Delivering Dementia Capable Care Within Health Plans: Why And How?

Credit Information

- If you are a social worker in a National Association of Social Workers (NASW) state and would like to receive CE credits through NASW for this event or a nurse looking to obtain CNE credits through the California Board of Registered Nursing, please complete the pre-test posted here: https://www.surveymonkey.com/r/dementia1_PreTest
  - You will also be required to complete a post-test; a link to this test will appear at the end of the presentation.
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Delivering Dementia Capable Care Within Health Plans: Why And How?
Overview

- This session will be interactive (e.g., polls and interactive chat functions), with 60 minutes of presenter-led discussion, followed by 30 minutes of presenter and participant discussions.

- Video replay and slide presentation are available after each session at: https://www.resourcesforintegratedcare.com.
Accreditation

- Individuals are strongly encouraged to check with their specific regulatory boards or other agencies to confirm that courses taken from these accrediting bodies will be accepted by that entity.

- The American Geriatrics Society has been approved by the California Board of Registered Nursing to provide continuing education.

- The American Geriatrics Society is accredited by the National Association of Social Workers (NASW) to provide continuing education for social workers.
Disclosure Statement

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- Gregg Warshaw, MD
  No relevant financial interests or affiliations

- Nancy Wilson, MA, MSW
  No relevant financial interests or affiliations

- Christopher Callahan, MD, MACP
  No relevant financial interests or affiliations

- Megan Dankmyer, MSG
  No relevant financial interests or affiliations

- Katie Scott, MPH
  No relevant financial interests or affiliations

- Debra Cherry, PhD
  No relevant financial interests or affiliations
# Continuing Education Information

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<th>If You Are A:</th>
<th>Credit Options</th>
<th>Requirements</th>
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<td><strong>American Geriatrics Society</strong></td>
<td><strong>Please note:</strong> other health care professionals can receive certificate of participation from AGS</td>
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<tr>
<td>Social Worker</td>
<td>The American Geriatrics Society designates this webinar for a maximum of 1 Continuing Education (CE) credit hour through NASW</td>
<td>1. Complete the pre-test at the beginning of the webinar</td>
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<td><strong>Please note:</strong> New York, Michigan, and West Virginia do not accept National CE Approval Programs for Social Work. New Jersey, Idaho, and Oregon do not recognize NASW National Approval</td>
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<td>2. Complete the post-test with a score of 70% or higher</td>
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Support Statement

- This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated, coordinated care to dually eligible beneficiaries, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar.

- To learn more about current efforts and resources, visit Resources for Integrated Care at: https://www.resourcesforintegratedcare.com.
Introductions

- **Christopher M. Callahan, MD, MACP**
  Chief Research and Development Officer, Eskenazi Health
  Professor, Indiana University School of Medicine
  Scientist, Indiana University Center for Aging Research
  Research Scientist, Regenstrief Institute, Inc.

- **Debra Cherry, PhD**
  Executive Vice President, Alzheimer’s Los Angeles

- **Megan Dankmyer, MSG**
  Associate Vice President of Case Management, Molina California

- **Katie Scott, MPH**
  Sr. Director of Dementia and Caregiver Support Services, BakerRipley
  Senior Services Division
Learning Objectives

1. Recognize how cognitive impairment and dementia impact the well-being of older adults and family caregivers
2. Identify opportunities to reduce the high health care and societal costs of dementia
3. Recognize key features of dementia capable health systems and quality dementia care coordination
4. Identify key approaches for health plan collaboration with patients, family caregivers, and community organizations
Webinar Outline/Agenda

- Poll Questions
- Dementia Capable Care Overview
- Strategies and Tools to Improve Dementia Care in the Financial Alignment Initiative
- Implementing the Texas Takes on Dementia Program
- Q&A
- Evaluation
Dementia Capable Care

Christopher M. Callahan, MD, MACP
Chief Research and Development Officer, Eskenazi Health Professor, Indiana University School of Medicine Scientist, Indiana University Center for Aging Research Research Scientist, Regenstrief Institute, Inc.
Millions of People Will Develop Alzheimer’s Disease

- The number of people aged 65 and older in the U.S. with Alzheimer’s disease (AD), the most common type of dementia, is projected to rise dramatically.

We Have No Disease-Modifying Treatments for Dementia

- There are no known medications to prevent, cure, delay the onset, or slow the progression of AD and other dementias\(^1\)
- Since 2000, more than 100 AD drugs failed in clinical trials\(^2,3\)

1. Alzheimer's Association, 2019
People Often Live with Dementia for 10+ Years

Dementia is Among the Costliest Conditions in the U.S.

- In 2019, Medicare and Medicaid will spend an estimated $195 billion caring for those with Alzheimer’s and other dementias—67 percent of total costs\(^5\)
- 27% of people with dementia who are receiving Medicare benefits are dually eligible for Medicaid\(^1\)
  - Home- and community-based services represent 57% of Medicaid spending on long-term services and supports while institutional care represents 43%\(^1\)
  - 50% of nursing home residents have AD or other dementias\(^1\)
  - Medicaid costs associated with AD were 70% higher for women than men\(^1\)
- Comorbid conditions associated with dementia (such as falls, hip fracture and replacement, and urinary tract infection) are the strongest drivers of health care costs\(^6,7\)

1. Alzheimer's Association, 2019
Dementia Pushes Some Families into Poverty

- Medicare expenditures for dementia are similar to other chronic conditions, but out-of-pocket costs are 81% higher
  - Costs such as assistance with dressing and personal hygiene may not be covered
- Out-of-pocket medical expenses relative to total household wealth are much higher for dementia than other conditions
- Family spending on dementia reduces amount available for intergenerational wealth transfer

Medical Care for Dementia Sometimes Falls Short

- Most persons with dementia are cared for in primary care settings, but the typical primary care physician (PCP) cares for only 25 older adults living with dementia\(^9-11\)

- Less than 50% receive recommended evaluation for dementia diagnosis\(^1\)

- Less than 50% of Medicare beneficiaries with a diagnosis of dementia are told they have the diagnosis\(^1\)

- More than 20% are prescribed inappropriate medications, including anticholinergic medications that are linked to worsening of dementia symptoms\(^11\)

- Half of caregivers of people with dementia indicate no experience performing nursing-related tasks and information for managing complex medication regimens\(^1\)


1. Alzheimer’s Association, 2019
Patients with Dementia Have Frequent Transitions


Unpaid Family Caregivers of Individuals with Dementia

- Persons living with dementia often adapt to provide their own care for years
- Family caregivers provide ~80% of total care to persons with dementia
- Most persons with dementia have multiple caregivers
- Most caregivers are women
- All medical and social models of care rely on family caregivers, high risk of burnout
- In 2018, 18.5 billion hours of care, valued at $234 billion, were provided by family and unpaid caregivers

1. Alzheimer's Association, 2019
Systems of Dementia Care Need to Address Multiple Issues

- Integrated dementia care models attempt to address the range of medical and non-medical issues related to dementia care.
  - Support for caregivers (e.g., including improved education and access to different resources)
  - Quality of medical care (avoiding inappropriate prescriptions, improving PCP education regarding persons with dementia)
  - Coordination of care (across different providers and settings of care, working with community resources)
Research On Redesigining Systems of Dementia Care

Medical Components of Integrated Dementia Care Models

- Identify individuals at risk of AD and diagnose early
- Evaluate for treatable conditions
- Evaluate for reversible causes of dementia
- Discuss diagnosis and prognosis
- Continue care for comorbid conditions
- Treat behavioral symptoms

Example Models
Collaborative Care for Dementia
Partners in Dementia Care
MIND at Home
UCLA Alzheimer and Dementia Care Program

Social Components of Integrated Dementia Care Models

- Engage community support agencies for individualized and culturally competent services
- Use an individualized care plan to focus on goals, needs, and maximizing independence
- Discuss advance care planning
- Facilitate physical and social activity

Example Models

- Resources for Enhancing Alzheimer's Caregiver Health (REACH)
- Skills2Care
- SAVVY Caregiver
- SHARE for Dementia

Social Components of Integrated Dementia Care Models (continued)

- Provide guidance on risks of financial fraud (e.g., telephone scams), wandering, driving, and preparation for emergencies
- Consider home modifications that support independence and increase comfort
- Provide culturally sensitive emotional support to caregivers, and track their well-being and outcomes

Example Models

- Resources for Enhancing Alzheimer's Caregiver Health (REACH)
- Skills2Care
- SAVVY Caregiver
- SHARE for Dementia

Evidence Base for Dementia Care Models

- Multiple dementia care models have been tested in clinical trials and evidence from these trials has been reviewed.
  - These models have been shown to improve patient and caregiver symptoms
  - These models may also delay nursing home use and reduce total health care utilization or cost
  - There is only limited evidence that these models reduce total health care utilization or cost
- Under-developed research on home redesign and incorporation of technology

One-Third of Dementia Cases May Be Preventable

Strategies and Tools to Improve Dementia Care in the Financial Alignment Initiative

Dementia Cal MediConnect Project

Debra Cherry, PhD
Executive Vice President, Alzheimer’s Los Angeles

Megan Dankmyer, MSG
Associate Vice President of Case Management, Molina California
Structure of California’s Dementia Cal MediConnect Project
Indicators for a More Dementia-Capable System of Care

1) Better detection and documentation of people living with dementia

2) Better identification, assessment, support, and engagement of family/friend caregivers

3) Better partnerships with community-based organizations
# The Dementia Cal MediConnect Project

## Key Activities

<table>
<thead>
<tr>
<th>Advocacy</th>
<th>Health plan technical assistance</th>
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<tr>
<td>• Making the case for focusing on dementia care</td>
<td>• Identification of people living with dementia</td>
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<tr>
<td>• Making the case for training care managers and other staff</td>
<td>• Validated screening and assessment tools</td>
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<td>• Workflow processes</td>
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<thead>
<tr>
<th>Case manager training</th>
<th>Support services for patients and caregivers</th>
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<tr>
<td>• Case manager training 8 hours</td>
<td>• Disease education</td>
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<tr>
<td>550 care managers</td>
<td>• Caregiver support</td>
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<tr>
<td>• Dementia Care Specialist trainings 12 hours plus case conferences</td>
<td>• Care planning</td>
</tr>
<tr>
<td>150 dementia care specialists</td>
<td>• Connection to home &amp; community-based services</td>
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Better Detection of Patients with Dementia

- Include cognitive impairment questions in the Health Risk Assessment (HRA) and other assessments
- Adopt a validated screening tool
- Document cognitive assessment in the medical record
- Establish a follow-up protocol if the cognitive screen is positive

Sample Screening Tools*

- AD8 Dementia Screening Interview
- Mini-Cog
- GPCOG Screening Test
- Mini Mental Status Exam

Available from: Alzheimersla.org/professionals or in the KAER toolkit

* All tools are validated
Caregiver Identification & Support

- Identify the caregiver(s)
- Document
  - Record in the medical record
  - Keep emergency contact information current
- Assess
  - Consider caregiver distress and needed support areas

Sample Assessment Tools

- Care Needs Assessment Tool
- Benjamin Rose Institute Caregiver Strain Instrument*
- The Caregiver Self-Assessment Questionnaire*
- REACH II Risk Appraisal*

Available from: Alzheimersla.org/professionals

* Validated tool
Engage both client and caregiver, as appropriate, in care planning
  - They have the most knowledge of their own situation

Develop a care plan based on person and family-centered needs
  - Their goals may differ from health care system goals

Provide education and supports
  - For example, in-home assistance like respite
Connect to Home- and Community-Based Services

- Community-based organizations (CBOs) can offer:
  - Disease and caregiver education, either one-on-one or in group classes
  - Care counseling and case management
    - Alzheimer’s L.A. uses a confidential referral form called Alz Direct Connect; available on website and free to adapt
    - Alzheimer’s L.A. focuses care counseling on disease education, community-based supports such as legal services, support groups, arranging for home delivered meals, and addressing emergencies
  - Nutrition programs like Meals on Wheels
  - Engagement programs
  - Support groups
  - In-home services
  - Adult day services
Evaluation of Dementia Cal MediConnect Project’s Impact

- The Institute for Health & Aging (along with partners) evaluated the program’s impact.
- The evaluation focused on the key program activities of:
  - Advocacy
  - Training
  - Technical assistance
  - Supports
- The evaluation sought to measure systems change through:
  - Tracking indicators of dementia capable systems of care
  - Data collection through staff reports and key informant validation
Changes in Screening and Diagnosis

- 10 health plans include at least one cognitive issues question in their Health Risk Assessments
- 6 health plans adopted a validated screening tool and integrated results into an electronic medical record or electronic case management record (EMR/ECMR)
- 1 health plan uses a proactive letter to notify PCPs if the screen is positive for cognitive impairment
  - 10 report sharing information with the PCP about a positive screen through shared care plans
Other Systems Change Indicators

Caregiver Identification, Assessment, Support and Engagement

- 8 health plans report documentation of caregivers in their EMR/ECMR
- 10 health plans report engaging caregivers in care planning and integrated care teams
- 3 health plans had adopted validated measure of caregiver stress or needs and integrated it into their ECMR

Referral to Community-Based Organizations (CBOs)

- 10 health plans refer to CBOs for caregiver education and support
The Dementia Cal MediConnect Project

Funding

This project was supported, in part by grant numbers 90DS2002-01-00 and 90DS2017-01-00, from the Administration on Aging, U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201 and the California Department of Aging.

Additional funding was provided by:

- The Change AGEnts Initiative Dementia Caregiving Network, funded by The John A. Hartford Foundation through a multi-year grant to The Gerontological Society of America
- The Harry and Jeanette Weinberg Foundation
- The Ralph M. Parsons Foundation
- The Allergan Foundation
- The Rosalinde and Arthur Gilbert Foundation
Molina Healthcare of California – Cal MediConnect

- Molina Healthcare has a Medicare-Medicaid Plan in 7 states, including in California as part of Cal MediConnect
- The Cal MediConnect plan is a Medicare-Medicaid Plan (MMP)
- Molina Healthcare of California currently has almost 600,000 members. Of those, ~10,000 are Cal MediConnect members
- Meetings between Molina staff and Alzheimer’s Los Angeles staff began in 2014 to discuss the following:
  - Molina Healthcare of California’s Approach to Dementia Capable Care
  - MMP three-way contract requirement to train “Specially designated care coordination staff in dementia care management”
Molina Healthcare of California’s Approach to Dementia Capable Care

Case Manager Training
Member Cognitive Screenings
Caregiver Screenings
Referrals to Community Resources
Case Manager Training

- Case Manager Training from Alzheimer’s Los Angeles is provided in two tiers:
  - Tier 1 – Dementia Care Manager Training
  - Tier 2 – Dementia Care Specialist Training

- Dementia Care Manager Training is a prerequisite for Dementia Care Specialist Training, which is an advanced-level training.

- All training was in collaboration with Alzheimer’s Los Angeles
Case Manager Training (Continued)

- Tier 1 – Dementia Care Manager Training from Alzheimer’s Los Angeles - 48 Molina staff members trained
- Topics include:
  - Fundamentals of Cognitive Impairment, Alzheimer’s Disease, and Related Dementias
  - Practical Dementia Care Management (Role of CM, Mandatory Reporting/Elder Abuse and Driving, Medication Management, Co-Existing Conditions, Safety, Managing Behavioral Symptoms)
  - Cognitive Screening Tool Administration
  - Caring for the Caregiver
  - Resources/Tools/ Support Services in the Community – Making Referrals
Case Manager Training (Continued)

- Tier 2 - Dementia Care Specialist Training from Alzheimer’s Los Angeles - 30 Molina staff members trained
  - More in-depth coverage of basic training topics
  - IDEA! 3-part behavior management strategy
  - Caregiver assessment

- Alzheimer's Monthly Huddles for Dementia Care Specialists
  - Discuss case studies for input
  - Additional time to discuss concepts and ask questions
  - Dedicated time to reinforce and build dementia care management skills
Member Cognition Screening

- Health Risk Assessment (HRA) identifies member’s memory concerns and any recent changes in cognition

- Molina added a validated tool (AD-8) into the clinical software to screen members for dementia
  - Case Managers utilize screening based on responses in the HRA

- Molina notifies the PCP of AD-8 score in a letter that includes:
  - Recommendations regarding the need for a complete dementia diagnostic evaluation
  - Information on the KAER toolkit for additional recommendations

- Interventions were incorporated for all CA members and not just Cal MediConnect
Caregiver Screenings

- HRA and other methods identify caregivers of individuals with dementia
- AMA Caregiver Self-Report Questionnaire was added to the clinical system used by case managers as a method to assess the stress levels of family caregivers
  - Case Managers utilize tool when interacting with caregivers
- Case Managers link caregivers to appropriate resources based on identified needs
  - Alzheimer’s organizations
  - Long-Term Service and Supports (LTSS)
- Caregiver engagement in care planning
  - Identification of caregiver goals and preferences
Referrals to Alzheimer’s Los Angeles: Molina / Shield Health Care Pilot

- Pilot began in January of 2019
- Shield HealthCare – a supply Vendor - began adding additional Molina specific questions to their existing intake process to identify members in need of Case Management and referrals to Alzheimer’s Los Angeles
  - Do you feel as if you have any difficulty with tasks such as bathing, dressing, or grooming?"
    - *If yes:* “Do you have a caregiver to help with any of those tasks?”
    - *If speaking to the caregiver who provides the help:* “Are you getting the support you need as a caregiver to keep up with those tasks?”
  - “Many individuals find remembering to take their medication to be difficult; do you feel as if you have any trouble remembering to take your medications?”
  - “When thinking about the past six months, have you gone to the emergency room or hospital?”
  - “And have you fallen within those past six months?”
Molina / Shield Health Care Pilot Continued

- The questions are based on research on predictors of nursing home placement
- Responses are provided to Molina on a weekly basis
  - Referrals are sent to Alzheimer’s Los Angeles
  - Referred internally to Molina Case Management
Benefits of our Partnership

Molina Healthcare of California & Alzheimer’s Los Angeles

- Important to Molina that we do our best to support our members and their caregivers
- Molina leadership has direct access to Alzheimer’s Los Angeles expertise to discuss workflows, tools, and resources
- Ability to create pilots to increase identification of caregivers in need of education and support
- Partnership has helped to ensure Case Management staff have the additional training from experts in dementia care
- Provided education and training for our providers
Implementing the Texas Takes on Dementia Program

Katie Scott, MPH
Sr. Director of Dementia and Caregiver Support Services, BakerRipley Senior Services Division
BakerRipley exists to keep Greater Houston a welcoming place of opportunity where everyone can earn, learn, belong and be well.

BakerRipley Senior Services provides programs that impact
  - Health and Wellness
  - Engagement
  - Connection

BakerRipley Dementia and Caregiver Support programs promote the independence and dignity of older adults through our
  - Dementia Day Center
  - Dementia Case Management Program
  - Caregiver Support Services
Dementia in the Texas Dually Eligible Population

- Over 390,000 Texans have dementia\(^1\)
- 112,000 (23\%) of Texans 65 years and older and dually eligible are estimated to have Alzheimer’s disease.\(^{25,26}\)
- In 2017, only 12\% of Texas Medicare-Medicaid Plan members over 65 had a formal diagnosis of Alzheimer’s, dementia, or stroke listed in their medical record.\(^{27}\)
- In 2018, BakerRipley served 16,461 older adults across a range of programs and services.
  - Total includes 1,304 individuals with dementia, as well as their caregivers; some of those served were dually eligible.

1. Alzheimer’s Association, 2019
Texas Takes on Dementia

This presentation was supported in part by a cooperative agreement (No. 90DS2023) from the Administration on Aging (AoA), Administration for Community Living (ACL), U.S. Department of Health and Human Services (DHHS). Grantees carrying out projects under government sponsorship are encouraged to express freely their findings and conclusions. Therefore, points of view or opinions do not necessarily represent official AoA, ACL, or DHHS policy.
Project Team

State Project Leads
Michael Aguirre, Texas Health and Human Services
Alyssa Guzman, Texas Health and Human Services

Project Director
Katie Scott, BakerRipley

Harris County Project Leads
Jane Bavineau, BakerRipley
Andrea Williams, BakerRipley

Tarrant County Project Leads
Don Smith, United Way of Tarrant County
Dana Abbott-Glazier, United Way of Tarrant County

Training Partners
Alzheimer’s Association Chapters:
- Houston & Southeast Texas
- North Central Texas

Evaluation Partners and Advisors
William Landon, Evaluation Lead, BakerRipley
Debra Cherry, Alzheimer’s, Los Angeles
Mark Kunik, Baylor College of Medicine,
Alan Stevens, Baylor Scott & White Health
Nancy Wilson, Baylor College of Medicine.
Project Development

- Built upon established frameworks for dementia capable systems
  - Dementia Cal MediConnect (California)
  - Houston Alliance to Address Dementia (Harris County, TX)
  - Model for Alzheimer’s/Dementia Services (Tarrant County, TX)
- Limited geographic regions for implementation
- Secured Medicare-Medicaid Plan (MMP) support before project
- Leveraged interest in quality of care, not contract requirements, for process change
# Texas Takes on Dementia Process

<table>
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<tr>
<th>Texas Takes on Dementia Project Team</th>
<th>Health Plans</th>
<th>Community Resource Providers</th>
<th>People with Dementia and Caregivers</th>
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<tr>
<td>• Organizational Assessment</td>
<td>• Identify persons with dementia and caregivers</td>
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<tr>
<td>• Education and Training</td>
<td>• Provide and refer to resources</td>
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<tr>
<td>• Screening and Identification Tools</td>
<td>• Provide Direct Services*</td>
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<td>• Referral Procedures</td>
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### Texas Takes on Dementia Community Services

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<th>Harris County</th>
<th>Tarrant County</th>
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<tr>
<td><strong>Dementia Specific Case Management:</strong> A case management program designed specifically for individuals with or at risk of dementia living alone or with limited support</td>
<td><strong>Dementia Options Counseling:</strong> Person-centered support in decision making for long term support.</td>
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<tr>
<td><strong>Benjamin Rose Institute Care Consultation:</strong> An evidence-based care-coaching program comprised of assessment, action planning and ongoing support for caregivers.</td>
<td><strong>Resources of Enhancing Alzheimer’s Caregiver Health II (REACH II):</strong> An evidence-based multicomponent psychosocial and behavioral training program for caregivers comprised of individual and group sessions.</td>
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<td><strong>Stress Busting for Caregivers:</strong> A 9-week evidence based class designed to help caregivers manage their stress and cope with their situation.</td>
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<td><strong>Caregiver Education:</strong> Seminars and workshops designed to increase caregivers’ knowledge of dementia and related care.</td>
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Texas Takes on Dementia Numbers

- **10** trainings (initial and refresher) provided to **164** MMP service coordinators and case managers
- **56** warm handoff referrals were made to dementia-specific community services
- **35** people with dementia and their caregivers enrolled in community services offered by the project.

Note: Numbers as of April 2019. Referrals began Dec. 2018
The Texas Takes on Dementia’s evaluation team works to identify the adoption of dementia capable practices by the plans and identify quality improvement opportunities. Methods and measures include:

### Dementia capacity and knowledge
- Structured interviews with plan leadership
- Capacity surveys completed by plan service coordinators/case managers
- Focus groups with service coordinators/case managers

### Dementia care practice integration
- Tool and process adoption rates
- Referral rates
Baseline Assessment

According to a baseline assessment of dementia capacity, knowledge, and practice:

- **MMP service coordinators** need:
  - Knowledge of community resources
  - Easy referral system for community resources
  - Coordination and communication with community services

- **MMP members** with or at risk of dementia and their families need:
  - Caregiver education and support
  - Care coordination across healthcare and community services
  - Advocacy while navigating care systems
### Indicators of Systems Change

#### Screening and Diagnosis

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<th>Action</th>
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<td>Include cognitive impairment questions in the HRA and other assessments</td>
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<tr>
<td>Adopt a validated screening tool</td>
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<tr>
<td>Document cognitive assessment in the e-MR</td>
<td>2</td>
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<tr>
<td>Establish a follow-up protocol for positive cognitive screen</td>
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#### Caregiver Identification

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<td>Identification</td>
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<tr>
<td>Documentation and Assessment</td>
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#### Referrals to Community Services

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<th>Action</th>
<th># of MMPs</th>
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<tr>
<td>Operationalized formal referral system</td>
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Three MMPs adopted key processes to improve their dementia capability.
Case Study 1

92 year old woman living with daughter
(dually eligible beneficiary)

- **Referred by:** Molina Case Manager
- **County:** Harris
- **Referral Reason:** Identified cognitive impairment and refused assistance from anyone but her daughter. Daughter showed signs of caregiver stress and burnout
- **Community Service Provided:** Caregiver Consultation and Stress Busting for Caregivers
- **Outcomes:**
  - Daughter attended Stress Busting for Caregivers
  - Daughter better able to manage the stress of caring for her mother
Case Study 2

80 year old man living alone with cognitive impairment (dually eligible beneficiary)

- **Referred by:** Amerigroup Nurse Case Manager
- **County:** Harris
- **Referral Reason:** Identified cognitive impairment and resistance to help from Amerigroup Nurse Case Manager
- **Community Service Provided:** Dementia-Specific Case Mgt
- **Outcomes:**
  - Obtained diagnosis to qualify for the waiver program
  - Moved to a safer, more supportive living environment
  - Entered into application process for guardianship
Questions
Upcoming Dementia Webinar!

- Save the date!
  - July 30, 2019: 11:30am – 1:00pm EDT
- Diagnosing and Treating Dementia – Current Best Practices
- Registration link and additional information coming soon at https://www.resourcesforintegratedcare.com/
Additional Resources

- Sample HRA Questions
- Training Curricula for Care Managers
- Direct Referral Form (for adaptation)
- Dementia Care Management Toolkit
- Dementia Screening Tools
- Caregiver Identification Tool
- Caregiver Assessment Scales
- Care Needs Assessment Tool
- IDEA! Strategy for Managing Challenging Behaviors
- Best Practice Care Plans
- Plain Language Caregiver Tip Sheets
- Advocacy materials

Tools Available for Download at: www.AlzheimersLA.org/professionals
Resources for Integrated Care: More Information

- These tip sheets summarize information from previous webinars for the use and reference of care coordinators, case managers and other non-clinical people who support people with dementia:
  - https://www.resourcesforintegratedcare.com/GCC_TipSheet_Applying_Promising_Practices_to_Advance_Care_for_Individuals_Dually_Eligible_for_Medicare_and_Medicaid_with_Dementia
  - https://www.resourcesforintegratedcare.com/GCC_Tip_Sheet_Beyond_Alzheimers_Disease_Other_Causes_Of_Progressive_Dementia_In_The_Older_Adult
- Visit the Alzheimer’s Disease And Other Related Dementias (ADRD) page for additional resources
- Visit https://resourcesforintegratedcare.com/ to view previous webinars and obtain continuing education credit.
Thank You for Attending!

- The video replay, slide presentation, and a summary of the Q&A will be available at: [https://www.resourcesforintegratedcare.com/GeriatricCompetentCare/2019_GCC_Webinar/Delivering_Dementia_Capable_Care_Within_Health_Plans](https://www.resourcesforintegratedcare.com/GeriatricCompetentCare/2019_GCC_Webinar/Delivering_Dementia_Capable_Care_Within_Health_Plans)

- If you are applying for CNE or NASW CE, you must complete the post-test in order to receive credit: [https://www.surveymonkey.com/r/dementia1_PostTest](https://www.surveymonkey.com/r/dementia1_PostTest)

- For more information about obtaining CNE or NASW CE, please visit: [https://www.resourcesforintegratedcare.com/sites/default/files/GCC_Delivering_Dementia_Capable_Care_Prewebinar_Continuing_Education_Credit_Guide.pdf](https://www.resourcesforintegratedcare.com/sites/default/files/GCC_Delivering_Dementia_Capable_Care_Prewebinar_Continuing_Education_Credit_Guide.pdf)

- Questions? Please email RIC@lewin.com

- Follow us on Twitter at @Integrate_Care to learn about upcoming webinars and new products!
Webinar Evaluation Form

- Your feedback is very important! Please take a moment to complete a brief evaluation on the quality of the webinar. The survey will automatically appear on the screen approximately a minute after the conclusion of the presentation.

- We would also like to invite you to provide feedback on other RIC products as well as suggestions to inform the development of potential new resources: https://www.research.net/r/MVGNWVJ
Sources and Citations


https://www.ResourcesForIntegratedCare.com