Dementia Care and Population Health: A Paradigm Shift

By Joanne Kaldy

Population health has been around for decades, but it is now taking center stage in Alzheimer’s disease (AD) and dementia care. The Centers for Disease Control and Prevention (CDC) are encouraging and empowering these efforts with a Public Health Approach to Alzheimer’s Disease and Dementia Curriculum. “This is an important strategy,” said Arif Nazir, MD, FACP, AGSF, CMD, Signature HealthCare chief medical officer and president of AMDA – The Society for Post-Acute and Long-Term Care Medicine. “We have millions of patients with dementia, and these numbers will increase. It’s important to have a population health strategy to track patients’ progress no matter what setting they are in.”

The CDC defines population health as “an interdisciplinary, customizable approach that allows health departments to connect practice to policy for change to happen locally.” (Public Health Approach to Alzheimer’s, 2019; http://bit.ly/2tamo2f) This approach uses non-traditional partnerships among different sectors of the community — including public health, industry, academia, health care, and local government entities — to achieve positive health outcomes. It is a natural partner to value-based medicine because it focuses on aligning outcomes and costs.

The increased interest in population health is partly due to the growing realization that socioeconomic, psychosocial, and behavioral factors all contribute to patient outcomes and quality of life. Investing in resources and services that keep patients out of the hospital, prevent complications and new problems, and promptly identify condition changes has proven to positively impact outcomes and costs.

Population Health in PALTC

Population health makes sense for post-acute and long-term care, where teams are already in place along with systems for communication between practitioners and settings. A population health approach to managing AD and behavioral issues can help ensure that there is a safety net to prevent problems or issues from falling through the cracks.

For example, Dr. Nazir said, “Family members may not notice a change in behavior or that mom or dad isn’t eating, especially if they don’t see their loved one every day or week. Population health strategies involve social workers and others in the community who can partner with clinical teams to prevent or enable early identification of problems or issues.”

Population health has to be taken as positive news for PALTC providers because this strategy is about a whole episode of care,” said Dr. Nazir. “It’s about how we keep patients happy and healthy no matter where they are. We need to include nurses, social workers, and other practitioners as partners, and we have to ensure that facilities have the resources and training to ensure good care throughout the continuum.”

Population health “breaks down silos to provide good outcomes and enable shared savings. More systems will be moving to risk-sharing, and we will see more opportunities for gains in terms of good outcomes.”

Population Health in the Community

At the same time, Dr. Nazir noted, “We need to identify and connect with resources in the community.” These include Meals on Wheels, legal aid, help with cooking and cleaning, and financial services. “The good thing about geriatrics is that we have practiced some kind of population health for years — we just didn’t define it as such. But now it’s being recognized more formally, and geriatricians and geriatric teams are ahead of the curve.”

Also, according to Dr. Nazir, “education is taken to a whole new level in population health. Health systems have resources to create effective education for team members who can use evidence-based strategies to identify the highest-risk patients for preventive measures.” This also includes a focus on caregivers.

Caregivers “can’t provide quality care if they get depressed, sick, or burned out. This is where population health strategies can be very helpful,” Dr. Nazir said. In a population-health model, practitioners can involve family members. For example, families can be trained in non-pharmacologic behavioral management about who will do the educating, how they will be paid, and when it will be done.”

He emphasized, “We need technology to monitor our patients more meaningfully, and we need to collaborate with visionary entrepreneurs and frontline physicians to accelerate successes and enable these technologies to reach the front lines.”

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An Old Idea Gets New Life

As the CDC states, population health “brings significant health concerns into focus and addresses ways that resources can be allocated to overcome the problems that drive poor health conditions in the population.” The CDC’s four-module population health curriculum (http://bit.ly/2tamo2f) focuses on key aspects of AD to help develop a workforce with the competency to manage care for people with AD, whatever the setting:

- Module 1 frames AD and other dementias as a public health epidemic.
- Module 2 describes the symptoms, stages, risk factors, diagnosis, and management of AD and other dementias.
- Module 3 discusses three tools of public health: surveillance/monitoring, primary prevention, and early detection and diagnosis.
- Module 4 addresses the public health response to the AD epidemic on a state and community level: enabling a “dementia capable” system that incorporates public health research and translation, support services and programs, workforce training, and the creation of dementia-friendly communities.

Senior contributing writer Joanne Kaldy is a freelance writer in Harrisburg, PA, and a communications consultant for the Society and other organizations.

Population Health That Works

Embracing population health for older patients with AD and other issues is the wave of the future. “We have to create a win-win,” said Dr. Nazir. “We know people are burning out on the front lines. A top-down approach will never work. To get on the bandwagon, we need the commitment of frontline practitioners. We need to address the pros and cons and keep patients in the center.”

While the team must be intricately involved, Dr. Nazir stressed that, “it has to be all about the patient and not based on the team’s wishes. The team has to be able to continuously learn and modify approaches based on outcomes.”

Dr. Nazir also observed, “If you are really good at population health, you have good data, a team that can analyze it without bias, and a good chance it will all be accurate and efficient.” But there are challenges. For instance, he said, “Not every small practice has the ability to capture data in the right way, so there needs to be a way to get good, accurate data with limited resources. At the same time, the patient and family have to understand why the practitioner wants to make changes to care or medications.”

No challenges are insurmountable, he observed, but they do require funding and commitment.