

**The Lewin Group and AARP**  
**How Managed Long-Term Services and Supports Can Help Family Caregivers**  
**April 27, 2017**  
**2:00 p.m. EST**

**Caroline Loeser:** My name is Caroline, and I'm with the Lewin Group. Welcome everyone to the webinar, How Managed Long-Term Services and Supports Can Help Family Caregivers. The audio portion of the presentation will automatically stream through your computer. Please make sure to have the volume turned all the way up on your speakers. If you are experiencing any audio or technical difficulties, please send a message directly to the moderators, and we will assist you. Phone dial-in information is available upon request if you did not receive a phone line.

Today's session will include a 45 minute presenter led discussion, followed by 15 minutes for a discussion among the presenters and participants. This session will be recorded and a video replay along with a copy of today's slides will be available at <https://resourcesforintegratedcare.com/>. This webinar is presented in conjunction with AARP and the Lewin Group, is supported through the Medicare-Medicaid Coordination Office (MMCO) at the Centers for Medicare and Medicaid Services (CMS). MMCO is developing technical assistance and actionable tools based on successful innovations in care models, such as this webinar series. To learn more about current efforts and resources, please visit our website or follow us on Twitter for more details. Our Twitter handle is @Integrate\_Care.

On the screen here you will see the learning objectives for today's webinar. This webinar will explain how MLTSS can advance person and family-centered care, describe promising practices demonstrating effective family caregiver support, and provide tools and recommendations that address family caregiver needs.

We have an excellent group of speakers today. All of them are experts in health and human service policy and caregiver research. First, we will be hearing from senior leaders at AARP Public Policy and Research Institute: Susan Reinhard, Lynn Feinberg, and Wendy Fox-Grage. We will then hear from Michelle Bentzien-Purrington. For more information about our speakers, please find their bios on our website.

At this time I would like to introduce our first speaker, Susan Reinhard.

**Susan Reinhard:** We are thrilled with the number of people joining us today. We're going to talk about our report that is known as Family Caregivers and Managed Long-Term Services and Support. This is the first major research report in this emerging field. We have been looking at the issues of family caregiving and separately the issues of managed care and long-term services and supports for quite some time at AARP Public Policy Institute, but several years ago, we started thinking about putting those together and determining what is going on as the field emerges larger and larger in long-term services and support. What do we know about how those organizations work with new family caregivers, and what kinds of supports do they offer them?

We actually did a round table a number of years ago. At the end of that round table, which was really to discover what might be going on, the group there said we want to keep talking. They asked us to form a learning collaborative, which Wendy and Lynn have been facilitating. I just want to acknowledge they have given us a great deal of information and support in pursuing this area.

So just a bit about the rationale. Why would we look at this? Of course, I'm sure that the folks who have joined us on the phone are doing so in part because they already know that family caregivers are providers

of care, both in acute care and in long-term services and support, but we want to emphasize that some, and perhaps many, family caregivers are in need of support themselves. They are care providers and often in danger of becoming clients themselves. The field is rapidly expanding, and we are already finding that managed care plans can lead the way to more person and family-centered care. We need to learn more about what is going on in the field now.

This is an emerging issue. We know, or at least we think we know from this learning collaborative and the work that we've done thus far, that family caregiving support is not typical. It's not expected in managed long-term services and supports, and therefore it's not commonplace. The focus has been on the individual member, the beneficiary as we say, not the family unit. Consumer organizations, including AARP and others, have focused on preventing harm and making sure consumer protections are in place, but there is much more we need to be thinking about. We are thinking and finding that there's several promising practices currently in place and lots of opportunities for plans to better support family caregivers so they can do their job and perform the kinds of support they give to that beneficiary.

These are estimates from a study we did with the National Alliance for Caregiving and AARP Public Policy Institute in 2013. An estimated 40 million family caregivers provide about 37 billion hours of care. This is a huge amount of care, and most, 60%, are working as well. They have a paid job as well as working in the field of family caregiving.

This is the survey we did with Carol Ravine of the United Hospital Fund in 2012. We were looking at what the job of a family caregiver is. We know bathing, dressing, shopping, and the usual activities of daily living. We wanted to look at what they were doing in complex care like mood care, administering injections, managing multiple complex medications, operating specialized medical equipment, different dietary needs, and a whole range of other care activities. Wound care is a big one.

We found that about half are doing those kinds of tests now, and that's another whole area we can fill you in on, but we think that managed long-term services and support organizations should be thinking about the full range of what family caregivers are doing including this complex care.

Also, the Public Policy Institute has periodically given estimates of the value of family caregivers to the nation, not only to the person they're caring but to the country. We found in our last one, which we published not too long ago in 2015, that if you had to pay for family caregivers it would be an estimated \$470 billion. We have this by state estimates as well for those that are interested. This compares to the \$75 billion we spent for Medicaid home and community-based services. By the way, it's more than or about the same as the annual sales of Walmart, which is the largest organization like that in the world. It's a huge amount of money.

I'm going to turn this over to Lynn to talk about caregivers themselves and how they are vulnerable and at risk. Lynn, let me turn it over to you.

**Lynn Feinberg:** Thank you, Susan, and hello, everyone. It's a pleasure to be here today on this webinar with my colleagues, Susan and Wendy and also with Michelle. Let me start by saying that family caregiver support matters because chronic illness and disability affect the family as well as the individual person. We know from 35 or more years of research that shows that many family caregivers experience daily struggles, worries, and frustrations. It's these family caregivers that are vulnerable and at risk themselves. As Susan said earlier, not all families need help, but many do. Family caregivers can experience enormous stress from their responsibilities and from the physical demands of intense and complex care. They experience financial burdens with high out-of-pocket costs.

AARP research finds that family caregivers spent, on average, nearly \$7,000 in out-of-pocket costs on caregiving alone in 2016. Then there are workplace issues from juggling caregiving and work because most family caregivers are in the labor force, and we also know from research that family caregivers age 50 and over who quit their jobs to care can lose an estimated \$304,000 in lost wages and benefits over their lifetime. That's a lot of resources, which leads to potentially retirement insecurity in their old age. Then there is also emotional strain and mental health problems that family caregivers can experience; depression and anxiety are common. Last, but certainly not least, is the social isolation from heavy care needs that a family member or a close friend may be involved with, and we know that social isolation impacts health and well-being.

So people with self-care needs rely on their family and friends to remain in their communities, but the stresses on caregivers can lead to negative consequences. The stress can impede the caregiver's ability to continue providing care, which is a main incentive for providing support to families early on. It can lead to higher costs for healthcare and long-term services for health and support for the member or care recipient, especially if the older adult moves to assisted living or a nursing home and can affect quality of care and quality of life for both the care recipient and family members. Research shows that high caregiver stress is an important and highly significant predictor of a person's place in a nursing home, and negative impacts are especially the case when family members are caring for somebody with dementia.

Although families are viewed as the backbone of long-term services and supports and the main providers of care, the concept of recognizing them and assessing and addressing their own unmet needs is not well understood in policy or practice including in managed long-term services and supports. Yet, we know that support for family caregivers is a key component of a high performing long-term services and support system, which has been documented twice in the AARP state LTSS scorecard. I guess I'll give a plug for the third edition of the scorecard that will be released shortly on June 14th.

So the idea here is that practitioners must consider not only how the family caregiver can help the member or the care recipient, but also consider managed long-term support the family needs to continue in their caregiving role. This is known as a person and family-centered perspective. Using this framework means the family should be viewed not just as resources but also as clients too who can benefit from information, counseling, training, and respite care, for example.

So in the caregiving 2015 survey, that Susan referenced earlier, we found that only one in three family caregivers in this national survey said a doctor, nurse, or social worker had ever asked them about what was needed to care for their close friend. Half as many, only 16%, said a health provider had asked what they needed to care for themselves, simply by asking how you are and what help you might need. So families traditionally have been invisible in the care process.

Managed care plans are well suited to operationalize the recommendation from the recent landmark report from the National Academies of Sciences, Engineering, and Medicine on Families Caring for an Aging America, whereby family caregivers have their own health and well-being considered, their preferences, needs, and strengths recognized and addressed by those healthcare and service professionals, where families are supported, and last, but not least, where payment and delivery evolves from person-centered to the notion of person and family-centered caretaking to take into account both the individual and the family, especially when the care plan depends upon the family caregiver. Annotated payments can incentivize plans to engage and support family caregivers, especially with evidence based programs. We'll be hearing from Michelle with some programs that are operationalized in a few minutes. I'm going to turn it back to Susan.

**Susan Reinhard:** Thanks, Lynn. How can managed care plans help family caregivers? Lynn mentioned

feeling invisible. This is a very common experience among family caregivers across the healthcare and social system.

The first thing is that we can recognize family caregivers. It may not be the next of kin or the legal guardian, but the person who is providing that on-going care. It could be hands-on care or many different forms of care, as I indicated earlier, but we need to recognize them and write them into the medical or electronic health record and the service they are involved in providing services, so everybody is clear who that individual or individuals are that are helping this beneficiary. Once they are identified, it's much easier to include them in participating in the care planning. Of course, you always need the consent of the individual, but the individual is often relying on the family caregiving for services. That assessment is important in understanding the family care unit to be able to proceed. The family caregivers and care coordinators can exchange contact information since the family caregivers are often the one arranging for services and is the one that can answer questions. Again, you need the approval of the beneficiary, but to be able to communicate with each other they have to have contact information.

What kinds of skills do family caregivers need? It might be that basic care, like bathing, dressing, helping people get in and out of bed or more complex tasks like administering meds and wound care, helping people with dementia and dealing with those behaviors that are often very difficult to manage. There is also the process of trying to get referrals to services such as respite care, which are often desirable and needed services.

This is just a map of the states with Medicaid managed LTSS programs. It's one that has to be continually updated. This includes those that already have it and those that are focusing on people with both Medicare and Medicaid eligibility. So you can read that at your leisure and figure out which state you're in and where your progress might be going on. Most of the country is shaded, and that means they are involved in some way in one of these programs.

We did a study with Truven. This was our first systematic way of beginning to look how plans might be including or working with family caregivers. This was a study of care management across contracts at that time in the United States; there were 19 at that time. We asked, in addition to many other questions around care management, which of the contracts acknowledge family caregivers in any way? How does that show up? Are care coordinators provided information? Is contact information given to family caregivers, and is there any mention of training? Is educating and supporting family caregivers a covered benefit?

You can see 15 out of the 19 mention family caregivers in some way. That's a start. Only nine of the 19 have contact information exchanged, and only three explicitly mention training. So that's just a first toe we dipped in in terms of quantitative or qualitative information, but it helped us identify some promising practices. I'm going to turn this over to my colleague Wendy who wanted to share some of that.

**Wendy Fox-Grage:** Great. Thank you so much. Yes, this is Wendy Fox-Grage with AARP. Susan and Lynn both said family caregiver supports in managed LTSS is uncommon. However, there are some promising practices, and that's going to be the highlight of my talk. I'm going to highlight four promising practices. We have two state Medicaid managed LTSS programs, a large national plan, and then a dementia care project I'm going to be speaking about.

First, we will go to Tennessee. TennCare is the first state managed LTSS program to fully support family caregivers in both their contract language and in their protocols. In fact, that language is in our report, and Susan shared the link to that report with you all earlier.

Who's a family caregiver? In TennCare, it is defined broadly. It does not have to be a blood relative or your spouse. Somebody, as Susan said, who is routinely involved in providing unpaid support in assistance to the member. As AARP, we are very supportive of that as well. We also define it broadly. In this program, the family caregiver is typically assessed face-to-face one a year, whenever there's a change or when it's recommended by the care coordinator.

So how does this work? At each face-to-face visit, the care coordinator, while he or she is there, asks how the family caregiver is doing and how they are doing with the care plan. If the family caregiver is concerned in any way, then the care coordinator can conduct a full family caregiver assessment. As Susan and Lynn were saying earlier, some family caregivers need help and some don't.

The assessment may occur for one family caregiver or if there are more family caregivers that would like an assessment, that also can take place. The assessment is a separate assessment from the individual. It is an assessment for that role, health and well-being, or any services or support they might need.

Now, we are going to go to South Carolina. The program administrators in South Carolina spoke with the program administrators in TennCare, and they modeled their program off of TennCare but with a South Carolina twist. That's because every Medicaid program is different. Just to give you a little bit of background, the Healthy Connections Prime program is what we refer to as the U.S. Centers for Medicare and Medicaid Services dual demonstration. That means this is aimed at people who have both Medicare and Medicaid, and it is for older adults. So it's for people enrolled in that program who are age 65 and older. The caregivers are identified up front. Again, they are assessed for risk for burnout, and then they can refer them to a variety of caregiver information education and different covered services. We have some listed there. They also can leverage flexible benefit if it's indicated for more services. One of the things that I really like about Healthy Connections Prime is their partnership with the University of South Carolina's Office for the Study of Aging. They are the ones who have been contracted with to do the trainings for the care coordinators. What is really nice is that the social workers in this program can earn continuing education units, and there are a wide variety of trainings ranging from abuse, neglect, to interviewing skills to care planning. The plans are required to have a caregiver quality improvement project and also required to track respite care. I think this is really important because by measuring respite care and tracking respite care, it is assigned to the plans as a benefit that is important and that family caregivers are an important part of the care team.

Now we are going to go from programs to a plan. We are going to talk about United Healthcare and their Solutions for Caregiver programs. This program is offered to some of United Medicare members and to large employers. They also offer a variety of family caregiver supports through some of their Medicaid programs. Since time is limited, I am just going to show you a few items with their Medicare advantage plans. I did want to point out that caregiver supports are through all of their product lines; I'm just focusing on the one today. In this program, family caregivers can call geriatric experts or coaches, and they can refer them to information and services. Also, geriatric case managers can conduct one in-person assessment at their home if they want or up to six hours of consultation over the phone. So what they can do is a variety of things. They can do an at-home assessment, write a care plan, provide information and referrals, and they can go over different options, different community based options and different residential options.

Lastly, we are going to end in California. This is the Cal MediConnect Dementia project. This is for people with dementia. We know this is a group that is often in need of services because of dementia. This program is part of California's dual demonstration, which I described earlier. Dual demonstration meaning it's for both Medicare and Medicaid beneficiaries in seven counties of that state. This project is run out of the Greater Alzheimer's Los Angeles project, so a big shout-out to Debra Cherry and her colleagues. Even

though it's run by that group, it's in partnership with the California Department of Aging, and then they receive funding for this project through the U.S. Administration for Community Living.

This project has several components to it. One that I like, because you all can download their items for free and they are evidence based, is the dementia care management toolkit. It is developed for both care managers as well as family caregivers of people who are caring for someone with dementia.

I have just a few more items to mention. There is the tool for identifying family caregivers. There's a very good caregiver stress and strain instrument. There's a needs assessment for caregivers. There are fact sheets, and they're in Spanish as well as English. There's also standardized care plans. We gave you the website where you can go and download those. Plans can also make referrals to the Alzheimer's of Greater Los Angeles for supportive services. Again, what is nice about this is that there is an independent evaluator. It's the University of California, San Francisco. So far the results have been positive for both family caregivers as well as care coordinators. With that we're going to wrap it up with some findings and recommendations.

**Susan Reinhard:** Thank you, Wendy. This is Susan again, and you can see our list of findings and recommendations. We've said already that plans should have a strong financial incentive to support family caregivers because we know that family caregivers are the ones providing most of the care in the home to make that possible. Caregiver burnout prevention can delay or prevent costly nursing home placement. As Lynn as pointed out, that research indicating that managed long-term services and support can be a leader here is documented in the National Academy of Science report. We believe that because of the strong financial interest and also the caring ethic, they can bring to this to focus on family caregivers and improving the experience of care for both the beneficiary and the family caregiver. To do that you need to involve the family caregiver, especially when the care plan specifies they need to be involved in the care. It is a big part of that person and family-centered process. We believe that family caregivers need to give feedback; they can tell us more about how they can receive help and perhaps a better way they can be reached. We're just beginning that research.

For next steps, we are commissioning a health associates management partnership to explore promising practices in Medicaid managed care plans. We are doing this through an interview process. This is more qualitative and really focusing on what is working. We are interested in learning, in general, about promising practices, care planning, benefit design, education, training and services that support family caregivers. We have drafted this. We are looking to complete and publish it later in this year. Again, we are also continuing our learning collaborative where we receive a lot of this information as well.

With that, we are going to turn it over to Michelle.

**Michelle Bentzien-Purrinton:** Thank you, Susan, and I would like to express our gratitude to MMCO and AARP supporting this very important group.

To give you a little bit of framework for the information I am going to be providing today, I am going to share briefly about Molina Healthcare. Our organization has been dedicated to serving low income individuals for more than 35 years. We do this through health plans, twelve state managed healthcare plans and Puerto Rico. We operate management systems for state agencies in five states and the U.S. Virgin Islands, and we have a direct delivery provider system in six states. More of a decade of our experience is in providing Medicare and managed services long-term care services and support. Of the 4.2 million members we serve through managed care, more than 226,000 of them are in programs with MLTSS in nine different states. We are fortunate to be able to serve members through the MMP, Medicare Medicaid plan

demonstrations, which have been mentioned in six different states. We are the leader with over 55,000 members enrolled.

This slide provides a little bit of demographic information about the Molina specific members. What is important here is that we recognize the critical role that caregivers play in helping the members maximize their health outcomes and either achieve or maintain independence.

As you can see, cultural diversity and age are both varied amongst these populations, and it is really important to engage the members and their family caregivers in a way that's culturally respectful and responsible. I'll share a brief example from one of our states. We had a member who was at a nursing facility for care but living in the home with the family, and this particular family unit provided all the natural supports and all unpaid. The member expressed a desire to have more social interaction and actually wanted to participate in a day program, but the culture of this particular family and the member was to look to the eldest son for decision and direction. Although many family members were starting to experience fatigue, it was the member's desire to get into a day program at least a couple of days a week. The eldest son felt that accepting that support was not doing their job as the family. So what we were able to do is have our care coordinator engage with a respected member of their community and a friend of the family who over time discussed the desires of the mother with the eldest son and the impact it could have not only on her but on the family unit. Ultimately, the eldest son decided to consent and support the mother in her wishes to attend a day program. As a result, the stress level of the family caregivers was reduced. The mother is benefiting from integration and has actually made friends outside of the direct family infrastructure and is thriving. I wanted to point out the importance of recognizing we serve culturally diverse populations of all ages, and it is important to honor not only the member's wishes but work within the norms of that culture of that particular family.

I would like to talk about implementing best practices. This has been referred by Wendy and Susan and Lynn, and we're going to share with you a few things going on at Molina. Specifically we work at a local and national level with our care groups, community partners, industry colleagues, advocates, and our members directly through advocacy committees and our own advisory committees to identify best practices. There's too many to go through today. I'm going to highlight three from a couple of our different states where we're actually serving members through the demonstrations reference.

First, I want to talk a little bit about South Carolina. As mentioned previously, South Carolina does a couple of unique things in their programs. One includes requiring a quality improvement project focused on family caregiving, which we think is an exceptional practice. Additionally, South Carolina uses a standardized health list assessment. What is particularly valuable about that assessment is that they have adopted and integrated the AMA, American Medical Association, caregiver self assessment questionnaire. When we assess members' needs in South Carolina, as long as the member and caregiver consent, we actually assess caregiver needs. I'm happy to report in South Carolina over 60% of our members have provided consent and our family caregivers have elected to participate. We found that on a scale of one to ten, ten being the highest level of stress and fatigue, 32 of 258 caregivers actually were at a six or higher. We employed two interventions to help assist in this process. First, all caregivers receive a Molina caregiver toolkit. This toolkit is a reference document that we produced in the preferred language of the caregiver with providers' tips for assessing their stress and depression, organizations that may assist them, support groups, information about contacts at Molina they can reach out for a lifeline and the members they serve. We provide contact information sections so they can keep all contact information for the member they serve, the family member, Molina, their own health support professionals, community resources, and the resources with the members they serve in one place. We provide tips and techniques on how to be organized and organize important information for themselves as well as those they serve. So everything is in one

place. We've received exceptional feedback from the caregivers and the members on. Additionally, for those caregivers at high risk of burnout and stress based upon the six or higher score, we are employing an intervention directly with the caregiver should they elect and thankfully 100% have.

So in addition to checking in on the member both face-to-face and by phone, we also interact regularly with the caregiver, both with the member involved and on a one-on-one basis. We work with them to try and help them achieve their goals of reducing their stress levels, gaining additional training, and participating in support groups to assist them.

Now, I would like to move on to California and their Cal MediConnect program. Debra Cherry and her team do an amazing job. They have provided training to our care coordinators. Additionally, we have incorporated not only their screening interview and caregiver stress instrument but additional tools made available to the members and caregivers that support the members we serve. We have also found that through monitoring the stress levels of those caregivers, we are seeing reductions in stress by employing several of the same interventions that I described in South Carolina.

A second program that we implemented in California for Cal MediConnect members included a grant. There is a training organization that does an amazing job providing caregiver trainings around stress reduction, CTR, wound care, and how to care for members. However, they had no content for managed care, integrated care teams, and how to leverage resources available to you through managed care systems. Additionally, these caregivers had no incentive to attend the training. So through the grant that Molina provided, it became a paid training incorporating content with integrated care management, the purpose of an integrated care team, and how to talk with your member about being a part of that integrated team.

We would like to call out some of the feedback we got as a result of that caregiver training. First of all, people are very satisfied with the training. We found that most of the caregivers were unaware of the value that their managed care organization could bring to them and their members. Most of them were unfamiliar with the role of the integrated care team, resources available to them and the member, and not even aware of how to have a conversation to become part of the integrated care team.

As a result, we have seen an increase in members who want their caregiver as part of their care team, and we are happy to report the caregivers have been participating. Additionally, we have also seen an increase in utilization of respite as we focused on the needs of the caregivers and how we can best support them in helping the members achieve their health outcomes, high levels of independence, and help them remain in the community-based living environment.

With that I'm going to close out and turn it over for questions.

**Caroline Loeser:** Thank you so much, Susan, Lynn, Wendy, and Michelle for your presentations. This has been incredibly informative. Thanks so much for joining us today. We have a few minutes now for questions from the audience.

Susan we have a question directed towards you. They asked if you could please provide more information about the learning collaborative that you mentioned, such as membership structure and current focus.

**Susan Reinhard:** I'm going to turn that question over to Wendy who is sitting next to me because she and Lynn are doing most of that coordinate.

**Wendy Fox-Grage:** Sure. I am happy to discuss it. As Lynn said, it grew out of this round table that we

had. So, it is a monthly hour phone call, and we hear from a variety of speakers. It is very interactive where you can ask questions. We've had different speakers from different plans. We've had federal officials and state administrators. It's really just an informal opportunity for us to share, and it very much is an emerging field. We have found it's important for all of us to keep talking to each other each month.

**Caroline Loeser:** Thanks for expanding on that. We have a question specifically for AARP. So in the Truven study, what were the three state contracts receiving training for family caregivers as a covered benefit?

**Wendy Fox-Grage:** We do. The three states with training are Tennessee, South Carolina, and Wisconsin.

**Caroline Loeser:** Thank you. We have another question that came in. I think this can really speak to all of our speakers today. Are there any standardized measures that states should use to determine how effectively MLTSS plans are addressing caregiver needs? If so what are these measures?

**Susan Reinhard:** This is Susan. I think it is pretty early to do that. In a hospital with the acute care world, there are measures. The HCAPS measures get to some things around family, but, unless Lynn you have some thoughts on that, I think it is rather early to have national questions or survey items. Speaking of the scorecard, we don't have any measures of quality and community-based services across the country, so it is hard to develop those measures.

Lynn, if there's anything you want to add?

**Lynn Feinberg:** Sure. I would just add that there isn't that magic bullet. There isn't that one uniform caregiver assessment out there, although I know having talked with a number of plans many people are interested in going in that direction, but there are resources out there. One thing I'll just throw out is our colleagues at the Family Caregiver Alliance in San Francisco with a partnership with the Benjamin Rose Institute in Cleveland put together a resource inventory about two years ago of a variety of different measures looking at caregiver needs. That could be helpful to plans as they are deciding what questions and what measures to look at to determine the best need for services and then for outcomes. So that might be a tool that would be useful.

**Michelle Bentzien-Purrrington:** This is Michelle to add on. I agree it is early for such work. There is currently a great deal of focus on quality based measures for managed long-term services and support programs, and there have been many discussions about how to incorporate caregiver feedback. It is a topic of interest to all of us, and I can also say that while that work is evolving and emerging, Molina as well as several other health plans I'm aware of, have great interest in caregiver feedback and are directly engaging in caregivers to solicit that feedback. While the work is emerging at a national level, there are things care plans can do to serve caregivers and get feedback immediately.

**Caroline Loeser:** Thank you for elaborating. Michelle, we have a question for you. For the family training, was this required in the NCO contract or was this something Molina provided on their own accord?

**Michelle Bentzien-Purrrington:** If we are referring to the training program that we offered, Molina did that of their own accord based upon our own observations from our care coordinators as well as strong relationships we have. In California, it is called in-home service and supports, which are training centers that support those functions. Through those collaborations, we identified a gap in the needs, so we elected to provide that grant of our own accord. Now, the training that is offered to the health plans or care coordinators in South Carolina for managed care plans was part of a contractual requirement. Although in many states where such training is offered, Molina elected to voluntarily participate because we find it

extremely valuable.

**Caroline Loeser:** Thank you, Michelle. We have another question that I think all of our speakers can address today. Do you consider exercise or healthy living programs as useful resources for caregivers to access under a managed care plan?

**Susan Reinhard:** AARP is focused right now on healthy living initiatives and see these kinds of programs as helpful to the beneficiary as well as to family caregivers. Exercise is for the mind body and spirit, so it is a very holistic approach to improving the well-being of the person and the family.

**Michelle Bentzien-Purrington:** Absolutely. This is Michelle. We wholeheartedly agree. Providers refer caregivers to community-based programs and other resources, so they're focusing on their whole holistic approach to health and wellness.

Caroline Loeser: Thank you. We have a general question here as well. Are there evidence based support services to help family caregivers? Anything that is specifically evidence based?

**Lynn Feinberg:** There are evidence-based caregiver support services. Most of the proven programs that have been evaluated through randomized clinical trials, really the gold standard of research, have focused on family's care for people with dementia. We will be releasing, at AARP Public Policy, a paper probably in the fall on these evidence based practices. There really are programs that need to be taken to scale and spread across the country that show they make a difference in the quality of life for the family caregiver as well as the person with dementia. We also need to encourage more research to develop evidence-based programs for families who may be caring for people with other chronic conditions or with multiple chronic conditions too, but there is an evidence-base out there. We just need to get these programs and services into health plans and community-based organizations, so families can find the help they need.

**Caroline Loeser:** Thanks, Lynn. All right, Michelle, we have a general question for you here. What is one of the biggest takeaways that you discovered while implementing caregiver support for Molina members? I don't know if you could just answer the biggest takeaway, but if you could maybe just highlight some of your top thoughts on that.

**Michelle Bentzien-Purrington:** Absolutely. Probably one of the things we see most frequently is that there's been several references to current long-term services and support models being person-centered but they are specifically member-centered and do not extend to the caregiver. So one of the things that we focused on and the biggest takeaway is to help members recognize how natural supports play a significant role in them achieving dependence, and they are helpful. By doing so and raising that awareness for something that's around them every day and that they may be taking for granted, we are able to help wrap support around the caregiver to extend the longevity of the time they are able to continue to provide quality support and service and care for their loved one. That is probably the key takeaway. Do not be so focused on the member that you do not look to see what is really integral in supporting that member and achieving their goals. I don't know if Wendy or Susan or Lynn have other insights to add.

**Wendy Fox-Grage:** We couldn't agree you with more. Beautifully said.

**Michelle Bentzien-Purrington:** Thank you.

**Caroline Loeser:** All right. We have another kind of broad question for you here. Can you speak more about your next steps as an organization and exploring promising practices in Medicaid Medicare plan?

**Wendy Fox-Grage:** I mentioned research we are currently doing with health management associates, and I think that will lead us to trends such as the patterns and interests. We will also likely have a convening in November with at least some of those organizations and perhaps our state offices and other experts in family caregiving to discuss it.

I call ourselves a think and do tank. Our goal is to get the research that makes something happen from the research. I'm not sure what other research we need as much as to continue to get the word out and to spread these promising practices.

**Caroline Loeser:** That's great. Thank you for sharing. Do any of you have any recommendations for care managers serving beneficiaries living in long-term care that can help engage families or unpaid caregivers?

**Michelle Bentzien-Purrrington:** This is Michelle. I will take a first jab at that. Yes, care managers and care coordinators are amazing at thinking outside the box. A few things I've seen, as I've visited folks particularly those in long-term care, is that it may be difficult to engage family members due to scheduling issues or where they are living geographically. So one of the things we do is employ technology to engage family members. Even though the members we serve do not always embrace current technology, we find their family caregivers thrive on it. Interacting in secured HIPAA compliance, text applications can all be helpful. You've really got to hone in on what are the individual's specific needs of those family members and what are the barriers preventing the engagement and interaction, and then devise a plan around that. It's exciting and fun to do. That is just one example.

**Lynn Feinberg:** I'll just jump in on top of Michelle to say that in monthly care planning meetings in nursing homes, which include the beneficiary living in the nursing home, may have the family member either present at that meeting or conferences by using technology or can simply be a conference call with the family caregiver. The adult daughter or son, for example, may be living in another state but can still call in and be part of that care team, so everyone is on the same page about the person's goals and outcomes.

**Michelle Bentzien-Purrrington:** Absolutely. It is also a way to engage with family events. When you are in a long-term care, you can Skype into a birthday party and guess what? Great grandma gets to see and be part of a life event. It is pragmatic and practical to leverage that technology for involvement in the care process but also for socialization and engagement and staying connected. These are really important opportunities care managers can employ.

**Caroline Loeser:** Great. Thank you all for sharing. I'm glad we were able to get that last question right in. If anyone has any additional questions or comments, please e-mail us at [RIC@Lewin.com](mailto:RIC@Lewin.com).

The slides for today's presentation, a recording, and a transcript will be available on the Resources for Integrated Care website shortly. As a reminder, if you do have any questions, please don't hesitate to e-mail us at [RIC@Lewin.com](mailto:RIC@Lewin.com). Thanks again to all of our speakers. Have a wonderful afternoon, and thank you so much for your participation.