified by CMS as a member of the MMC Participant Roster; Moderate complexity with a caregiver
GUIDE HCDyad	Added when GUIDE Beneficiary is identified by CMS as a member of the MMC Participant Roster; High complexity with a caregiver
GUIDE LCIndv	Added when GUIDE Beneficiary is identified by CMS as a member of the MMC Participant Roster; Low Complexity no caregiver
GUIDE MC_HCindv	Added when GUIDE Beneficiary is identified by CMS as a member of the MMC Participant Roster; Moderte to High Complexity no caregiver

Look to the Patient Dashboard

- Dashboard is the Hub of activity
- Access to Flowsheets
- Treatment plans
- Medications



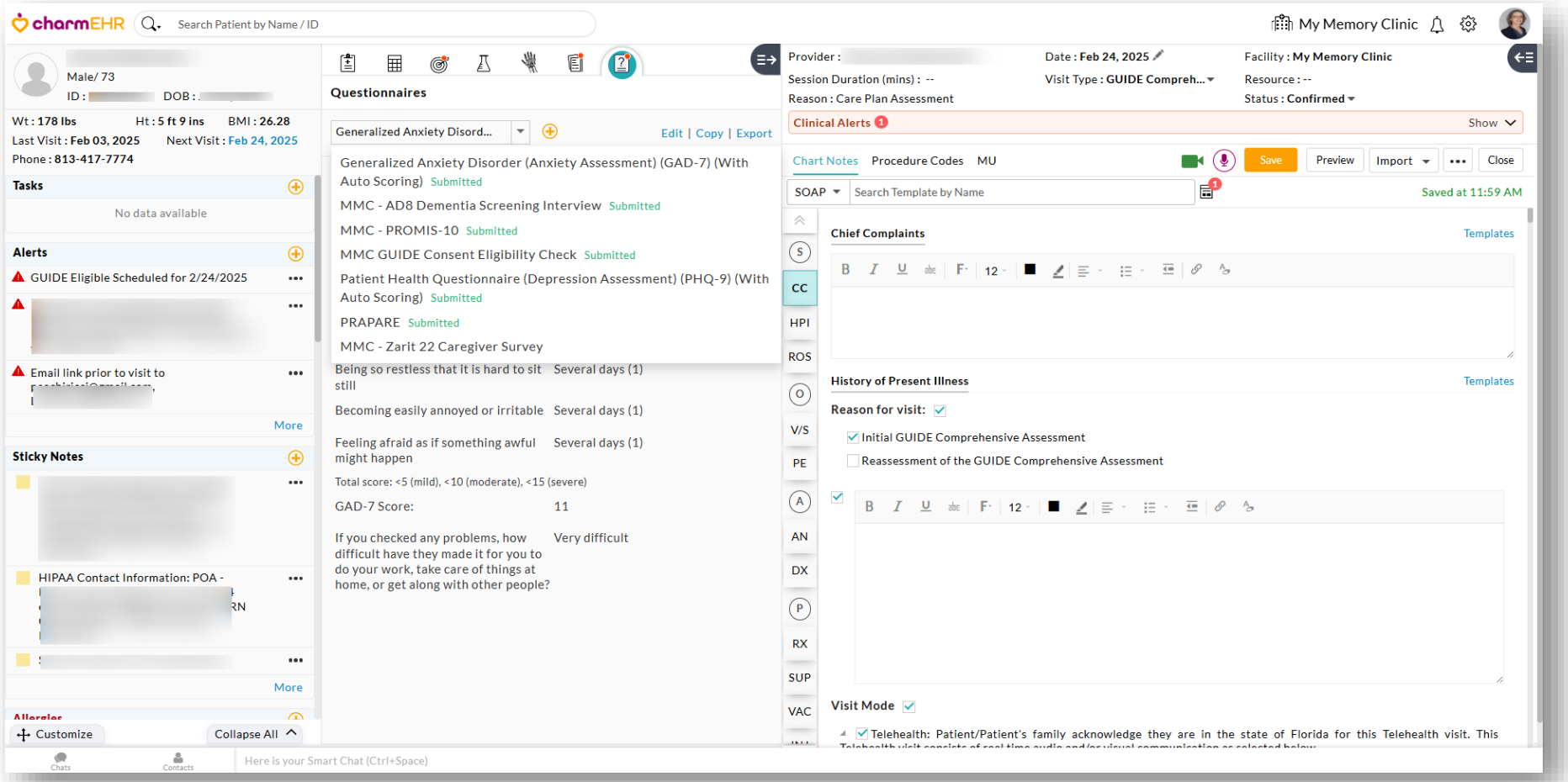
Function:
Encounters

Tools used: EHR Modules, PHR

Comprehensive Assessment

- The Comprehensive Assessment will initiate the model for the beneficiary and serve as the initial GUIDE visit.
- EMR 360 Encounter view is used to see
  - Questionnaires
  - Documents
  - Treatment Plan
  - Flowsheets
- Encounter SOAP note used to document all the sections of the Assessment

EHR 360 Encounter View



Care Plan

- Located in the EHR Treatment Plan
  - Allows for updates outside of the assessment note
  - Available to Dyad in PHR, allowing them to lead the care plan effort
- The participant shall develop elements of the person-centered care plan with recommendations speaking to the following:
  - Addressing the GUIDE Beneficiary's goals, strengths, preferences and needs,
  - The required domains of the Comprehensive Assessment,
  - The coordination of community-based services and supports, including respite services if applicable, and a listing of recommended service providers and which individual or program is responsible for payment of each service provider and
  - The caregiver's education and support services

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Function:
On-going monitoring and support

Tools used: EHR Modules, PHR, MS Lists, Phone system

Ongoing Monitoring and Support

- Primary staff responsible:
  - Care Navigator
- Contact Frequency Requirements
  - Low Complexity and Moderate Complexity Dyads and Low Complexity Individuals Tiers - Minimum once per month
  - High Complexity Dyad and Mod / High Complexity Individual Tiers – Twice per month
  - Encounter created with SOAP notes to document visit
- Modality of Ongoing Support
  - Phone,
  - Telehealth
  - Documented in CharmEHR as an encounter

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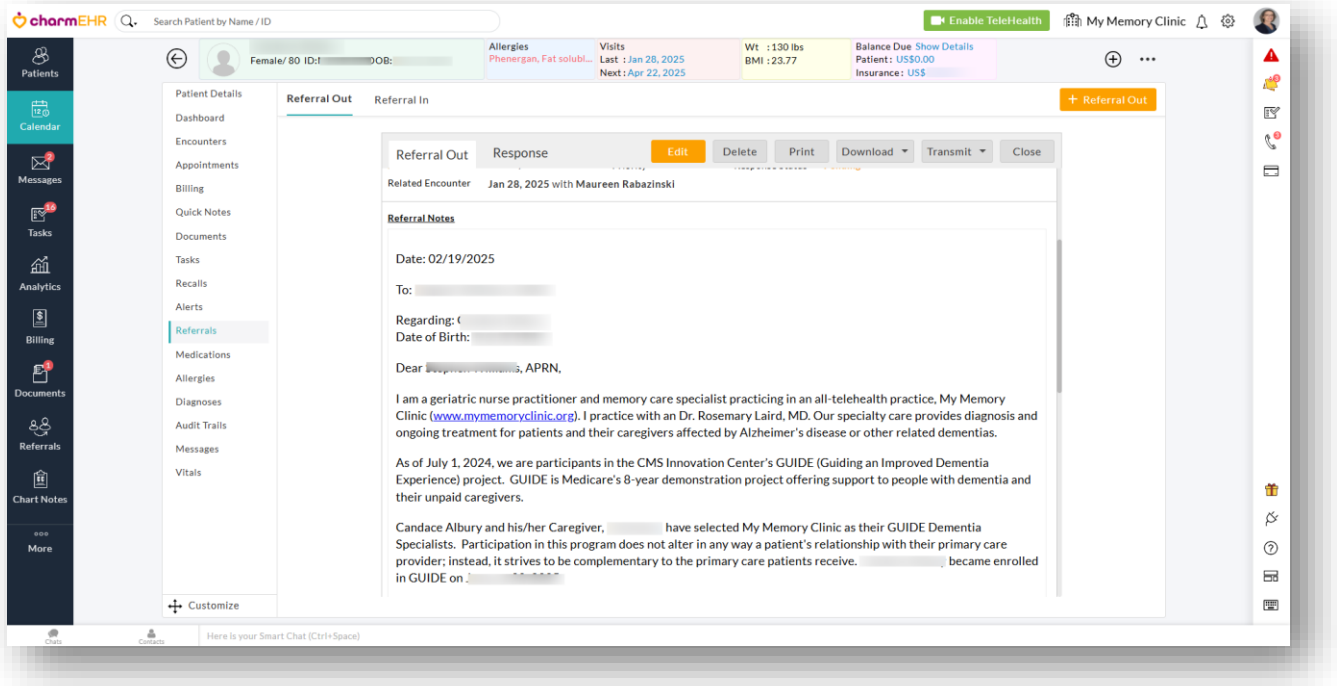
Medication Management and Reconciliation

- Our Clinical Team handles Medication Review as part of their standard workflow processes for all patients
- Communication with other Healthcare Providers
- Discussed and documented at Follow-up visits

Function:
Referral Management

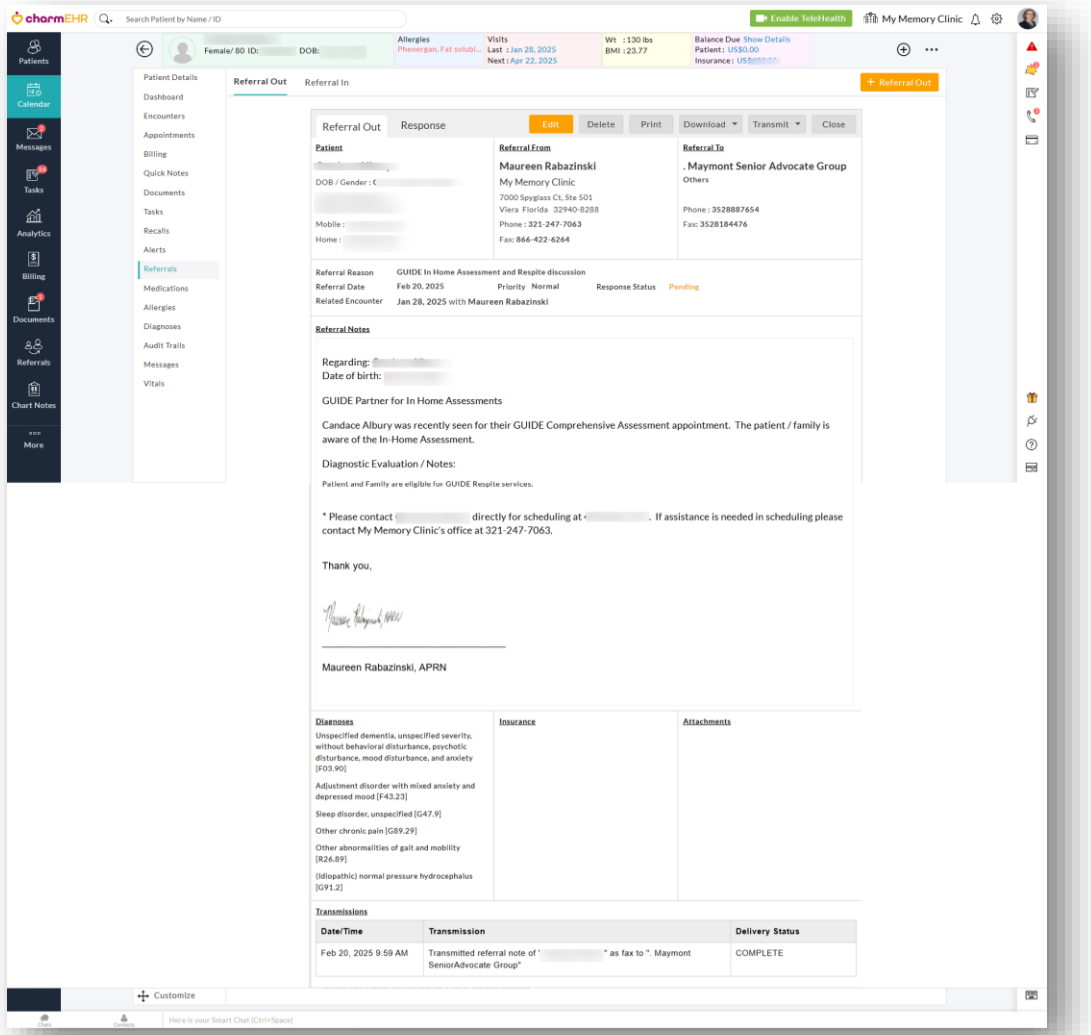
Tools used: EHR Referral Module, Florida HIE Dashboard, MS Lists

Care Coordination Communications



- Coordination with Primary Care Provider using EMR template function
- Referral to Specialists
- Care Transition Support communication documented in the same location as other communications

Referral letter for GUIDE Partner



Function: Billing/Claims

Tools used: Billing Modules, GUIDE Payment file

Billing/Claims

Initial Assessment Timing

- Wait to conduct the initial assessment until the alignment with the provider is confirmed.
- Attesting provider is the billable provider

Monthly Calls

- Keep track of the monthly calls that are assigned to the aligned provider. During these calls, a SOAP note gets created for each monthly visit. The aligned provider signs the chart to ensure

Importance of Timing

- Pay attention to timing. If a patient is aligned and the start date falls on the last day of the month, it's crucial to engage in some activity in the following month.

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Lessons Learned

- Being flexible is an absolute must; The GUIDE program is changing processes and details often; Paying attention to the changes has been critical
- When a patient moves from NPFF to EPFF catching that the billing code must change. There is no automated way to do this
- Our EMR system is not enough to cover the workflow. We need to use other systems to keep track of the program details. However, use what we have as we work through the details

Summary

- Using our existing toolset to implement GUIDE into our practice flow
- Existing patient journey as a baseline; Developed GUIDE flow from the baseline
- Additional requirements for GUIDE added into the flow
  - Submission and Alignment: Manual data collection, Alignment checklist, Managing disenrollment
  - Billing/Claims: Hold initial assessment till alignment, Monthly calls tracked to aligned provider, Lessons Learned
  - Monthly Check-Ins: Scheduled and Non-Schedule calls; created an Alignment List (MS LISTS) to track calls
- Work with other support processes to fold GUIDE into your existing practice process (E.g, contracting and onboarding Partners and tracking respite utilization)

Contact Information

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Electronic Health Record Modification: Brown Medicine GUIDE program

Thomas Bayer MD ScM

Aman Nanda, MD

Disclaimers

- The content in the presentation does not represent the views of Brown Medicine, Brown University Health, eClinicalWorks, the Department of Veterans Affairs, or the US Federal Government
- No conflicts of interest

Background

eClinical Works

Alzheimer’s and Dementia Care Program

Availability of Skilled Technical Support

Getting to work

CORE COMPONENTS
‘MUST HAVES.’

PARALLELS TO
EXISTING WORKFLOWS

LEARN FROM OUR
MISTAKES

Designing a Viable Product

Process Map

Review with Physician Lead and Care Navigator

Draft EHR Modifications

Meet with EHR Support Team

- Shared Draft
- Scheduled Meeting
- Item-by-item Walkthrough
- Real-time Edits

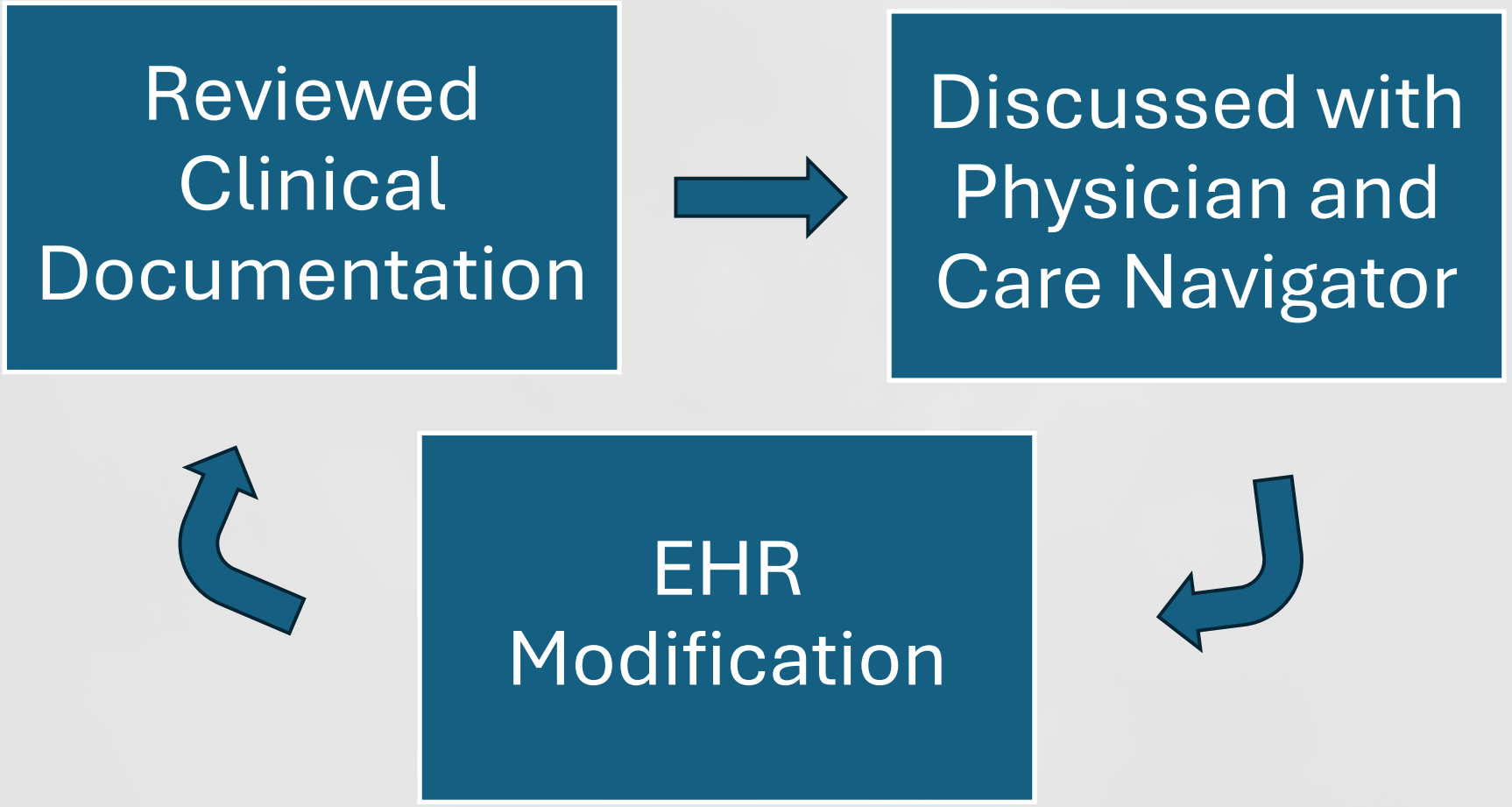
First 2 Weeks

Reviewed Clinical Documentation

Discussed with Physician and Care Navigator

Facilitate Relationship Between Physician Lead and EHR support

First 2 Weeks



Goals to create a Template

- Concise
- Easy to use by any provider
- Data entry by multiple disciplines - SW, CN, MD
- Incorporate existing bullets (SOAP note) built in ECW
- Info can be used for alignment by data analyst
- Flow of the note- User friendly for PCP
- Lessons learnt from ADC template in e-clinical works
- Structured fields- for future research, Quality Improvement

Process

- Team- MDx2, NCM, SW, CN, EMR specialist
- CMS guidelines for assessment
- Include all needed scales- Structured fields
- Arranged in sequence - Easier for alignment data entry
- Multiple drafts

Subjective:

Chief Complaint(s):

HPI:

Attending

.....

Social Service

.....

GUIDE

Patient Assessment and Alignment

Results From: *Initial Assessment* .

Is this patient an existing patient of the practice or a new patient? .

Provide patient referral source .

Functional Status

Katz Scale .

Lawton and Brody .

1Q Hearing screen .

Resides in .

Healthcare Providers

PCP .

BH Provider .

Specialists .

Home and Community-Based Services

Home-based services .

Community- based services .

Caregiver

Does the patient have a primary caregiver? .

First Name .

Last Name .

Date of Birth .

Relationship .

Lives with .

Patient Assessment and Alignment GUIDE

Results From: .

- [x] Initial Assessment
- [ ] Re-assessment

Is this patient an existing patient of the practice or a new patient? .

- [ ] Existing patient
- [ ] New patient

Provide patient referral source .

- [ ] Referred by a health care provider
- [ ] Referred by a community-based organization
- [ ] Self-referral

OK Cancel Next

Default | Default For All | Clear All

Name	Value	Notes
Does the patient have a primary caregive ...		.
First Name		.
Last Name		.
Date of Birth	mm/dd/yyyy	.
Relationship		.
Lives with		.
Start of Caregiving	mm/dd/yyyy	.
Knowledge, Needs, Wellbeing		.
Street Address		.
State		.
City		.
Zip code		.
Email Address		.
Phone Number		.
Phone Type		.

Prev | Next

OK | Cancel

Lives with .
Start of Caregiving .
Knowledge, Needs, Wellbeing .
Street Address .
State .
City .
Zip code .
Email Address .
Phone Number .
Phone Type .
Medicare Status .
Medicare Number .
Zarit .
Gender .
Race/Ethnicity .

0/0
To Do

0
App...

Health-Related Social Needs

Do you often feel that you lack companionship? .

History and Physical

Capacity .
Dementia Stage .
Med Review .

Behavioral and Psychosocial Screening

Depression .
Anxiety .
Substance Use .
Suicide .
PROMIS-10: Physical health .
PROMIS-10: Mental Health .
PROMIS-10: Total Score .

Zarit

Do you feel stressed between caring for your relative and trying to meet other responsibilities for your family or work? *0(Never)*

Zarit

Do you feel stressed between caring for your relative and trying to meet other responsibilities for your family or work? *0(Never)*
Do you feel embarrassed you're your relative's behavior? *0(Never)*
Do you feel angry when you are around your relative? *0(Never)*
Do you feel that your relative currently affects your relationship with other family members or friends in a negative way? *0(Never)*
Are you afraid what the future holds for your relative? *0(Never)*
Do you feel strained when you are around your relative? *0(Never)*
Do you feel that you do not have as much privacy as you would like because of your relative? *0(Never)*
Do you feel that your social life has suffered because you are caring for your relative? *0(Never)*
Do you feel uncomfortable about having friends over because of your relative? *0(Never)*
Do you feel that you have lost control of your life since your relative's illness? *0(Never)*
Do you wish you could just leave the care of your relative to someone else? *0(Never)*
Do you feel uncertain about what to do about your relative? *0(Never)*
Do you feel that you should be doing more for your relative? *0(Never)*
Do you feel you could do a better job in caring for your relative? *0(Never)*
Overall, how burdened do you feel in caring for your relative? *0(Never)*
Do you feel that your relative asks for more help than (s)he needs? *0(Never)*
Do you feel that your relative asks for more help than (s)he needs? *0(Never)*
Do you feel that because of the time you spend with your relative that you do not have enough time for yourself? *0(Never)*
Do you feel your relative is dependent upon you? *0(Never)*
Do you feel your health has suffered because of your involvement with your relative? *0(Never)*
Do you feel your health has suffered because of your involvement with your relative? *0(Never)*
Do you feel that your relative seems to expect you to take care of him/her as if you were the only one he/she could depend on? *0(Never)*
Do you feel that you will be unable to take care of your relative much longer? *0(Never)*
Do you feel that you do not have enough money to care for your relative in addition to the rest of your expenses? *0(Never)*

Depression Screening

PHQ-9

Little interest or pleasure in doing things *Not at all*

Current Medication:

Medical History:

Allergies/Intolerance:

Gyn History:

0/0
To Do

0
App...

Current Medication:
Medical History:
Allergies/Intolerance:
Gyn History:
OB History:
Surgical History:
Hospitalization:
Family History:
Social History:
ROS:

Objective:

Vitals:
Past Results:
Examination:

0/0
To Do

0
App...

Assessment:

Assessment:

Major neurocognitive disorder - F03.90 (Primary)

Plan:

Treatment:

Major neurocognitive disorder

Clinical Notes: In my clinical judgement, the assessed patient meets the National Institute on Aging-Alzheimer's Association diagnostic guidelines for dementia and / or the DSM-5 Diagnostic Guidelines for Major Neurocognitive disorder. or I have received a written report (electronic or hard copy) of a documented dementia diagnosis from another Medicare qualified health professional.

- Yes, the patient meets the National Institute on Aging-Alzheimer's Association diagnostic guidelines for dementia and / or the DSM-5 diagnostic guidelines for major neurocognitive disorder.

- Yes, I received a written report of a documented dementia diagnosis

- No, I can not attest to either statement

Attesting Clinician:
First Name ..... Middle Name..... Last Name .....
NPI Number
GUIDE Model Participant identification Number (TIN)

EHR -Customization

- Templates
  - Initial Assessment / F/u or Reassessment Template
  - Care Coordination plan Template
- Document section- GUIDE folders and subfolders
  - Consent
  - Home visit
  - Respite
  - Misc.
- Electronic Forms:
  - Initial visit form for caregiver
  - Caregiver demographics needed for alignment
  - Consent form for alignment
  - FAST scale
  - Advance directive/ MOLST form
- Billing codes - Created billing codes in the ECW for first 6 months and f/u codes
- Patient's dashboard- Yellow note: GUIDE patient/Tier

Work-Flow- Initial Assessment

- Time- Schedule for 90 minutes
- Social Worker - First 30 minutes social worker
  - History
  - Scales including ADLs/IADLS/, MOCA and SLUMS, ZARIT, PROMISE
- Care navigator
  - Consent form
  - Data Entry - Caregiver form- Demographics etc
- Physician/ NP
  - Review records from PCP and specialist
  - History and Physical examination
  - FAST Scale
  - Hearing questionnaire
  - Advance directives
  - Medication review
  - MD certification- Template for certifying

GUIDE Care Plan Template

Reason for Appointment

1. Guide Care Plan and Coordination

History of Present Illness

GUIDE:

Care Plan and Coordination

Potential location for Guide CARE PLAN and Coordination .
Intervention: .
Follow Up Week Of: .
Total time spent (minutes): .
GUIDE Beneficiaries Goals: .
Barriers to Goals: .
Active Problems: .
Strengths: .
Preferences: .
Needs: .
Care Plan Given to Beneficiary/Caregiver: .
Coordination of Community Based Services and Support .
GUIDE Caregivers: .
Caregiver Education and Support Services: .
Plan: .
Treatment: .
GUIDE Care Team: *Aman Nanda MD - Co Director Thomas Bayer MD - Co Director Louis Pina - Care Team Navigator - 401-572-3072 Katherine Johnson - Social Worker - 401-649-4010 ext. 1021 Karolyn McKay - Nurse Care Manager* _____ *- Beneficiary PCP - *PCP Phone Number**

24/7 Access: ** Anything Dementia or GUDIE related please contact your Care Navigator - Louis - 401-572-3072 - Hours: Mon-Fri 8:00am-4:30pm After business hours you will be connected to the Brown Medicine answering service * For all other health concerns please call your Primary Care Provider*

Ongoing Challenges

- Interdisciplinary Care Team
- Communication with providers
- Development of Patient-Facing Materials

Brown GUIDE Team

Clinical Care Team

Aman Nanda, MD – Co Director
Thomas Bayer, MD – Co Director
Gary Epstein-Lubow, MD
Jeanne Knight, Psych RNP
Karolyn McKay, RN – Nurse Care Manager
Katherine Johnson, LICSW – Social Worker
Marco DelBove, Pharm.D
Louis Pina – Care Team Navigator
Mikaela Carrillo- Medical Student

Administration Team

Melinda Diaz – Program Manager
Susan Traverse– Office Manager
Brad Crough- Sr. Director Analytics
Donna Gordon-Sr. Director, Revenue
Douglas Osier- Data Analyst

Yemi Whesu- EMR Application Specialist

Peter Hollman, MD- Advisor

GUIDE Tel Number: 401-572-3072