Concierge Dementia Care Management Program
AT PACIFIC BRAIN HEALTH CENTER

Benefits:

- Priority unlimited telehealth visit access over 1 year with Dementia Care Specialist Nurse Practitioner for ongoing dementia care
  - Dementia care management includes comprehensive assessment, care plan, ongoing monitoring and support, care coordination, referral and coordination of services and support, medication management and reconciliation, caregiver support and education
  - High level care coordination between visits (via telephone, virtual, email, in person)
  - Family meetings
  - Coordination of care with your team of providers
  - Monthly check in by Dementia Care Specialist via phone or email (preferred method)
- Priority office appointment with Dementia Care Specialist Nurse Practitioner for ongoing dementia care
- Priority access to Pacific Brain Health Center Lifestyle program
- Priority access to Pacific Brain Health Center multi-disciplinary team
- No cancellation fees
- No office policy charges (including completing forms)
- Appeal insurance company decisions on claims
- Email the Dementia Care Specialist and Concierge Coordinator directly
- Dedicated phone line with Concierge Coordinator* (Is this possible?)

Contact

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Dementia Care Nurse Specialist

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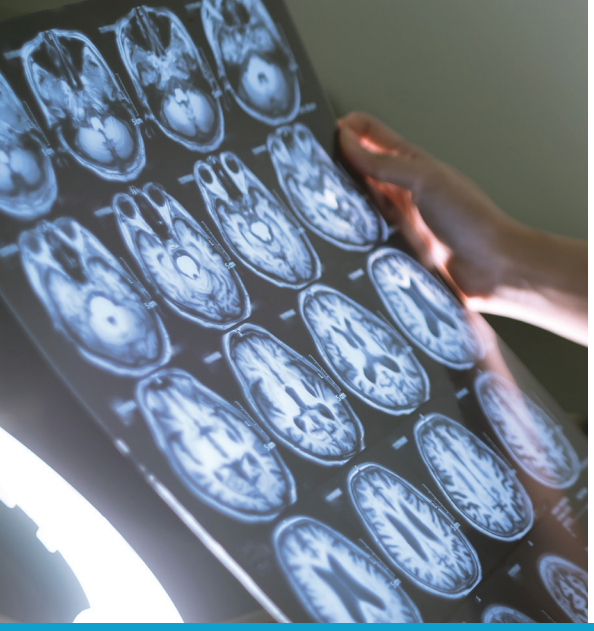

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Some examples of Dementia care management services are listed here.

- Conduct a holistic and comprehensive needs assessment.
- Provide medical, behavioral, and psychosocial recommendations for neurocognitive disorders such as memory loss, mild cognitive impairment, as well as dementia related to Alzheimer's disease, Lewy body disease, Vascular disease, Parkinson's disease, Frontotemporal lobar degeneration and Traumatic Brain Injury.
- Screen for neurocognitive-associated behavioral and psychiatric symptoms and provide management guidance with non-pharmacological and pharmacological interventions.
- Educate on neurocognitive disorder diagnosis: its course, prognosis, cognitive enhancing agents, traditional and alternative management options, as well as clinical trials.
- Provide comprehensive collaborative care with your team of health care providers which may include an Internist, Geriatrician, Neurologist, Psychiatrist, Social Worker, Home Health, Health Coach, Dietitian and Palliative/Hospice team. Referral to specialists as needed.
- Help connect to community-based organizations and resources, such as patient and caregiver support groups, educational events, activities, socializations, adult day care, and cognitive training programs.
- Provide care management for challenging psychosocial issues associated with neurocognitive disorders (such as concerns for substance abuse, hoarding, wandering, elder abuse, and financial scams).
- Counsel on advance care planning and goals of care. Provide guidance on legal advocacy and planning (activating Advance Directive for Health Care, guidance on capacity evaluation, conservatorship/ guardianship, referral to elder law lawyer and fiduciary service). Referral to palliative or hospice care when appropriate and assistance with the transition.
- Guide patients and families regarding long term care and emergency planning.
- Implement high-level care coordination when there is an Emergency Room visit or hospitalization related to neurocognitive disorder or preventative causes (such as geriatric syndromes). Assist with transitions of care, communication with inpatient hospital care teams and Skilled Nursing Facilities, as well as provide family support.

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