Geriatric-Competent Care: Applying Promising Practices to Advance Care of Medicare-Medicaid Enrollees with Dementia
Overview

- This is the first session of the “2017 Geriatric-Competent Care Webinar Series”

- Each 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
Applying Promising Practices to Advance Care of Medicare-Medicaid Enrollees

- Developed by:
  - The Lewin Group
  - Community Catalyst
  - The American Geriatrics Society

- Hosted by:
  - The Medicare-Medicaid Coordination Office (MMCO)
  - Resources for Integrated Care
Support Statement

- This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare and Medicaid Services (CMS) to ensure beneficiaries enrolled in 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 Medicare-Medicaid enrollees, 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
Webinar Learning Objectives

This webinar will emphasize:

- Presentation of the business case for a dementia capable delivery model of care
- Review of key components of an effective care model (e.g., identification and screening for a high-risk population of beneficiaries and caregivers, workforce preparation, and collaboration with community-based organizations for caregiver assessment and support)
- Interventions implemented within two state capitated financial alignment model demonstrations
Webinar Outline/Agenda

- Polls
- The Dementia Cal MediConnect Project
- Implementation Within Health Plans
- Family Caregiver
- Healthy Connections Prime
- Q&A
- Evaluation
Introductions

- Debra Cherry, Executive Vice President, Alzheimer’s Greater Los Angeles
- Linda Wade, Director of Care Management, Health Net
- Tracey Brown-Lindsey, Family Caregiver
- Teeshla Curtis, Program Manager, Healthy Connections Prime, South Carolina Department of Human Services
The Dementia Cal MediConnect Project: Promising Practices from California’s Financial Alignment Pilot

Debra L. Cherry, Ph.D. Executive Vice President, Alzheimer’s Greater Los Angeles
Funding

This project was supported through a cooperative agreement between the U.S. Administration for Community Living 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 Dementia Cal MediConnect Project: Components

- Advocacy with health plans
  - Making the case for focusing on dementia care
- Care manager training and support
- Caregiver education and respite
- Support services through referrals to Alzheimer’s organizations
- Technical assistance to create systems change
The Case for Improving Dementia Health Care

- Increasing prevalence
- High cost of care
- Multiple quality challenges
  - Poor detection
  - Poor treatment and management
  - Poor recognition of family caregiver’s role
  - Poor access to home-and community-based services

![Cost of Care Chart](chart.png)


Tools for advocacy: www.alzglao.org/professionals
Project Goal: Creating Dementia Capable Systems of Care

1. Better detection and documentation of patients with dementia
2. Better partnerships between health systems and family/friend caregivers
3. Better partnerships with community-based organizations
Indicators of a Dementia Capable System

1. Better detection and documentation 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 for diagnosis if the cognitive screen is positive
Challenges to the Recognition of Dementia

- Some HRAs do not include screening questions for cognitive impairment
- Families of Medicare-Medicaid enrollees may be less likely to bring dementia to the physician’s attention
  - Lack of understanding of the condition
  - Stigma
- Providers in diverse communities may share cultural views about dementia and help families hide or deny the disease
Actions to Promote Better Detection of Patients with Dementia

- Review of HRA content
- Train and provide technical assistance to care managers and others to encourage them to
  - Screen for dementia with a validated tool
  - Develop a follow-up protocol if cognitive screen is positive
Indicators of a Dementia Capable System

2. Better partnership between health system and family/friend caregivers

- Ability to identify family/friend caregiver and document this in the chart(s)
- Ability to briefly assess family/friend caregiver’s needs
- Integration of family/friend caregiver education
- Assignment to Dementia Care Specialists
- Adoption of standardized care plans
Challenges to Family/Friend Caregiver Engagement

Medical providers may not have institutionalized systems for identifying, documenting, and engaging the caregiver:

- Poor management of co-morbid conditions
- Apparent non-compliance
- Medication mismanagement
- Behavior symptom mismanagement
- Unnecessary hospital readmissions, ER visits, and possibly even nursing home placement
Recognize and Partner with Family/Friend Caregivers

- Document the family/friend caregiver(s) in the electronic medical record or case management medical record
- Assess and document the caregiver’s needs
  - Caregiver Identification Tool
  - Caregiver Needs Assessment Tool
  - Benjamin Rose Institute Caregiver Strain Index
    (Ref: Bass, Noekler & Reschlin, 1996; Bass D, et al, 1994b)
- Assign patient and caregiver to a Dementia Care Manager
  - Standardized Care Plans

Available at www.alzgla.org/professionals
Recognize and Partner with Family/Friend Caregivers

- Links to home and community-based services need to be suitable for lower income people
  - Example: no cost or low cost legal and financial planning
- Provide or refer caregiver for education
  - Plain Language Fact Sheets (English-Spanish)
    - (hallucinations, home safety, anger, getting lost, bathing, medications, sun-downing, and more)
Keeping Home Safe

People with Alzheimer’s or dementia may have trouble knowing what is dangerous or making safe decisions. By helping him or her feel more relaxed and less confused at home, you can help stop accidents.

WHAT CAN YOU DO?

Keep Things Simple
- make sure rooms are neat
- place “often used” items in the same place
- remove things that might break and aren’t needed

Look at the Floor
- remove small rugs, rugs that are thick, or rugs that might slide on floors
- don’t shine or wax floors
- keep items off floors... cords, books, toys, bags, boxes, etc.
- make sure bathroom and kitchen floors are kept dry and avoid walking with wet feet
- use tables and chairs that are stable enough to lean on

Remove Dangerous Items
- keep all medicines... vitamins, aspirin, prescriptions... in a locked box, cabinet, or drawer
- place knives, scissors, guns, sharp tools, matches, and lighters out of sight or in a locked area
- move all cleaning supplies to a high shelf or lock them away
- take off knobs from the stove and oven

Don’t Leave Him or Her Alone
- in the kitchen with the stove or oven on
- in the bathroom with water running
- anywhere with burning cigarettes, cigars, or pipes
- near an open or unlocked door or gate
3. Better partnership with community-based organizations

- Adoption of a proactive referral tool to connect families to HCBS like:
  - Respite care
  - Support groups
  - Caregiver education
  - Care counseling
- Tool is called “ALZ Direct Connect”
- Connects families to local Alzheimer’s organizations
## Tool to Facilitate Referrals

### ALZ DIRECT CONNECT

**REFERRAL PROGRAM**

...partnering with Healthcare and Aging Service Providers to improve care and support for people with Alzheimer’s or dementias & their families.

ALZ DIRECT CONNECT allows healthcare and aging services providers to directly link patients/clients and families to Alzheimer’s Greater Los Angeles for:

- access to care coordination and psychosocial support
- referrals to supportive services (often at no cost)
- help with understanding the disease & navigating its progression
- a 360 approach to care through feedback to the referring provider

### ALZ DIRECT CONNECT Referral Form

Fax or email this form to Alzheimer’s Greater Los Angeles

<table>
<thead>
<tr>
<th>Fax #</th>
<th>323 666 3106</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email</td>
<td><a href="mailto:algicoconnect@alzla.org">algicoconnect@alzla.org</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Check ☑ if primary contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT/CLIENT NAME</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>City _______ Zip _______</td>
</tr>
<tr>
<td>Phone*</td>
</tr>
<tr>
<td>Email</td>
</tr>
<tr>
<td>Primary Language: □ English □ Spanish □ Other (specify)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Check ☑ if primary contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAMILY CAREGIVER NAME (if available)</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>City _______ Zip _______</td>
</tr>
<tr>
<td>Phone*</td>
</tr>
<tr>
<td>Email</td>
</tr>
<tr>
<td>Relationship to Patient/Client: □ child □ professional caregiver □ other (specify)</td>
</tr>
<tr>
<td>Primary Language: □ English □ Spanish □ Other (specify)</td>
</tr>
</tbody>
</table>

Is the patient/client on Medi-Cal AND Medicare? □ Yes □ No

I give permission to the referring provider to forward my contact and patient information to Alzheimer’s Greater Los Angeles. I understand that a representative will contact me or my caregiver about support, programs, and other services and will follow up with the referring provider. Referrals will be entered into our secure database, unless indicated otherwise by checking this box ☑.

Signature ___________________________________________ Date __________

[Patient/Caregiver or Authorized/Representative/Family Caregiver]

The person being referred provided verbal consent instead of signature ☑ Yes

### REASON FOR REFERRAL (please select all that apply)

- Social Work Consultation & Support
- Support for Newly Diagnosed
- Support Group
- Activity Programs
- Safety Issues
- Respite Services
- Caregiver Education
- Other (specify)

### REQUIRED INFORMATION

**Referring Provider Name** ________________________________ **Title**

**Provider Organization** ________________________________

<table>
<thead>
<tr>
<th>Phone #</th>
<th>Fax #</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________________________</td>
<td>________________________________</td>
</tr>
</tbody>
</table>

**How would you prefer to receive follow-up?** □ Fax □ Email □ Non-medical community organization

**Follow-up unnecessary** ☑ Yes

---

**Alzheimer’s Greater Los Angeles**

24/7 Helpline – 888 HELP ALZ | 335.7259 | algco.org
Challenges to Partnerships with Community Based Organizations (CBOs)

- Involves a culture change for both partners
  - Managed Care Organizations (MCOs) expect timeliness and feedback
  - CBOs may not be HIPAA-compliant or have capacity for large quantities of referrals
- CBO services may require allocation of new resources
- Partners will need to invest time in order to better understand one another’s cultures and services
Resources Available

- Sample HRA Questions
- Training Curricula for Care Managers
- Alz Direct Connect Form (for adaptation)
- Dementia Care Management Toolkit
- AD8 Dementia Screening Tool
- Caregiver Identification Tool
- Benjamin Rose Caregiver Stress and Strain Scale
- Care Needs Assessment Tool
- IDEA! Strategy for Managing Challenging Behaviors
- Standardized Care Plans
- Plain Language Fact Sheets

Available for download at: www.alzgla.org/professionals
Online Training Modules

- Fundamentals of Alzheimer’s for Healthcare Professionals (1 hour module)
- Effective Strategies for Managing Behavioral Symptoms of Dementia (2 hour module)
- Caring for Family Caregivers (1 hour module)

Access through: www.alzgla.org/professionals
Dementia Cal MediConnect Project Outcomes to Date

Knowledge Gain

(care manager self-report: pre-, post-, and 6 month surveys)

- Trained care managers showed significant knowledge gain as a result of the training
- Knowledge gain was sustained through the 6 month follow-up

System Change

(community managers self-report: pre-, post-, and 6 month surveys and documentation on a system change spreadsheet completed by project staff as health plan staff reported improved care practices)
Care Manager and Dementia Care Specialist Practice Change: When Working with a Member Who May Have ADRD…

<table>
<thead>
<tr>
<th>Activity</th>
<th>Baseline (n=258)</th>
<th>6-Month (n=97)</th>
<th>DCS 6-Month (n=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I usually encourage them to receive a formal diagnosis</td>
<td>80%</td>
<td>72%</td>
<td>67%</td>
</tr>
<tr>
<td>I usually determine whether they have an informal caregiver</td>
<td>74%</td>
<td>72%</td>
<td>74%</td>
</tr>
<tr>
<td>I usually involve the informal caregiver in the care planning process</td>
<td>71%</td>
<td>72%</td>
<td>72%</td>
</tr>
<tr>
<td>I usually refer the member to available HCBS</td>
<td>80%</td>
<td>78%</td>
<td>80%</td>
</tr>
<tr>
<td>I usually refer the caregiver to available HCBS</td>
<td>76%</td>
<td>83%</td>
<td>76%</td>
</tr>
<tr>
<td>I usually refer them or their informal caregiver to Alzheimer's organizations</td>
<td>85%</td>
<td>100%</td>
<td>85%</td>
</tr>
</tbody>
</table>
System Change Outcomes in 8 Health Plans per CMC health plan staff report

Cognitive Screening
- 3 changed HRAs to include cognitive screening
- 3 adopted AD8 in e-record keeping system

Partnership with Family Caregivers
- All say they are systematically identifying family caregivers
- 2 adopted a measure of caregiver strain
- 5 to provide respite under Care Plan Options- 2 refer to CBOs
- 7 offer caregiver education directly or through Alzheimer’s organizations

Partnership with CBOs
- 6 formally integrated ALZ Direct Connect/others use it less formally
The Dementia Cal MediConnect Project Team

Project Co-Directors
- Lora Connolly, MSG, California Department of Aging
- Debra Cherry, PhD, Alzheimer’s Greater Los Angeles

Project Manager
- Jennifer Schlesinger, MPH, CHES, Alzheimer’s Greater Los Angeles

Project Evaluator
- Brooke Hollister, PhD, University of California, San Francisco Institute for Health and Aging

Special Consultant
- Nancy Wilson, ChangeAGEnts, Dementia Caregiving Network

Alzheimer’s Greater Los Angeles Team Members
- Dawn Davis
- Susan Howland
- Barbra McLendon
- Dawn Davis
- Jessica Hodgeson
- Terry Garay

Alzheimer’s Association Team Members
- Ruth Gay, Team Lead
- Elizabeth Edgerly
- Pauline Martinez
- Alexandra Morris
- Angie Pratt
- Susan DeMarois
Implementation Within Health Plans

Linda Wade, RN, BSN, MBA
Director of Care Management, Health Net
Alzheimer’s Greater Los Angeles supported Health Net in the development of the Cal MediConnect Health Risk Assessment (HRA). The HealthNet’s HRA was drafted to include screening criteria for cognitive impairment derived from the Centers for Disease Control and Prevention (CDC) Behavioral Risk Survey Tool.

Health Net partnered with Alzheimer’s Greater Los Angeles to provide tools to case managers, members and caregivers to better manage dementia and related diseases.
Key Components of Executing the Plan

- Provided feedback to the Alzheimer's Association Greater Los Angeles for content development of the initial and specialist training programs
- Provided training to case managers
- Clinical reviews with experts
- AD8 assessment
- Caregiver assessment
- Strategies for member management identified for care planning such as combativeness, sleep issues, caregiver needs and safety
Education

- Training of Health Net case managers and delegated provider groups who perform case management on best practices for improving dementia care
- Health Net delegates case management to 17 provider groups for the CA Financial Alignment Demonstration – Cal MediConnect
Education (continued)

- Alzheimer’s Greater Los Angeles attended Health Net Provider Group “Huddle” during summer of 2015. Case managers from all 17 Physician Provider Groups (PPGs) were in attendance
  - Provided overview of work/partnership with Health Net
  - Reviewed best practices for dementia care, including tools that can be used by case managers
  - Extended opportunities for individual PPG pilots for further innovation
- As a result, several PPGs have incorporated tools and/or adjusted workflows within their EMRs to include or enhance screening tools and interventions
Education (continued)

- Trained Dementia Care Specialists who serve as an internal resource for our care managers at the health plan and delegated provider groups
  - Dementia Care Specialist training was provided by Alzheimer’s Greater Los Angeles
  - Dementia Care Specialists attended monthly huddles for ongoing education and collaboration with other health plans and Alzheimer’s Greater Los Angeles
  - Dementia Care Specialists provide ongoing guidance and education to care managers and members. Specialists also attend Interdisciplinary Care Team (ICT) meetings to provide consultation to clinicians on specific member cases
Promising Practices

- AD8 Assessment Tool is adopted by our Care Management Department and is used when a member does not have a diagnosis of dementia related illness, yet presents with thinking/memory issues during assessment. This is integrated into our medical management documentation system.
- If AD8 yields a positive result, the care manager works with the Primary Care Provider to make a follow-up appointment for evaluation for ADRD.
- The AD8 tool is incorporated as an indicator on our monthly internal health plan audits to assure care manager utilization and understanding of the tool.
- The caregiver assessment is integrated into our case management process.
Other Promising Practices

- 2014: Partnered with Alzheimer's Greater Los Angeles’ Community Education Department to develop a cobranded Health Net & Alzheimer's Greater Los Angeles "Alzheimer's Disease and Brain Health" educational flyer for members and the community

- 2015: Partnered with Alzheimer's Greater Los Angeles for 3 community education classes; reached 81 participants and 11 (14%) Health Net members

- 2015: Promoted the Alzheimer's Greater Los Angeles’ 24-hour Helpline on the Cal MediConnect member newsletter
  - Summer 2015 issue: the newsletter was mailed to 20,000+ Cal MediConnect member households

- 2014 – 2015: Health Net Health Education Information Line promotes the Alzheimer's Greater Los Angeles’ Helpline upon member requests/inquiries
Case Study

- Health Risk Assessment identified potential cognitive function deficit
- AD8 completed with member’s grandson who verified that member has been positively diagnosed with dementia but is being treated solely by his Primary Care Physician (PCP)
- Case manager contacted PCP’s office to discuss Neurologist consult
- Member’s grandson contacted PCP’s office to schedule a follow up appointment and neurologist referral will be discussed at that appointment
- Member receives In Home Support Services (IHSS) but insufficient hours to meet 24 hour care needs
- Member and grandson report issues with frequent caregiver turnover and caregiver burnout
Case Study (continued)

**Actions:**

- Case manager referred member to licensed clinical social worker to evaluate psychosocial needs
- Dementia Care Specialist reviewed case and provided the following recommendations:
  - During the next follow up with the grandson, complete caregiver assessment to identify issues based on report of caregiver burnout and frequent caregiver turnover
  - Provide education on regional Alzheimer's Association
  - Utilize Dementia Care Tool Kit resources to provide education on any behavioral issues identified during assessment and incorporate into the plan of care
Challenges

- Data access and collection issues, i.e., where the referrals for Long Term Services and Supports and In Home Supportive Services are housed, identifying who can best capture/extract the information and collecting data from our delegated groups
- Access to ongoing education for new team members
Outcomes

- Early identification and notification to the physician of a member’s dementia related symptoms for further diagnostic testing
- Continued support and education for care managers
- Increased caregiver knowledge and skill to better manage members
- Prevent, reduce or delay members need to be institutionalized
- Assure effective member treatment plan is initiated for better member outcomes
- Ability to provide appropriate resources for dementia related care
- Data review to identify improvement opportunities
- Creation of a knowledgeable team of care managers to optimally respond to member needs
Family Caregiver
Tracy Brown-Lindsey
South Carolina Financial Alignment Demonstration – Healthy Connections Prime and Family Caregivers

Teeshla Curtis, Program Manager, Healthy Connections Prime
Agenda

- Background
- Training and Other Requirements
- Medicare-Medicaid Plan (MMP) Accomplishments
- Lessons Learned
- Resources
Background

- Mandatory managed care implemented in 2010
- Excluded populations: Medicare-Medicaid enrollees, institutional and waiver beneficiaries
- South Carolina’s demonstration: older adults
Training Requirements

- Training requirements included in readiness review
- MMPs required to have policies related to dementia competent training for care coordinators
- Required trained personnel includes:
  - Care Team Members
  - Enrollee Service Representatives
Training Facilitators and Topics

Alzheimer’s Association, South Carolina Chapter

Advanced Dementia Training Topics include:

- Diagnosis, Prognosis, Treatment
- Communication and Feelings
- Intimacy and Sexuality
- Wandering
- Dementia and Driving
- Staff and Family Support
- Spiritual Care and End of Life Issues
- Alzheimer’s Association Resources

University of South Carolina Office for the Study of Aging

- Dementia Dialogues Certification Program
  - 5-part series, Continuing Education Units
- Dementia Dialogues T.I.P.S.
  - Talking Points, Interventions, Problem Solving Strategies, and Solutions
- Elder Abuse Identification and Reporting
  - Types of abuse, mandated reporting, Adult Protective Services
- End-of-Life Care
  - Advanced Care Planning, Hospice, Palliative Care
Training Material Repositories

University of South Carolina E-Learning Management System

- Needed accessible platform for training and other MMP educational material
- Launched E-Learning Management System in February 2016
  - Reduced training costs
  - Centralized learning
  - Tracking and reporting features
  - Assessment and testing

Sample Courses
- Dementia Dialogues
- Adult Protective Services: Working Together Is Better
- Dealing With Difficult People
- Determinants Of Abuse: Neglect And Safety Concerns

https://web.asph.sc.edu/hcp/
Training Material Repositories

- Introduced dedicated section of website for MMPs in December 2016
  - Presentations and other educational material
  - Frequently Asked Questions (FAQs)
  - Informational memos
  - Program guidance and instructions

Plan-Focused Webpage to Distribute Trainings, FAQs, and Memos

Sample Topics
- Serious Reportable Events
- Emergency Preparedness Protocol

https://msp.scdhhs.gov/SCDue2/site-page/healthy-connections-prime-memos
https://www.ResourcesForIntegratedCare.com
Other Requirements

- Uniform Assessment
  - Saint Louis University Mental Status (SLUMS) examination: identifies mild cognitive impairment (MCI)
  - American Medical Association Caregiver Self-Assessment: Assesses well-being, depression, stress, and overall quality of life

- New Benefit Tested: Palliative Care

- The National Committee for Quality Assurance (NCQA) Quality Measures: Monitoring drug-disease interactions in the elderly

- Consumer Protections: Serious Reportable Events guidance
MMP Accomplishments

Accomplishments
- Staff trained in *Dementia Dialogues*, including facilitators
- Dementia training integrated in new employee orientation
- MMP sponsored Dementia Dialogues community sessions (with CEUs)
- Caregiver resources including toolkits, respite, and fall prevention workshops

Promising Practices
- Leveraging *Dementia Dialogues* at the MMP-level
- Educating and supporting family members
- Connecting families to community resources

Challenges
- Access to care: barriers to institutional respite and Community Mental Health services; lack of provider capacity to support members with co-morbidities
  - Examples: dementia and intellectual disabilities/developmental disabilities
- Working with family members with dementia
Lessons Learned

- **Training**
  - Follow-up and on-going monitoring
  - Optimize existing state resources (e.g., *Dementia Dialogues*, Alzheimer’s Association)

- **Interventions**
  - Ensure meaningful care plan development through incorporation of appropriate interventions
  - Identify caregivers, both formal and informal

- **Clinical**
  - Address under-diagnosis of Alzheimer’s and related dementias

- **Care Coordination**
  - Support for members who refuse care coordination
  - Early identification of cognitive impairment in assessment process

- **Quality Measures**
  - Lack of measures related to utilization of seclusion across all care settings
Resources

Caregiver Self-Assessment

Dementia Dialogues
http://www.asph.sc.edu/osa/programs_dementia.html

Dementia Dialogues T.I.P.S.
https://www.youtube.com/watch?v=xgNUiHJJY0w

Saint Louis University Mental Status (SLUMS) Examination

Serious Reportable Events

South Carolina Readiness Review Tool
Thank You!
Questions
Thank you for joining our webinar. Please take a moment to complete a brief evaluation on the quality of the webinar.