

The Lewin Group
Navigating COVID-19:
Supporting Individuals with Dementia and their Caregivers
June 23, 2020 – 12:30pm EDT

Laurel Ruesch: Welcome to the webinar Navigating COVID-19: Supporting Individuals with Dementia and Their Caregivers. My name is Laurel Ruesch, and I'm with the Lewin Group.

Today's session will include a 60-minute presenter-led discussion followed up with 30 minutes for a discussion among the presenters and participants. This session will be recorded. A video replay and a copy of today's slides will be available at www.ResourcesforIntegratedCare.com.

The audio portion of this presentation will automatically stream through your computer. Phone lines for this presentation are also available. Access the number, click the black phone icon at the bottom of your screen. This webinar is supported through the Medicare and Medicaid coordination office at the Centers for Medicare and Medicaid Services.

MMCO is helping beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality healthcare that includes the full range of covered services in both programs. To learn more about the current efforts and resources, please visit our website or follow us on Twitter for more details. Our Twitter handle is [@Integrate_Care](https://twitter.com/Integrate_Care).

We acknowledge and appreciate the support of our speakers, who are funded by Alzheimer's Los Angeles and the California Alzheimer's Disease Program, through the California Department of Public Health and the University of Southern California, geriatric collaborative, and the USC Geriatric Workforce Enhancement Program.

At this time, it is my pleasure to introduce the faculty for today's webinar. First, we have Jennifer Schlesinger, who is the associate vice president of healthcare services and community education at Alzheimer's Los Angeles. Jennifer oversees multiple nationally recognized and award-winning projects, including a focus on transforming healthcare in the state of California for low-income older adults with dementia. Jennifer provides technical assistance and training to healthcare organizations to improve their care management for people with dementia and their families. She also oversees caregiver education programs and teaches plain-language approaches.

Next, we have Dr. Freddi Segal-Gidan, who is the director of the USC-Rancho California Alzheimer's Disease Center, and the assistant professor of clinical neurology and family medicine at the Keck School of Medicine at USC. Dr. Segal-Gidan is a member of the clinical and research staff with the NIH-funded USC Alzheimer Disease Research Center and served as a project lead with the USC Geriatric Healthcare Collaborative and the HRSA-funded USC geriatric workforce enhancement program.

Next, we have Joseph Herrera, the director of outreach and education at the USC-Rancho CADC. Joseph's passion is to assist families, communities, and professionals in understanding ADRD, educating them, and helping in creating a safe and protective environment for the person with ADRD, without stealing their independence, capacity, or abilities.

Joseph works to assist families in navigating the intricacies of ADRD and numerous systems to ensure that families have access to benefits and other subsidized programs. He works to strengthen family relationships, encouraging the creation of a peaceful and loving environment for the person with ADRD, and the family can thrive in a high-quality environment.

Joseph earned a BS in clinical psychology and a master's degree in social work, and has worked in geriatric social as a geriatric social worker, concentrating on ADRD and issues of aging for over 15 years. He offers both professional and personal experience in dealing with ADRD as a caregiver of someone with Alzheimer's disease.

Finally, we have Dr. Thomas von Sternberg, who is the senior medical director of Medicare dual eligible program and case management for HealthPartners, a large, integrated health plan and care delivery system. Dr. Von Sternberg develops and coordinates programs for the geriatric population at the health plan, with a focus on frail, complex elders. He helped develop the post-hospital sub-acute care network [inaudible-audio drop] space medicine and palliative care programs for the care [inaudible-audio drop]. Next slide.

Here we have our learning objectives for today's webinar. Today we will describe how COVID-19 may present in older adults with Alzheimer's disease and related dementias, and unique challenges facing individuals with ADRD and their caregivers during the COVID-19 public health emergency; identify strategies for supporting family and friend caregivers of older adults with ADRD during COVID-19, to build a daily routine and implement and then use infection prevention measures and plan ahead in case of COVID-19 diagnosis; and identify key considerations for providing care for people with ADRD diagnosed with COVID-19 across healthcare settings.

And here we have the agenda for today's webinar. First, we will start with a few polls, and then Jennifer will share some background information on dual-eligible beneficiaries, ADRD, and COVID-19. Then Dr. Segal-Gidan will share some considerations for people with ADRD and their caregivers, as well as considerations for providers and health plans.

Then Joseph will share some information on how to support people with ADRD and caregiver at home during COVID-19. Then Dr. Von Sternberg will share about how health plans can support these same individuals. Finally, Jennifer will share some additional resources, then we will turn to the audience for some Q&A and end with some additional resources.

To start us off, we will begin with two poll questions to get to know the audience a bit more. First, we'd like to know which of the following best describes your professional

area. Please choose one of the options provided. Give everybody a little bit to answer. And let's go ahead and move on to the results. Great, it looks like we have a fair amount of health plan case managers and care coordinators as well as some social workers, as well as some health plan administration and management, and some providers as well. Great.

I think we can go to our next poll, which is in which setting do you work. Please choose one of the options provided below. Okay. I think we can move on to the results. Great. It looks like we have about 50 percent of folks from health plans, that's great, as well as some people from community-based organizations, as well as some folks from long-term care facilities.

Great. Thank you all for joining today. I will now turn things over to our first speaker, Jennifer Schlesinger.

Jennifer Schlesinger: Thank you so much. I'd like to start by thanking our wonderful and supportive colleagues at the Medicare and Medicaid Coordination Office at CMS for recognizing the importance of this topic, and for making this webinar possible.

I'm gonna start by providing some context to duals--Alzheimer's diseases and related dementias and COVID-19. And we'll take a few minutes to paint some broad strokes of the current landscape.

We know that the current pandemic presents new and unique challenges for people with Alzheimer and other dementias, and these challenges may be particularly pronounced for people dually eligible for Medicare and Medicaid. It's estimated that approximately 23 percent of people who are 65 and older who are dually eligible beneficiaries have Alzheimer's or another dementia. That's almost one in four.

This is a significant number of people for whom care is often complex, and who often have unmet social needs. These factors, including multiple coexisting conditions, can lead to poorer health outcomes. Clearly, duals with Alzheimer's and other dementias are a vulnerable group, yet they are often underserved by our healthcare system. COVID-19 has magnified where there are inequities and deficiencies in the system. Next slide.

Alzheimer's and related dementia and COVID-19 have several risk factors that I will call parallel risk factors that are particularly pronounced for people who are dually eligible. These are risk factors that are not necessarily associated, but certainly run parallel to each other. First, people over 65 are more at-risk for Alzheimer's disease and other dementias, as well as COVID-19. Older age often results in worse COVID-19 outcomes, and case fatality rates increase with age. In fact, current statistics show that 80 percent of COVID-19 deaths in the United States are in people 65 and older.

Second, people with Alzheimer's disease and dementias often have multiple coexisting conditions, like hypertension, heart disease, diabetes. We know that certain medical conditions also put people at greater risk for developing serious illness from COVID-19. And Alzheimer's disease and related dementias, it's a hidden comorbidity in older people

who have COVID-19, especially in people who are living in nursing homes and have significantly heightened vulnerability.

And the third parallel risk factor, particularly sad and unjust, is race and ethnicity. We know that almost 50 percent of duals are of a minority race or ethnic group, and that Hispanics and African-Americans are one and a half to two times as likely as whites to have Alzheimer's.

We also know that emerging data on COVID-19 in the US shows that illness and death from COVID is disproportionately affecting racial and minority groups. This is yet another example of health disparities and inequities in our country. Next slide.

Nearly half of dually eligible individuals received long-term services and support. This may cover nursing home care or other supports, to allow for community-based living. Things like adult daycare, in-home personal care are just a couple of examples. It's estimated that 50 percent of people living in nursing homes have Alzheimer's or another dementia, and emerging data shows that 27 percent of COVID-19 deaths are in long-term care facilities, and I've seen reports of this number being much higher. This is a startling statistic that merits urgent attention and action.

Certainly for those who reside in facilities, Alzheimer's disease specific knowledge is among professionals is needed, as well as Alzheimer's-specific COVID care. Though different states have different models for their dual demonstrations, one of the goals nationwide in all of our demonstrations is to have better integration of home and community-based services with medical services.

Duals who have access to home and community-based services should be able to maintain community-based living and avoid or at least delay nursing home placement. However, in the current times, certain home and community-based services may be limited due to stay-at-home orders and social distancing measures. For example, families may not be able to use adult day services because centers are closed. They therefore lack the respite that adult day provides.

Or there may be disruptions in in-home care services due to the spread of infection. Certain programs that provide in-home assessments may currently be suspended. Lack of robust home and community-based services during the COVID-19 pandemic complicates the situation for healthcare professionals and families alike. Healthcare professionals must find ways to continue supporting families through these stressful times, understanding that some of the services previously in place to support community-based living may be limited.

And with that, I will hand over to Dr. Segal-Gidan to discuss considerations for people with Alzheimer's and their caregivers.

Freddi Segal-Gidan: Thank you, Jennifer. It's really a pleasure and an honor to be able to speak with you all today on this very important topic and emerging topic that I think we're all struggling to better address as we learn to better address the issues around COVID throughout our country.

So first of all, I wanna speak about people with Alzheimer's and other dementias and their caregivers, and then I'll speak about issues related to providers and health systems. Next slide, please.

So the presentation of COVID in individuals with dementia is a little different and a little challenging, and requires a change in how we think about things. It can present as delirium or other cognitive changes, as with any other infection. So we definitely think about people with dementing illnesses presenting with delirium with underlying urosepsis or pneumonia.

But in the influenza season, we think about this as well, and so we have to sort of put that framework in mind when we think about COVID and its presentation in this population. And as in other infectious diseases, delirium is often the presentation when there's a lack of oxygen, underlying hypoxia, that causes more confusion and more brain dysfunction, and the COVID-19 infection is no different.

COVID-19, which is a primarily respiratory infection but does have other manifestations in persons with dementia, can result in hypoxia and then in a delirium presentation. So delirium in COVID-19 doesn't look any different than COVID in other--delirium in other populations when it presents, but to review, it involves a change in consciousness--that is, a change in alertness.

That could be hyper alert, where the person is awake during more of the day and not sleeping very much, or where the person is sleeping for longer periods of the day, a hypoactive state. There is characteristically in this acute confusional state, delirium, which can present on top of a dementing illness.

Impaired attention--a person cannot follow through, cannot attend, cannot answer questions, because they can't pay attention, cannot follow directions. There is a sleep-wake cycle disturbance that often occurs, where people are awake at night, sleeping during the day--very disruptive. And this can be disruptive regardless of the setting the person is in.

Psychotic features, particularly hallucinations, can occur in delirium, and so oftentimes in people with dementing illnesses who didn't have previous psychotic features may present with increased confusion and hallucinations. And emotional disturbances, from the range of tearfulness and crying to anxiety and nervousness.

So we have to think about our population with dementing illnesses and COVID as a population that's predisposed to the presentation and occurrence of delirium. Next slide, please.

So to continue, when you think about the clinical presentation of individuals, caregivers have to be aware that older adults with Alzheimer's and other dementias, when presented with an infection, may not present with a typical symptom, such as cough, fever, shortness of breath.

And if that's what you're focused on, and not on the other changes, you may miss the early signs, a caregiver may miss the early signs of a COVID-19 infection. When people with dementia experience symptoms, they may also not be able to alert a caregiver, and depending on the stage of the dementia, the individual may not be able to express if they're having shortness of breath, they're having feeling of distress, and so it may go unrecognized by both the person with dementia as well as the caregiver.

So changes in the key areas of cognition, function, and behavior, which are the three areas of dementia, diagnosis, and dementia care, need attention in this population. So thinking about our individual with dementia, they can present with an infection with changes in cognition, increased confusion, slower processing, where they are taking longer to do things.

This impacts function, so a decline in usual ability--somebody who was able to toilet themselves now is having more difficulty toileting themselves. Somebody who needed cues for dressing may now not be able to dress themselves, and this may be an early tip-off that there's actually some other change going on when this is happening acutely.

Behavior changes are very common when people have an infection overlying a dementing illness, and this can be, again, as I said, full range, where there's an enhanced response of anxiety, agitation, or aggression in somebody who either never had these symptoms or presents with these symptoms. Or missed sometimes and overlooked is the hypoactive response, where there's more apathy, depression, fatigue, or increased sleep.

So in our caregivers with individuals with dementias in this era of COVID, we need to be making them aware of these kind of changes to look for as a potential sign that the person may be coming down with this illness, and try to find it early rather than late. Next slide.

There are things external to the individual that may actually be more disruptive, so the person in this environment of COVID, where everything is changing, the external environment is changing, and we know that external environmental changes can trigger changes in persons with dementia.

The majority of people with Alzheimer's and other related dementias live at home, and home environments and routines have been dramatically impacted by COVID, with changes in all of our lives, so we have to think about this. As Jennifer mentioned, adult day programs have stopped functioning because of the ban on congregating, so individuals are no longer able to attend their adult day program, and their schedule may be disrupted from this.

Because of stay-at-home orders, individuals are unable to go outside, spend much time outside, depending on where they live, or on walks as often as they used to. Or they may be restricted in areas where they can walk, depending on what the rules and regulations are where the individual's living.

Older adults with dementia may be spending more time sleeping and napping during the day because of the lack of stimulation and the lack of routine. With increased use of masks by caregivers with close contact, there may be more difficulty in communicating.

Even for those of us without dementing illnesses, communicating with masks in front can be challenging. And so for individuals who have dementing illnesses who need all the sensory cues necessary, when you put a mask over someone's face, it may make communication more difficult.

They may be experiencing difficulties in understanding the pandemic, and why these changes are occurring. Trying to explain to an individual with a dementing illness, particularly in the moderate to later stages, what is going on, is not the useful approach, but everybody naturally wants to explain to somebody why they're doing something, and this can lead to lots of frustration amongst both caregivers and individuals with dementia.

If the person with dementia needs to wear a mask because they're going out and masks are required, or they're going to an appointment or something, trying to get them to wear a mask, or they need to wear a mask because of close contact with individuals, can be difficult. Individuals may not understand why they need to wear a mask, and may become very agitated by this.

And then there is maybe a change in caregiver. Outside caregivers who were coming in may no longer be able to come in; family members who have been doing caregiving may change because of changes in routine. And so there may be increased distress amongst the person with dementia just related to the change in caregiver, and the caregiver not understanding the person's routine.

So all of these things in the environment combine to make for the perfect recipe for increased agitation, increased disturbance, frustration, amongst individuals with Alzheimer's, other dementias, and their caregivers. Next slide, please.

So when there are changes to the home environment and routines, as I said, there can be other things that occur. So boredom, loneliness, nervousness and anxiety due to physical distancing, and canceled and closed programs may occur amongst individuals with Alzheimer's. And how do we address these issues and try to prevent them?

There may be increased confusion and disorientation when there's difficulty understanding the pandemic and associated changes, including the use of masks and changes in caregivers. So the individual expresses more confusion; appears to have deteriorated, perhaps.

Behavioral changes, where there's irritability and agitation due to frequent requests for hand-washing, to wear a mask, to have another person wear a mask, changes in routine. So expecting behavior changes, I think, is something we need to anticipate and do planning for.

And then, again, sleep difficulties--increased sleep disturbance, increased wandering and pacing, associated with being indoors and frequent nap time. So all these changes in environment and routine are, again, a recipe for increased distress for the individual with Alzheimer's as well as for the caregiver.

Caregivers and family members, because of changes in their routine and our routines, may be spending more time around the person with the dementia, and if the person was going to a day center, if the person was at home with a caregiver and somebody was leaving to work and only home for short periods of time when the person was asleep at night, they may not be fully aware of the extent of the person's dementing illness and how it has progressed.

So there may be increased awareness of limitations of the person they are caring for by the family member, and this may result in calls to healthcare providers saying that things are getting worse, something's wrong, when it's really the external environment, and their changing in routine that has resulted in them spending more time at home. Next slide, please.

I wanna now move on to understanding these changes in the person with Alzheimer's and their caregiver, what consideration for providers in healthcare systems need to occur, with this population in mind. So, next slide, please?

So health systems and medical providers need to think about providing support for people with Alzheimer's disease and other dementias during COVID, I would suggest, in a proactive way. There is really no one-size-fits-all model, and quite honestly, we're all learning as we go here.

So having a culture within a health system that recognizes that there are populations with special needs, populations at higher risk, and that this population with dementia is one of these populations, I think is the first step. And health plans and providers can establish and implement specific strategies for working with people with dementia and with their caregivers.

And so I think about it in these sort of three buckets, of people with known Alzheimer's disease or other dementia, people who are in your health plan or who are you providing care for who have underlying cognitive [inaudible] dementia but are not yet diagnosed, and then people without cognitive issues who present with delirium who are a separate population.

So for those we know in our health plans and in our medical practices who have a dementing illness, having a plan where we reach out to these individuals, to their families and their caregivers, to provide information on the signs of COVID-19 infection, strategies on how to deal with the changes that are going on in our environment, and the risk for infection, I think are important.

In our practice, we actually identified our active patients with dementing illnesses, which is the majority of our patient population, and created a letter that went out to caregivers and patients, letting them know about early signs and symptoms, and letting them know how to contact us and what to do.

Educating staff on how to handle a call about infection that may be COVID-19 from a distressed family member or somebody with a dementing illness who is in the early stages is important. This is not your typical patient, and if the staff don't recognize that

this is an individual with dementia that's known in your population or a caregiver, their advice may not be appropriate, given the unique issues in this population.

So there's also this undiagnosed population sitting in many health systems and practices that we know--people who have dementia, maybe mild, maybe moderate, depending, but who are not diagnosed. It's not part of their chart, it hasn't been recognized. So we have to think about establishing steps to take if someone presents with delirium, confusion, change in alertness or other signs of dementia and delirium, that this may be a person who has an underlying, undiagnosed dementing illness.

And when we get them through this acute confusion state, how are we going to address this undiagnosed problem that may be lurking there? And if there's a missed dementia, what is protocol within the health plan, within the practice, for bringing this person in for further evaluation and testing, now that they've shown signs of possible dementing illness by their presentation?

And then there are other people who are presenting with delirium who are older adults who don't have an underlying dementia, and so we have to recognize that delirium can be the first presentation of a dementia, but that not everyone with delirium has a known or undiagnosed dementia, and not automatically assume that the older adult presenting with a delirium who is not diagnosed with dementia will have a dementia post-delirium. So understanding that it needs some processes in the health plan to deal with this situation. Next slide.

So there's additional ways that health plans and providers can support individuals with Alzheimer's disease at the health system level. This is a new environment that's been created by COVID, and we're all learning new ways of functioning. So ensuring that all levels of a health system are aware of the threat that COVID-19 presents to the person with Alzheimer's disease and related dementia.

So everything from the emergency room to the laboratory to the inpatient hospital system has to have a slightly different tilt and awareness and approach to dealing with the person who has an underlying dementing illness.

Strongly consider having interdisciplinary care teams. If you already have one, that's great. If you don't, then thinking about developing one that can be addressing the special needs and unique needs of this population in the various settings within the health system. And I would suggest that telehealth is an example that can actually facilitate the development of teams or enable providers to use these teams by creating consultation services that meet without being in the same room, bringing multiple providers in multiple specialties together.

Videoconferencing, group emails, discussion groups should be considered ways of enhancing interprofessional care team functioning, and even creating interprofessional care team function where it doesn't exist. So COVID may present an opportunity for us to do things differently in many ways that can enhance care during COVID and post-COVID.

Looking for opportunities to integrate dementia care across your organization, so it's not siloed just in specialty psychiatry or specialty geriatrics or specialty neurology, or wherever that silo may be, but for integration across medical specialties and across professions, so nursing is involved, laboratory is involved, home health services are involved in integrated dementia care.

Consider the use of an identified single person, a dementia care navigator, to assist caregivers and families and patients with Alzheimer's disease and related dementia. This is a tool that's been used in non-COVID times, but has increasing importance in COVID times, where there's a single person in your organization who's the communicator, both with patients on a consistent basis, and the communicator between patients and providers.

This can be a point person or several people, depending on the structure of your organization, but it certainly can help to coordinate and improve care for individuals and families when there is a dementing illness, and COVID is a time when this kind of person becomes a very valued member of the healthcare team.

And for the person with Alzheimer's disease and related disorder, making sure you identify a primary contact person. Who's the caregiver, who's gonna be the contact person for this individual that you as a health plan can reach out to, or the dementia care navigator can reach out to. And maybe establishing time for regular updates. Maybe it's not a regular appointment, but there's a monthly check-in.

And particularly for a hospitalized person, that might be a daily check-in at a certain time, where this one person for the family's going to get a call from somebody in the health plan to tell them what's going on with the person in the hospital or the person in the nursing home, so that the family is kept abreast of what's going on and isn't making multiple phone calls.

So a kind of regular plan for contact is something that may help actually avoid complications and minimize hospitalizations and emergency room visits for these individuals. Next slide, please.

So one of the issues we've faced with COVID and with individuals with Alzheimer's disease and dementia in particular is the last place we want people with Alzheimer's and other dementias to be is in the hospital in usual times, and in COVID, this is really no different. We need to think about how can we minimize hospitalization and intensive care unit placements for people with dementing illnesses.

This requires family and caregiver support strategies ahead of time. Enhanced outreach, as I suggested, when there might be a person who contacts family members on a regular basis; somebody who is tasked with making sure that individuals and their families who have these--are in vulnerable populations are provided support through the health plan.

Engagement with the person with Alzheimer's disease and the family prior to COVID infections, setting up a system that can then be used during the pandemic. But if you don't have such a system, thinking about creating it. And this is, again, an opportunity--an opportunity for collaborative and proactive work within a health plan to develop a system

of support for patients with Alzheimer's disease and other dementing illnesses that can best serve them and the health plan at the same time.

So prior to a potential hospitalization, family and caregivers should develop a detailed plan in the event of a COVID infection. So this is advanced care planning in light of COVID, but it's really no different than advanced care planning prior to COVID. So we encourage all families to create a single sheet of paper that includes lists of current medications, names, dosages, frequencies, a list of comorbidities, the person's primary language.

A friend of mine who was working in the hospital during COVID here in Los Angeles said one of the issues that they had where people were coming in where--and no one knew what their primary language was, and tried to find somebody who could identify what that language was and speak to that person in that language, and realize that the person was not making sense, was speaking--in this case, they were speaking Armenian, and it was salad soup, but people thought this person was saying something, when they weren't saying something of substance.

So knowing what the person's primary language is, and if you know the primary languages in your health system, then making sure you identify individuals who can act as translators, as well as technology that can help us with translation, although some of that technology has been found to be difficult to use with individuals with dementia.

Understanding the severity of someone's dementia, including the type of dementia the person was diagnosed with on this sheet of paper, and when they were diagnosed. So it's different if somebody was diagnosed six months ago versus someone who was diagnosed six years ago.

And most importantly, I would say, is the name and contact number for a family member or other primary contact, so that individuals in the hospital, in the ED, on the unit, in the ICU, as people progress, know who is the person that is to be contacted for this individual in the hospital when we're not allowing family members to come in. So who is that primary contact person, and they serve as the sort of means of--the bridge between the family and the individual in the hospital.

And if it's not provided at admission, if people don't appear with this paperwork, that you haven't proactively done it, maybe you could have a form that you can request this information at the time of hospitalization, in order to deliver what we know is really important, which is person-centered care, where we take account of the individual and not assume that everybody should be given cookie-cutter care, even in the time of COVID. Next slide, please.

So when it does happen that we have somebody who's hospitalized, and if they deteriorate to the point in the ICU when they have dementia, there are, again, certain special considerations that we need to take in consideration for this population. People with ADRD require different intervention than others when receiving care in the hospital.

This is true in usual times, but even more in these times. So a plan to prepare staff to care for people with ADRD in the hospital or in the ICU is important.

And I would suggest that this plan should be developed from the ground up, rather than from leadership down. A plan where individuals on the unit, in the ICU, in the ED, wherever the care is being delivered, who know the personalities in that system, they know the needs in that system, and it's not just the health professionals, but it's also including the housekeeping staff and the nurses aides and the other people involved.

What is the plan and how are we going to create a plan that allows us as a unit to best meet the needs of people with dementing illness when they're brought into our ED or into our ICU. Again, the issue of personalized care is really important, and requesting that staff include a picture of their face on their gowns when people are in full PPE, in these spacesuits. It is frightening for individuals who are sick and don't have dementia, and for the person with dementing illness, it can be incredibly frightening.

So we learned this from the Ebola crisis, the need for personal identification of people in these spacesuits, in the PPE. Having someone's picture, so that people can know who the face--person is behind the mask. Their name, in large letters, so the person can read their name, because again, communicating through a mask can be difficult.

Very, very important, to think about personalized care and how we can personalize care for persons with dementia when they are brought into the hospital, or further into the ICU. And I would point out that the National Center on Advancing Person-Centered Care Practices and Systems has developed a healthcare person-centered profile tool that can assist with COVID-19 person-centered care planning, and we have a link to this tool at the end of the presentation. Next slide, please.

So quickly, things to think about in the hospital and ICUs that are considerations for making challenges for people with Alzheimer's disease and related dementia. Isolation, use of gowns and masks, noise from machines, hospital noise, can cause increased confusion, sleep problems, behavioral problems, with anxiety and agitation, hearing difficulties related to the use of masks, so thinking about having a pocket talker or hearing-assistive devices that can aid.

These are all situations that lead to the development of delirium in the hospital that we wanna try to minimize. And preparing for these behavioral changes by thinking about assigning a care manager to provide additional bedside contact, direct communication with family--again, having that one person whose job it is to do this, not an added job. And using technology at the bedside, having iPads, having access to technology at the bedside can improve communication between persons with dementia and their caregivers.

Training on this technology is something we're all getting up on, but doing it as part of expected practice I think is something that is what COVID is teaching us has to be part of the way we deliver care. Next slide.

I wanna quickly go through a case. Ms. C phones and informs the primary care provider that her husband, Mr. C, who has been diagnosed with Alzheimer's, he's in the mild, early

stages, fell in the bathroom three days ago and has been in bed, sleeping a lot. He's more confused, and today he has a cough and a fever of 100 degrees Fahrenheit. She's worried he may have COVID, and she's not sure what to do, so she calls the health plan, she calls the medical provider, and saying, you know, this is--what do you tell me to do. Next slide.

So the primary care provider reassures Ms. C that she doesn't need to call 911, she shouldn't call 911, or bring Mr. C to the hospital yet, based on his symptoms; that he can be cared for at home. Primary care provider should share education with Ms. C about how to treat Mr. C at home, thinking about Tylenol on a regular basis to get the fever down, hydration with frequent presentation of water and maybe electrolyte, maybe through a straw, maybe ice chips.

Waking him every few hours to make sure that he is not becoming somnolent, and then advising the wife when to bring him to the hospital or call 911. If he becomes unarousable, she should call 911. If he's no longer able to get up every two hours and walk to the bathroom, that would be an indication things are getting worse. And if even using the Tylenol does not bring the fever down, then that would be a reason to bring the patient in. Next slide.

So other things to think about in Ms. C is the possibility of testing. Testing may depend on location, availability, and accessibility, where you're working in your area. For Mr. C, can you actually get him in the car and take him to be tested. Is anybody doing home testing here in Los Angeles? I haven't heard about that, but maybe other places, that's going on.

But remembering that testing for people with dementia presents unique challenges. They may not be cooperative for swabbing or for blood testing. So there are unique challenges that we have to think about when thinking about testing for people with dementia.

In Mr. C's case, I think monitoring progression by having someone follow up every day or two with Ms. C to see how he's doing, not waiting for her to have to get to the emergency room, and if available, recommending a home health assessment would be things to think about in this kind of situation.

So with that, I am going to turn it over to my colleague, Joseph Herrera.

Joseph Herrera: Thank you. Good morning, and thank you to MMCO and CMS and the Lewin Group for coordinating this presentation. And so I am going to focus on strategies for care managers that can be used to work with primary caregivers of a person with Alzheimer's disease and related dementia during the pandemic.

And also with the added stressors of staying at home orders and restrictions to avoid exposure, and how COVID has also highlighted deficits and needs of the system, and also presented with opportunities to improve care delivery, whether it is in person or through telehealth systems. So next slide, please.

So I wanted to talk a little bit about the care for Dyad. Dyad is represented by the person who is a primary caregiver, and the person who has Alzheimer's disease or related dementia. It is very important that we look at them as the focus of the care that you as social workers, care managers, or healthcare systems provide for them.

So we need to identify who is a person with dementia, but also focus on the needs of the caregiver. So this is a little bit different than usual than the medical model, that it's not just patient-centered, but patient-centric, with involvement of the family, at the discretion and permission of the patient, of course.

So given the lack of insight of the person with dementia, they may deny or resist involvement or assistance from family members or primary caregiver, but there's also a growing situation of persons with dementia who are alone, have no family members to assist them, and that presents a set of different challenges as well.

So in case of care for the Dyad, we're addressing the common [normity] situation, where there is a family member or another person who has been identified as the primary caregiver for the person with dementia. So it's important to focus on the couple as opposed to just the individual with Alzheimer's disease. Next slide, please.

So let's talk a little bit about preventive measures for caregivers. So caregivers can help prevent COVID infection by assisting the person with Alzheimer's disease and related dementia by posting written reminders related to hygiene around the house. So remind them to continually wash their hands and assist them in ways that are gentle, and to decrease their risk for aggression.

Observe physical distancing when outside of the house; that is a little bit of a challenge, but it has to be done. Cleaning and disinfecting all surfaces around the house, especially when there are multi generations living in the same household, and some of them, especially the younger members, might come and go and touch surfaces around the house. Make sure that everything is clean and disinfected.

And it's also important to remind caregivers to be hyper vigilant about personal hygiene of the person with Alzheimer's disease, and their own hygiene, to make sure that they decrease the risk of infection. Demonstrate proper hygiene practices frequently. For example, wash their hands for 30 seconds or 20 seconds, singing their favorite song. There are people that like to play games around certain things and certain activities, so this is one of those where if caregivers don't think that they are creative, this is where the creative juices will start flowing, because it is important to observe all the guidelines.

So as a care manager it is important that you stay on top of that and remind caregivers to be gentle, but at the same time try to figure out how, in creative ways, they can observe physical aspects of staying healthy and avoiding transmission of COVID-19. Next slide, please.

So planning ahead to avoid the infection. There's always a possibility, right? So we have to make sure--again, hyper vigilance--about infection, and identify and designate who the caregivers are, and alternate caregivers must observe the rules as well, right? When they

come in the house, ensure that they are not dealing with cold symptoms or fevers or things that might expose the caregiver and also the person with Alzheimer's disease.

So who is the alternate caregiver? Ensure that they are aware, ensure that you have, or the caregiver has, the correct information that is available--contact numbers, email addresses, whether it is a relative or it is a paid caregiver. Also, in case the primary caregiver is infected or is exposed and develops the symptoms, how are they going to be isolated.

Can they isolate at home? If the alternate caregiver will take care of the primary--of the person with Alzheimer's disease as their legal representative, signing the power of attorney, updating living wills, all those things are very important, and as somebody mentioned earlier, this might be a new situation for a new caregiver who, because of moving into the home or because of a recent diagnosis of Alzheimer's disease or dementia in the family, they assume the role, and they know absolutely anything [sic] about caregiving, let alone about the disease and how the progression affects the functioning of the individual.

So you will receive further information about document toolkit for caregivers at the end of the presentation that The National Center on Advanced Person-Centered Practices and Systems has prepared for you. Next slide, please. So some of the things that are important for the primary caregiver and you as care manager, or even a health plan, to develop guidelines or develop a plan to follow when dealing with a Dyad.

So it is important to urge and assist the primary caregiver in planning certain things and anticipating some of the changes. Again, we don't know, necessarily, that the person will develop or be exposed to COVID-19, but it is important that there is a plan in place to follow in case of.

So compile a guide for potential alternate caregivers. Have that conversation with them, of course. All this should have been done before the person loses capacity or at the time of diagnosis. It's very important that when the person is diagnosed, that all this documentation is put in place--the power of attorney for medical [inaudible] power of attorney for medical decisions, financial decisions, if there are some assets involved, medication management plan, what medication, how often, how much, chronic illnesses and what illnesses the person is dealing with.

So all that should be in place in a centralized place so that the primary caregiver has easy access to it in case of an emergency or the person who is the alternate caregiver has access to it, in case the caregiver needs to isolate or needs to go to the hospital or needs to go somewhere else.

Again, it's important to consider the location of the primary caregiver in how, if they become--if they develop COVID-19, how the person with Alzheimer's disease or related dementia will be cared for. Where would the person be cared for, and who will care for that person? Very important to be part of the care plan. Next slide, please.

So with COVID-19, it is important--because it is so uncertain what will happen or how things can happen, it is very important that both caregiver and the person with

Alzheimer's disease or related dementia have updated power of attorneys and healthcare directives.

A lot of the times, especially, I would say, within African-American and Latino communities, or communities of color as a whole, it's very difficult to have those conversations. Most people feel that talking about possibility of death and dying is a little morbid, and we try to stay culturally away from that. But it is important to create advanced healthcare directives for both caregiver and the person with Alzheimer's disease and related dementia.

That will help either the caregiver or the alternate caregiver, and will avoid a lot of legal issues in the future. So it's important to identify who the legal representatives will be, including primary caregiver, alternate caregivers, organize all documentation that will be required--living trust, advance directives, power of attorney, wills, anything that has to do with medical history, medical care. And that will be a toolkit that is developed that includes all the person with Alzheimer's disease history as well. And the identification of a person with--who will take care of a person in case the person with Alzheimer's disease becomes ill as well. Next slide, please.

So this section, we will look a little bit at what to do if the primary caregiver is exposed to COVID. So the caregiver develops COVID infection; of course, there's a need for immediate isolation to avoid contact with the person with Alzheimer's disease, and avoid getting them sick as well.

Contact the alternate caregiver as well, so that they can take over the care. Be aware that bringing somebody into the home increases the risk of exposing the person with Alzheimer's disease. But so they will require they check their temperature before entering the home, required to wear the mask at all times within the house, determining if they have been exposed or exposed anyone else who has tested positive for COVID, and ensuring that there's hand-washing when entering the home and throughout the day. And also suggesting that they disinfect any frequently touched surfaces, just to be safe. Next slide, please.

So, conversely, what should happen when the person with Alzheimer's disease become exposed? So in the event the person becomes exposed or stressed by the primary caregiver, they're apart from the typical caregiver, they notice that, so how do you deal with those issues?

So provide assurance to have the person contact by phone, phone conversations, or maybe through a video chat or something, so that the person can be present and assure the person with Alzheimer's disease that they are there. That they are away, but, you know, so that they can keep the person calm and without any behavioral outbursts. And remember that the person with Alzheimer's disease doesn't have the same sense of time that we do, because that is actually affected by the dementia. Next slide, please.

So what should care managers do to assist, and what are some of the considerations for health plans and providers? So health plans and providers can help assist caregivers of

adults with Alzheimer's disease or related dementia in their response to COVID, provide support to lessen the caregiver burden. You need to identify some of the needs that they have. Cultural needs, religious needs, family dynamics needs--what are other stressors that are affecting the care now at home.

Then, help develop a plan to manage the daily routines and integrate some of the new things that they are going to have to do while they have the person with Alzheimer's disease at home, to make it easier and decrease their--the caregiver's stress, but also the stress and the probability of the person with Alzheimer's disease to become a little--to have some behavior issues.

So especially we talked a little bit about providing support for first-time caregivers, so identifying what are some of the considerations that you can give first-time givers. What is some of the advice that you can give them, given that they practically do not know much about the condition, or haven't dealt with this issue before.

And identifying considerations related to cultural competence, so know who your patient is, know who your caregiver is, at a cultural level, and what are some of the traditions, family traditions, and some of the issues that they deal with on a daily basis. Next slide, please.

I think it's also important in supporting the caregivers to recognize that they are having an increased burden during this time, so help them address possible--and identify what are the stressors. What is--are they depressed, are they getting more anxious than usual, what are some of the things that you can do to less that.

Use coaching modeling to help develop responses to the person with ADRD, so you can model for them how to respond when there are some things that they feel they lost their patience, or they feel that their own anxiety is being triggered by the behaviors being displayed by the person with Alzheimer's disease.

Encourage them to stay in contact with family and friends, to share some of the responsibilities, and network the people that live in the home. And if they don't live at home, then how do you stay--to stay in contact with them, so that they can also be able to ask for needs or accept needs if somebody is asking--or offering assistance.

And adjust the expectations--understanding the infection control protocols, like proper hand-washing, will be extremely difficult to achieve with the population of people dealing with dementia or Alzheimer's disease. Okay, so let me see--next slide, please.

So it is important for care managers to develop a relationship with the primary caregiver, and learn to identify that the physical and emotional needs of the person as they are taking care of a person with Alzheimer's disease, so that you can provide a better care plan for them. Next slide, please.

So the care manager can support primary caregivers by assisting in the developing of in-home activity plans. So what does the person with Alzheimer's disease like? Do they like arts and crafts, painting, playing music, gardening? What are some activities that you can

assist them, the caregiver, to develop a plan so to avoid some of those behaviors? Next slide, please.

It is important to understand that it is not easy for the caregiver. That some family members have taken care--again, kinda taken on caregiver responsibilities for the first time. So provide education for them, share tips on how to discuss potential sensitive topics, like finances, paying bills, medical care, appointment representation, and all that information. Let's skip--next slide, if we can skip it. Next slide, if we can skip it.

So in the event that a COVID diagnosis is given to the person with Alzheimer's disease, determine any potential cultural considerations by identifying any religious beliefs that providers should take consideration of, including what is the family composition, what are the family dynamics, their beliefs in health based on religious--the power of prayer.

Identify multigenerational households and the possibility of multiple family caregivers. So who is the person that would be the representative or the spokesperson for the family, and determine legal representations, or representative of the person.

So now it is my pleasure to introduce Dr. Von Sternberg, who will be discussing the role of health plans in supporting their members with Alzheimer's disease and related dementia during the pandemic.

Laurel Ruesch: Hi, Dr. Von Sternberg, are you with us?

Tom von Sternberg: Yeah. Hello, yes, Dr. Von Sternberg here. Thank you, I think I was on mute for a minute. So, having said that, I appreciate the opportunity to help in many ways reinforce what's already been said about the incredible complexities of this pandemic on top of the needs and the challenges of caring for a population of folks with dementia-related conditions, that on a good day are extraordinarily difficult.

The HealthPartners approach will be, again, something, I think, that you can learn from and have your own perspectives on, based on the organizations that you're in. HealthPartners provides a fully integrated dual-eligible special needs plan for our population. It's called--and it's based on Minnesota's Senior Health Options platform.

And prior to the COVID pandemic, we were already in an approach where we were emphasizing the need to both identify our patients with dementia and provide extra attention, extra resources, and as well extra education to our case managers. We are also an organization that has done our care management within the health plan, and then partnered with care delivery and then partnered with community service organizations for most of the LTSS services that are available.

And that this idea of becoming a dementia-friendly care model at a health plan level indeed allowed us to then have a position where more proactive identification for our case managers, panels of patients--who has dementia, and therefore, what are the suite of services and attention to pay for them, very important.

Actually, adding dementia-friendly supplements to our supplemental benefit package we felt has been a very effective tool. Specific education to case managers about dementia, its progress, its details, its optimal care, the nuances and challenges to caregivers. So the idea of educating case managers specifically about dementia, very important.

And then, again, a much more intentional, proactive communication strategy for patients and families, but as well as to providers. Our case managers have the ability to communicate with our care delivery partners through the electronic medical record, and so that's been a very helpful opportunity for us to actually enhance our partnership with point-of-care, and at the same time be able to make sure we're giving information that our partners would find helpful. Next slide, please.

The identification of the dementia population at a health plan level, again, this idea of if indeed we have said that conditions like rheumatoid arthritis or diabetes are very important to identify and, quote, unquote, "manage," we have found that approaching dementia in the same way has value. This is novel, it is not as easy as, again, a simple pharmacy-based; whosoever on a biologic for rheumatoid arthritis. You'll actually know who your population is.

But we've been able to do active outreach based on claims data, health risk assessment results by patients and families, our own care management assessments, and clinical information from hospital and clinic as well as the annual wellness visit for Medicare is also a helpful tool to identify individuals with cognitive difficulties. Next slide, please.

So offering, if you will, dementia-friendly supplemental benefits and services is also something we feel, again, creates that platform for us to be that much more supportive of our patients and their caregivers. We have a variety of approaches that we've done to help ensure we've got a full array of services. Our caregiver support from the care manager is primarily telephonic, but face-to-face as well. And so our care managers actually go to the home. We're now more challenged with the pandemic.

Our support for caregivers from the community perspective is that we've partnered with some community agencies that provide very effective caregiver education and caregiver stress support for those managing family members with dementia. Wilder and the Volunteers of America, Lucent Social Services, are some of the agencies that we've partnered with to help us with our attention towards dementia population.

And then I also mentioned that our supplemental benefits have featured and emphasized opportunities to help families with dementia members. Our supplemental benefits are not exclusive focused on dementia, but the ones that we think are important to consider, we've been providing iPads that are also loaded with specific apps that can help members of the community that have dementia and their caregivers.

We have personal emergency response systems, motion sensor-operated lighting, and we've even added the availability of animatronic cats, and we are actually in the process of doing some research in this space, in the fact that the early evidence shows that these animatronic cat devices really do have a calming effect on some dementia patients.

We're lucky enough to be able to be partnering with our organization's center for memory and aging, which is an Alzheimer's center of excellence, and so we've been able to have a really good source content, expertise, and support for the kinds of activities that we're trying to provide.

Nutrition services, again, have been touched upon here, but what we've found during pandemic--which, again, Meals on Wheels and delivery services are not novel by any way. However, being aware of the fact that the massive disruption of the pandemic, we've actually doubled down on attention to issues around disruption in grocery delivery, disruption in meal availability.

Many of our individuals in congregate living lost the ability to have meals provided. At the onset of the pandemic, we actually ensured that two weeks' worth of meals were delivered to our members, to kinda ensure there was at least some degree of stabilization for this work.

As has been mentioned, the disruption to day centers and some home-based services and caregiver support and transportation has been very problematic. I don't have magic solutions that we've provided, the point being, I think as was just mentioned earlier, the attention to the fact that every situation will be unique, but that being a, as you will, calm source of problem-solving and solution-finding is extremely important.

There really isn't an alternative to day center, and so I think our caregivers have been challenged quite profoundly. Transportation options--we have found that specialty transportation specifically has been problematic in terms of higher tech needs for some of our patients. And so in that space I think it's been difficult for us to ensure consistency, but our care managers are alert and problem-solving at all times.

And then I also would mention here that an additional service that goes along with our dementia friendliness is our attention to medication and therapy management, as well as our education to the care managers about safe medications, high-risk medications, medications to avoid in the dementia population. Next slide.

And so indeed, that attention about safe meds can often be where we're discovering things that our care delivery partners are either unaware of or really hadn't surveyed in a more intensive a fashion. The idea of providing those educations to caregivers continues to be important.

I would also point out here, again, our care managers are, if you will, they are a primary care management model. So they don't exclusively care for a population of dementia or a population of diabetes, but they indeed have a panel that has a broad spectrum of patients.

And so what we've talked about in terms of the support and education for caregivers, the education to the care managers, this is a constant reiteration. So we're needing to reinforce things, because as you know, the retention of well, what's best for this individual, if it's part of a larger panel, we need to make sure that they're prioritizing those resources. And so I would encourage us to make sure we're reinforcing those best practices the best we can.

Advance directives, goals of care have been mentioned, about their priorities. I would simply point out that that should be basic blocking and tackling for your care and management of the Alzheimer's population. But that actually, more emphasis on palliative care considerations and hospice considerations in the setting of acute setbacks with the illness is absolutely appropriate.

We've always emphasized the need for advance directives for our entire population, but especially for those with dementia, with caregiver issues, spokesperson issues that have been mentioned. And then I think that what we're also finding is that in the setting of COVID, it is indeed a time to be asking those questions of what is most important in terms of knowing the challenges that occur when a dementia patient is hospitalized. Amplifying that to when a dementia patient is hospitalized with COVID, the degree of significant stress that puts individuals under, I think, is really, really important. That those conversations can be helpful for caregivers and families to make the right decisions. Being culturally sensitive, also very important. Next slide.

The critical nature of communication in terms of well, what's different during a pandemic, I think what we're really encouraging for people to do is to increase your frequency of proactive contact, being less reactive. Understanding that your caregivers are gonna be significantly stressed. We've adopted a Google Duo platform for video interactions, for video visits, if you will, for our care managers, and we even provide a video chat so that multiple people can be part of that conversation in a video way, including interpreters, other family members, et cetera.

We're also just about to re-embark on face-to-face encounters with our individuals in the home, with appropriate PPE. Not an easy decision to make. And that being aware of those disruptions that occur, the challenge here, I think--again, the training to a caregiver about being hyper vigilant, the training to a caregiver about how to control their environment that they are, on a good day, minimally in control of, discussions about goals of care--these things elevate the stress to that caregiver to a level that I think cannot be overestimated.

And I think how we can come to those interactions, with calm and comforting and understanding that we're on a journey with you, we don't have all the answers, either. So my kind of collective message for our care manager partners and our care delivery partners is knowing that this is a situation with a dementia along with the pandemic, that is truly unique and extraordinary. I think again that can help some. Next slide.

There's been some discussion a bit about those individuals with dementia in nursing homes, but I would call out the fact that, again, from the baseline of being dementia-friendly, you should know, just in terms of dual population management in general, you should know who is in congregate facilities, who's in skilled nursing facilities, and again, do they have adequate on-site clinical care, and not kind of your classic disinterested telephonic care from office-based.

So best practice for on-site care for a nursing home, very important. And then how those clinical teams are responding to the care, and are they able to provide either video or

telephonic support for those nursing home staff for the care of patients. Nursing homes, as you've seen, have differing abilities in managing both infection control, staffing, and protective equipment, and so, again, we don't have answers for that, but knowing that our caregivers are gonna be even more stressed about what should we do and what is the facility doing.

So I think--next slide--what that also allows us to do is to be that much more supportive with families, especially around that decision of should we be hospitalizing our loved one if they do come down with COVID, and what that would mean for the individual, which then circles back for another opportunity for goals of care conversations, palliative or comfort care, if possible.

Our teams have been able to develop virtual palliative care and hospice care, and so we're doing much of that work video and telephonic, in addition to PPE face-to-face when appropriate. So I think for our long-term care population with advanced dementia, a really important opportunity for us to really emphasize those kinds of principles of goals of care and what's important. Lots of potential roles for the health plan, but again, supporting best practice is in our best interest.

I'm gonna pass it back to Jennifer now, because she's gonna talk a bit more about some resources that you all might find helpful. Thanks, Jennifer.

Jennifer Schlesinger: Great. So I'm gonna briefly wrap up by discussing resources that are available, because families affected by Alzheimer's desperately need education and support. There is Alzheimer's support that's available from coast to coast, and there are Alzheimer's organizations throughout the country that are available to provide education and support to families.

Alzheimer's organizations have pivoted their services to respond to the current situation, and are offering telephonic and online programs and services, and I put some examples up on the slide. My organization, Alzheimer's LA, is just one example of a local organization that's serving the community through web chats, telephonic care counseling with master's-level social workers.

We have regular support groups meeting virtually on specific topic areas too, such as bereavement, or caring for an individual in a facility. We've launched a series, learning at home, distance learning talks, and caregiver education classes that are available in English and Spanish, and we have virtual activity programs to help keep people with Alzheimer's and their caregivers engaged and active.

Professionals should contact their local Alzheimer's organization to see what programs and services are available in their community, so they can proactively connect families to these services. Next slide.

I also wanna share that Alzheimer's LA has developed four lower literacy or plain language caregiver tip sheets on COVID-19, and they're available for download on our website. They're available in English and Spanish, and we hope that you will share them with the families with whom you work and support.

We all know that caring for someone with Alzheimer's can feel very isolating, and now more than ever we are experiencing this isolation in a profound way. Professionals are the conduit to families, and in an effort to coordinate care and ensure that medical and non-medical needs are addressed, it's vital that we connect families to resources, programs, and services. Next slide.

And as you've heard, the healthcare person-centered profile is available. It can be filled out by a family member or caregiver on behalf of a person with dementia so that inpatient care can be more tailored and person-centered. A little additional information can go a very long way, and as Dr. Segal-Gidan mentioned, there's dementia-specific information that can also be included on this as well, so that it is enhanced. And I believe we may have a couple minutes for Q&A, so I will end there.

Laurel Ruesch: Thank you, Jennifer. Thank you for all of our faculty for your presentations, and for joining us today, and thank you for all those who've submitted your questions already. We see those coming in, and we have a few minutes to answer those. We'll also be following up with a Q&A document to address some of the additional questions that will come in from the audience.

So if you have any other questions, please submit that through the Q&A feature at the lower left corner of your presentation platform. Type your comments at the bottom of the Q&A box, and press submit to send it.

While folks are kind of sending in their questions, Jennifer, I'll direct the first question that came in to you. Obviously, COVID-19 has resulted in challenges of visiting loved ones in long-term care settings. How can we support families who are unable to visit or communicate directly with their loved ones who may be in facilities that are closed to visitors?

Jennifer Schlesinger: Yeah, this is a wonderful question that's affecting many, many people. It's really important to check in daily with staff to see how the person is doing. We wanna be discussing with staff precautions that are being taken, like hygiene precautions, at the facility, so where we keep our pulse on things.

It's appropriate to request Facetime visits, where staff can provide an iPad. We may need to remind staff, though, that they are going to need to help with the technology, because the person with dementia is likely gonna be unable to navigate Facetime or using an iPad. So it's something that needs to be assisted.

Ask staff to coordinate a visit. Can the person with dementia sit near a window and see family from the outside? I'm not suggesting the family comes into the facility, but I've seen many families are able to coordinate visits where their loved one is sitting at a window and they're on the outside.

Consider being really creative. Joseph spoke about those creative juices. Can you bring gift baskets and leave them for the person, with snacks, notes, have your children draw pictures, print out pictures, lotions--anything you can think to comfort the person and bring a touch of home.

And then, of course, I always suggest for the caregivers families participate in a support group, especially if you can find one that's specifically for caregivers who have someone who's placed. This is very challenging, and if we can share our ideas with each other, that can certainly help.

Laurel Ruesch: Thank you, Jennifer. On that note of supporting caregivers, Joseph, is there--just thinking about that, is there any suggestion that you have for checking in on and supporting caregivers, especially if they may be and probably are extremely busy, and may not be able to participate in something like a telephone support group.

Jennifer Schlesinger: I think he's muted.

Joseph Herrera: Okay, I think I'm unmuted now. So yes, there are a lot of things that--like both Jennifer and Dr. Segal-Gidan and Dr. Von Sternberg highlighted, technology is very important. So maybe the caregiver does not have use of technology, but there's always a telephone.

So I would suggest to schedule a check-in system, even if it's just a quick text or a quick call. How are you doing today, what are some of the issues that you're dealing with, how can I assist you. That is very important, because it not only shows the presence and the care of the care manager towards the caregiver and the patient or the person with Alzheimer's disease, but they feel that, and they really appreciate it.

And so they may not be able to initiate, but they do need the assistance. So the care manager assists in initiating those calls or those contacts, it's very important because it's gonna keep the person in the loop.

Laurel Ruesch: Thank you, Joseph. Dr. Von Sternberg, there are some questions about sort of how to best support somebody with ADRD and to encourage them to wear a mask. Do you have any thoughts or strategies that you could share around that?

Tom von Sternberg: I think a couple of things are important. One is I think we need to lower our expectations about what the importance of either that visit is or that mask is, so that we can have a bit of a reality check. However, I think social distancing and the other individual wearing a mask is probably as important or more important.

I think delicate, structured reminding, calm and reassuring reminder, important. And that instead of masks behind the ears and tied, I have seen that we are maybe finding that those gaiter-like clothes that just come up gently, like a turtleneck, that covers the nose and mouth, I think should suffice. Again, if we were paying attention that others are masking, others are socially distancing, I think those are the kinds of strategies that might make sense.

Laurel Ruesch: Wonderful, thank you for sharing that, and thank you for all of our speakers for both your presentations and your responses to the questions that came in. Like I mentioned, we'll be following up with a Q&A document that will address some of the additional questions that came in from the audience today, so thank you for submitting those.

And if you have any other additional questions or comments, please email RIC@lewin.com. Additionally, the slides to this presentation, a recording, and a transcript will be available on the Resources for Integrated Care website shortly.

Thank you all so much for joining us today. You can complete a brief evaluation of our webinar so that we can continue to develop high-quality presentations. And if you have any additional questions for us, please email us at RIC@lewin.com. And if you're looking for more information, we do have additional resources here on the slide, including a link to the Alzheimer's Association website, the American Geriatrics Society website, as well as the Alzheimer's Los Angeles website.

You can also visit the Resources for Integrated Care website for more information on this topic, including tip sheets and additional resources related to Alzheimer's disease and other related dementias, as well as resources for caregivers in times of stress and isolation, and resources for providers, healthcare leaders, and caregivers related to emotional support, coping, and managing stress.

Thank you all again for all the speakers, and I hope everyone has a wonderful afternoon. Thank you all so much for your participation today.