

The Lewin Group
Promising Practices for Meeting the Behavioral Health Needs of Dually Eligible Older Adults

August 2, 2018
2:00 p.m. EDT

Evan Vahouny: Thank you. My name is Evan Vahouny, and I am with The Lewin Group. Welcome to the webinar, *Promising Practices for Meeting the Behavioral Health Needs of Dually Eligible Older Adults*. This is the third session of our 2018 Geriatric Competent Care Webinar Series.

Today's session will include a 60-minute presenter-led discussion followed up with a 30-minute Q&A among the presenters and participants. This session will be recorded, and a video replay and a copy of today's slides will be available at https://resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar_Series/Behavioral_Health_Needs. The link to the website is provided at the bottom right of each slide.

The audio portion of the presentation will automatically stream through your computer. Phone lines for this presentation are also available. To access that number you can click the black phone widget at the bottom of your screen.

Should you have questions, now or throughout the presentation, feel free to enter them into the Q&A feature on the platform. We will be addressing your questions for our speakers during the Q&A portion of this webinar.

Continuing Medical Education and Continuing Education Credits are available at no additional cost to participants. AGS is accredited by NASW to provide continuing education for social workers. CMS is accredited by IACET to issue CEUs and also accredited by ACCME to issue CMEs. We strongly encourage you to check with your specific regulatory boards or other agencies to confirm that courses taken from these accrediting bodies will be accepted by that entity.

You will see on this slide that we have laid out the various credit options. If you are a social worker you can obtain continuing education credit through NASW if you complete the pretest at the beginning of the webinar and complete the post-test. CMS is also offering CEUs and CMEs for other individuals looking to obtain credit for attending this webinar. To obtain these credits you must complete the post-test through CMS's Learning Management System. Additional guidance about obtaining credits and accessing the links to the pretest and post-test can be found in the Continuing Education Credit Guide in the Resource List on the left side of your screen or at the Resources for Integrated Care website.

This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) at the Centers for Medicare & Medicaid Services (CMS). MMCO is developing technical assistance and actionable tools based on successful innovation and 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 at [Integrate_Care](#).

At this time, I would like to introduce our speakers. Our first speaker, Dr. Neha Jain, is an Assistant Professor of Psychiatry and Assistant Program Director for the Geriatric Psychiatry Fellowship at Uconn Health. Our second speaker, Andrea Lovell, is a family caregiver who will talk about her experiences with her mother, who receives care from Dr. Jain. Andrea is also a licensed professional counselor.

Molly Rees Gavin is President of Connecticut Community Care, a statewide nonprofit that identifies choices and provides services to help people of all ages, abilities, and incomes to live at home. And Sabrina Wannamaker is a Clinical Manager of the Behavioral Health Case Management Team at Absolute Total Care.

On this slide, you will see our learning objectives for today's webinar. We hope that you will learn about common behavioral health conditions among dually eligible older adults, be able to recognize effective treatment options, identify practical tips and strategies, and identify new opportunities for collaboration.

So, that concludes the introduction, and now I will go ahead, if you go to the next slide, I will now turn it over to Dr. Jain. Dr. Jain?

Neha Jain: Thank you, Evan, and good afternoon, everybody. I am very excited for this opportunity to talk to the group about a geriatric psychiatrist's perspective on meeting the behavioral health needs of dually eligible older adults.

What are the common conditions that we see among dually eligible older adults? First of all, they are much more likely to have a behavioral health diagnosis compared to Medicare-only beneficiaries of their age group. The most common behavioral health conditions that we see in this group include Alzheimer's disease or other dementias as well as depression.

Substance use disorders are also fairly common among older adults, mostly tobacco, alcohol, as well as psychoactive prescription drugs. This can be a significant factor in how the disease progresses and what the prognosis is, as you can imagine.

One of the challenges that we see with older adults and substance use is that they often experience symptoms like pain or anxiety or insomnia as they get older and are more likely to be on prescription medications. And then this becomes a challenge as the aging brain becomes more vulnerable to the side effects of these medications. They also tend to have lower levels of family support as well as financial resources in comparison to Medicare-only beneficiaries, which makes this sort of a double challenge to treat.

As a provider what are the common challenges that we see when we are caring for dually eligible older adults with a behavioral health diagnosis? The biggest problem is that less than 3% of all adults that are 65 and older actually see a mental health professional for treatment. This is a rate lower than any other adult age group.

And the reason for this is things like stigma around behavioral health problems, this discrimination that people feel that they would be subjected to if they sought help. Some misconceptions like depression is a normal part of aging. No, it's not. This idea that if as an older adult if you have a mental illness or a substance use disorder you will not be able to recover, which is not true. And, lastly, and this one really bothers me, this idea that older adults are no longer productive members of society so it really doesn't matter, which is absolutely not accurate.

There is also a high prevalence of comorbid physical health conditions, which makes it a challenge. And, lastly, the poverty and isolation that a lot of these older adults live in can be quite challenging and provides issues like trouble with access to care and lack of resources.

So, briefly, considering some challenges when prescribing medications. As we get older the way our body processes medications and the way the medications affect our body changes. So older adults tend to have more side effects as well as more intense side effects, which makes medication treatment a challenge. They're more likely to have multiple medical conditions and to be on multiple medications, both of which can be problematic, and we'll talk about this in more detail later.

And usually what I suggest to residents and trainees is start low, go slow, and sometimes you have to keep on going. So the other thing I see is people start low, they go slow, but then they stop because people are not getting better, when oftentimes it's a matter of keep on going until you get to a therapeutic dose.

Our focus today is going to be on one behavioral health condition in particular, which is late life depression. Late life depression can be defined as depression in anybody above the age of 60. This could be a recurrent depression, somebody who has been depressed for most of their life and are now depressed again. They just happen to be older than 60. Or it could be a new onset depression. They've never been depressed before but are now depressed. This is also called late-onset depression sometimes.

The prevalence of late life depression among dually eligible elderly is actually quite high, close to 19 percent. And some of the challenges that we see in this population with late life depression -- this is very important, I think, for people to be aware of, that the depression may not present in its typical way. It may not present with sad or low mood or crying spells. It's quite likely to present with unexplained physical symptoms like pain or fatigue or even with vegetative symptoms like sleep changes and appetite changes, because these are expressed more easily.

Oftentimes there are comorbid medical conditions, the common ones, such as hypertension, diabetes, heart disease, for us to be aware of. And then this next one, cognitive decline, this is something we'll talk about in more detail, because cognitive decline and late life depression seem to go hand in hand, and it has significant impact on management of the symptoms.

Suicidal ideations. Both suicidal ideations as well as successful completed suicides are more common in the elderly, which makes it a very vulnerable population. And, again, people are on

multiple medications, so there is polypharmacy and there are more side effects with these medications.

And, lastly, treatment resistance. People, elderly people, particularly, don't respond as quickly and as well to medications as younger populations do, which can make it a challenge.

So, late life depression and cognitive impairment. Broadly speaking, the idea is that the brain's circuits that are disrupted in depression overlap with the same circuits that are disrupted in cognitive impairment. So, having late life depression predisposes individuals to cognitive impairment, and some researchers have gone as far as to say that late life depression is a risk factor for a development of cognitive impairment or a dementia.

Older adults with late life depression have limited response to treatment with antidepressants. Treatments do work, but not as well as they do in the younger population. And then if they have a cognitive impairment it limits their ability to participate in nonmedication measures such as psychotherapy or exercise programs, which, again, adds to the challenge.

So, what do you do if you are actually seeing somebody that has both depression and cognitive impairment? I think addressing the cognitive impairment as a separate issue is quite important. That can be done through medication such as cognitive enhancers, medication for the behavioral and psychological symptoms of dementia such as sleep-wake disturbances or anxiety; talking about aid for daily management, such as keeping lists and calendars and labeling things in the house; discussing the use of safety aids like alarms, life alert systems, locks on doors if there is a wandering risk; communicating well with the patient. If they need hearing aids or other assistive devices making sure they have access to those, as well as with the caregiver, discussing both the diagnosis as well as the prognosis of the cognitive impairment. And then referring patients to outside resources, community resources like local chapters of the Alzheimer's Association, specialized dementia clinics, or national resources such as Centers on Aging.

So, talking briefly about how we treat depression with medications, the first-line medications are SSRIs and SNRIs, so medications like citalopram, escitalopram, paroxetine, SNRIs like duloxetine, venlafaxine, (inaudible). These are our first-line agents. If people don't respond well we sometimes end up using tricyclic antidepressants, which work well but have a worse side effect profile for the elderly. We use low-dose atypical antipsychotics for augmentation quite a bit, and atypical antipsychotics may be beneficial for the elderly who are emaciated or have a lot of weight loss with depression because they can help with some weight gain.

There are atypical antidepressants like bupropion or mirtazapine. And, lastly, there are non-antidepressant augmenting agents like the thyroid hormone or stimulants like methylphenidate or even lithium.

Moving beyond medication, there is evidence that psychotherapy is quite useful for treatment of late life depression, particularly cognitive behavioral therapy, or CBT; interpersonal therapy, or IPT; as well as group psychotherapy. There is research showing that exercise has a small but significant impact on depression, and that should always be discussed with a patient or a client.

Electroconvulsive treatment, or ECT, remains the gold standard for treatment-refractory depression, with excellent response rates, anywhere from 70 to 90 percent. ECT is also a well-tolerated and effective treatment for post-stroke depression in the elderly, which is extremely common.

And now there are emerging new neurostimulation techniques like transcranial magnetic stimulation, or TMS, which uses magnets to provide a small current in the brain, or deep brain stimulation. And there have been a lot of recent studies showing their usefulness in the treatment of depression.

So, some useful tips for providers when you are attempting to provide coordinated care for the elderly. The first and the most important thing, in my opinion, is to build an interdisciplinary care team. This could include a geriatric psychiatrist. It could include a geriatrician or primary care provider, a therapist, a program counselor, social workers, case managers. The more disciplines you include in your team the better off you will be.

And then ensuring that everybody actually talks to everybody else. And the way we like to do this is with a closed-loop communication. So, for example, say the primary care doctor sees the patient and refers them to me. I see the patient and I loop back to the primary care provider, saying thank you. I saw your patient. This is what I think. Blah-blah-blah. Then I make a referral to, say, a social worker and a psychotherapist. They both see the patient, and they loop back to me saying thank you for the referral. We saw your patient. This is what we think. Blah-blah-blah. And so we're all communicating with each other, utilizing whatever tools are available to us.

I'm a big proponent and believer in electronic health record portals, because they're HIPAA-compliant, they're documented. It's a nice way to back and forth. But when it comes to communicating with patients, a lot of older adults are not tech-savvy or don't have access to a computer or the internet. So, using phone calls using good, old-fashioned letters. The most important thing is to establish what the preferred mode of communication is, and then using that mode of communication as often as you can.

Working in partnership with community supports. So, this would include home health aides, visiting nurses. Again, what I like to do is obtain collateral from them before seeing the patient and then providing updated recommendations to them after seeing the patient. Also letting them know that if anything changes, even in between, please give me a call. Let me know what's going on. And I cannot emphasize the importance of this for the dually eligible elderly.

And lastly, adopting more of a comprehensive biopsychosocial spiritual approach. So, to give you an example, if I see a 75-year-old lady who comes in with, say, depression, as well as cognitive impairment, there is a family history of the same, but her depression's worsened after her spouse's death. The spouse was very controlling, and he was doing all of the driving and the cooking, and how she feels helpless. She has withdrawn from her social activities because now she is a widow, and they can't do couple activities anymore. Then she stopped going to church.

So I could give her an antidepressant, but it's just as important to address that learned helplessness that she learned in her relationship but she can no longer rely on, just as important

to address that social isolation and encourage her to increase those social activities, and just as important to address the spiritual aspect, where she's got a double whammy. She can't drive to church anymore, and her spouse died, so she's sort of conflicted about her relationship with God. So it's important to address all of these factors when we're developing a treatment plan.

Managing medical conditions as well as medications, anticipating common side effects, side effects such as sedation, low blood pressure that can then make people dizzy and have falls, constipation, confusion, these are very common in the elderly. It's very important to be aware of these.

Avoiding duplicative medications, clarifying brand name versus generic, because if you had a discussion using a brand name and then the patient gets a bottle with the generic on it they are going to be confused. So I often make a point of providing both the names, one in brackets written down. Clarifying doses. Clarifying frequency for as-needed medications. If it's an as-needed medication you can take it up to twice a day, up to three times a day. And trying to simplify the medication regimen as much as possible.

Addressing the medical problems, so considering how the physical conditions are affecting their mental condition. So if I see somebody who has chronic pain which is now feeding into their depression I can treat the depression, but unless that pain is addressed I'm not really going to be prioritizing their need, and so providing patient-centered care, addressing what is important to the patient when they come in.

Promoting approaches beyond medications, discussing nonmedication options like psychotherapy, exercise, self-care. Encouraging socialization, volunteer activities. And, lastly, but most importantly, probably, recognizing the individual as a whole person. This is a person separate from their disease, separate from whatever they're coming in with today, and making sure that we address that person.

Trying to consolidate treatment as much as possible, getting treatment under one setting as much as possible, because, again, that improves that communication.

Now we will go to Ms. Andrea Lovell for a family caregiver perspective.

Andrea Lovell: Hey, Dr. Jain. Good afternoon to all the attendees, and I truly appreciate this platform to be able to give a brief description and hopefully beneficial of my mom. She is currently 67, and I'm going to go a little further back. In 2013 my mother was residing in Winston Salem, North Carolina. She began to exhibit some concerning behaviors that were reported by family members.

At this time I was residing in Connecticut. We had daily communication and frequent visits, so I believed that she was doing quite well. At the time she lived independently. She drove her car at least two to three times a week to and from activities such as the Y and church services. After receiving these reported concerns I flew to Winston Salem to assess exactly what was going on with my mother at the time.

The reports and concerns expressed by family were that my mom was exhibiting some obsessive thoughts about her committing Medicare fraud and that she was being watched, and became very paranoid. Once there I began the process to have her assessed. And these were some of the challenges and obstacles that we encountered.

Knowledge of the behavioral health service system in Winston Salem and access to information. When I was finally able to get her evaluated it was through the emergency department. The process for admission for a behavioral health bed wasn't explained. The process, down to minor details such as restricted visitation hours in the inpatient unit wasn't provided. No one called for collateral information regarding her medical or prior mental health history. And Dr. Jain touched on how important some of that, most of that is for diagnosing and treatment.

After several days of talking and meeting with their care plan team I made a decision to relocate her back to Connecticut. And during her first year back I identified a prescriber and therapist that she saw routinely. And she remained stable for approximately a year until her second inpatient in January 2015. The regression at that time and currently continues to be unknown. Since then she's had a third hip replacement surgery and suffered a severe ankle fracture, which led her actually to be out of her home for eight months and in a rehab facility.

The medical issues have continued to exacerbate the mental health issues, which has led to two additional inpatient stays, the last one as recently as this past April. Dr. Jain, I'll turn it back over to you.

Neha Jain: Thank you, Andrea. When I first saw Andrea's mom she had had those two recent episodes of psychosis and she was inpatient in the hospital where I first saw her. She was already on the medications but still having a lot of delusions about having committed this fraud and that she was going to be arrested and imprisoned.

She ended up receiving acute electroconvulsive therapy, acute ECT, with good response. And then she was discharged from the hospital. She was doing quite well. A few months later I actually saw her in the outpatient setting since they decided to transfer care, and she was doing quite well. She was on her medications and she was doing well. But then that coming winter she declined again. The depression came back. The psychosis, the delusions came back.

But we were starting to recognize these by now. So we planned doing outpatient ECT, because she absolutely did not want to go back into the hospital if that was avoidable. But unfortunately the referral was made, and then she ended up having that fall with the fracture, which led to her getting hospitalized, and then several months' stay in rehab, and she couldn't get ECT. So when I saw her again several months later after she got out of rehab she was still fairly sick. So we made another referral to ECT, and she ended up getting outpatient ECT as well as maintenance, and she continued on medications.

And she did well for a while, but then she developed EPS, movement side effects, with these medications. So she developed some tremors, some stiffness and trouble walking, and she couldn't do all the things that she used to do, and family had to establish services with aides who would come into the home to assist her with these things.

And then she did okay for a while, and she developed a medical condition which was very painful and led to worsening of her anxiety. Ended up getting hospitalized for that medical condition. Had surgery. After the surgery the condition improved and her anxiety improved.

However, when she was discharged from the hospital, due to some sort of a translation error, her antipsychotic was accidentally lowered, and she continued on that lower dose. And it was very interesting, because I saw her at a follow-up and the caregiver -- not Andrea, the residential caregiver said to me, well, she's doing great since you lowered the medicine. And I said what? And so we went back and reviewed the medications and she was on a lower dose. So initially she looked great, and then her symptoms returned. Then she ended up receiving ECT again, which again led to improvement in symptoms.

But the point of the slide is to highlight those same challenges that Andrea talked about, the challenges with medical comorbidities, with communication between providers, with making sure that medications are transferred correctly from one setting to the other that a lot of people face.

So for the past few visits since I have been seeing Andrea's mom she has been doing well. She is currently receiving outpatient maintenance ECT once every few weeks. And, again, providing this continuity of care, making sure -- another incident that happened when she was last in the hospital was that I received an email from the doctor saying she's doing much better. We're thinking of discharging her.

And it just so happened that I was on call and I went in to see her, and she seemed very delusional to me. So then I spoke with Andrea, and Andrea said no, she is still delusional. She has just stopped telling the doctors what's going on. And so I was able to then reach out to the inpatient team and say, hey, we still think she's very sick, and then they made the decision to do some more ECT while she was inpatient. So providing that continuity, and imagine if we were all in a different setting. It would've been next to impossible.

Now she's doing well in terms of the mood and the delusions, but the quality of her life remains impaired. There's a lot of things that she was able to do that she can't do anymore. And, again, family is considering the move to an assisted living with more assistance. And the last time I spoke with her she's obviously ambivalent about it, because she likes being where she is, but, again, it has limited her quality of life.

So, we wanted to highlight some tips for caregivers, and I'll take this back to Andrea in a minute, that we've found helpful for caregivers when dealing with complicated situations like this, or really any situation where you're taking care of an elderly person.

Number one, making sure that you have an accurate and updated medication list. It's very helpful if you can do this on a computer document like Microsoft Word or Excel, because then you can just delete and add and change stuff. Don't forget to list supplements, over-the-counter medications, as-needed medications. If you bring the list to the doctor make sure they make a copy and take your list back, or have your own copy before you give it to them.

Another thing, make a list of questions to ask the doctor. It's very common if I'm seeing 20 people in a day for me to forget somewhere along the line that this person may be completely unfamiliar with the system. So asking questions like, well, once we leave here how do I contact you. What do I do if there's an emergency overnight? Do you have a social worker? What do I do if you're asking me to keep track of sleep? How do you want me to do that? Is there a chart? Is there a form I can use? If you go away, who's going to be covering for you? There are no silly questions, and anything that gives you more information will be useful to you.

And lastly, and, again, I want to highlight this, please do not hesitate to ask for help for yourself. Caregiver burnout is a huge issue. It's a very significant, real issue. And help is there if you need it.

And I will go back to Ms. Lovell for her insights as far as caregivers and tips that could be useful for caregivers.

Andrea Lovell: Thank you, Dr. Jain. So, my tips over the past five years of this journey with my mom would be these.

Don't be afraid to ask questions, as Dr. Jain has highlighted, or express concerns. Keep accurate and up-to-date medical records at all times. Building a supportive network, like she just mentioned, for yourself to aid you through this process, I can't express how beneficial that's been for me to have such a supportive network around me to help me be the best advocate for my mom.

I would also say research as much as possible. Build your own knowledge, and become better informed. Understand your legal rights to act on your loved one's behalf or as a caregiver, because I know initially early on that was -- that's an obstacle that we encountered. I thank God that my mom had things in place early on like power of attorney and her will and everything, but had I not had those things it would've restricted me to decisionmaking in this process.

Building a strong treatment team, like Dr. Jain mentioned. Our family is so blessed to have Dr. Jain and the other providers and caregivers that are aids in our life that help on a daily basis to keep my mom stable. And even when these inpatients have occurred they've been, as the years have gone on, addressed a lot sooner, and we've been able to catch things a lot quicker because the communication is there.

And last but not least I'd say don't be afraid to be a ferocious advocate. And I thank everybody for their time.

Neha Jain: So, just to summarize, dually eligible older adults are a uniquely vulnerable population because of all of the challenges we just talked about. Management of behavioral health conditions in this population is complex and challenging. The episodic nature, the waxing and waning of behavioral health conditions often makes treatment a moving target. You address one thing and something else pops up. And that's why having a multidisciplinary and multimodal

approach, incorporating not just pharmacological but also psychological, biosocial, and spiritual methods is very useful.

Thank you so much for your time, and we will go to Ms. Molly Rees Gavin next.

Molly Rees Gavin: Thank you so much. It is an honor to be participating in this webinar. And I wanted to just take one moment to particularly thank Andrea. It's far easier for the rest of us to be talking about this very challenging issue from a professional perspective, and the truth of the matter is that Andrea is talking about this not only from a professional perspective but regarding her mom. And so, Andrea, I just want to say a special thanks and a special vote of confidence to you for doing that.

I was delighted to see in the initial poll that many of you are social workers and care managers, and that is the profession that is nearest and dearest to my heart. And so the first thing I wanted to share with you as social workers is what I think are aspects of our social work role that are not necessarily unique. They might be unique, but not always, but are the skills that we really bring to this intervention.

And the first of those is the fact that we are looking at individuals from the perspective of individual in family, whatever that family may be. Individual in family, that doesn't have to be blood relatives. It's who the individual considers to be their family. So, as I said, individual in family in community and in society at large, and so that we are very conscious of the interplay between individual, family, community, and society, and we are working with all of those aspects as we are trying to address behavioral health needs of dually eligible individuals.

Secondly, the other contributions of social work historically has been an in-depth knowledge of community resources and of benefit programs available to individuals. And that knowledge of community resources and benefits is the logical consequence of or looking at that individual in family and in community.

Therefore, what I wanted to begin with is to let you know that this dually eligible population differs in many ways from our work with Medicare-only beneficiaries. And we're going to highlight two quick examples of that for you.

Dually eligible individuals are far more likely to indicate that they are in poor health, in fact three times as often listing or indicating that they are in poor health, and, strikingly, needing assistance with three or more activities of daily living, 30 percent versus 9 percent of Medicare only individuals. So we realize that when we have that dual complication of age, health status, and then all of the issues that are associated with Medicaid eligibility in terms of poverty, access, stigma, and so forth, that these result in some very, very significant needs with this population.

We also find that our older adults are facing many developmental changes. And I always find it fascinating that this is an aspect of the aging experience that sometimes we ignore, and it's very important when we're looking at behavioral health challenges. So we know, for example, that the simple impact of retirement on an individual who has worked outside the home can be very significant.

Individuals face a loss of engagement with their co-workers, with the tasks of their work. Retirement doesn't always happen the way that the individual might have perceived it. So sometimes people think that they have been kicked out of their place of employment, their job has been terminated early because of their age. And so the glow of the golden handshake package is not there for everybody.

In addition to that, we find that even those who are not working outside the home experience significant changes as they approach their later years in terms of their role within their family and the fact that they may not be caring for individuals anymore who they were caring with before, or they may have any number of other changes in that role inside the house as well as a role in retirement situations external to the home.

We know that individuals also experience a loss of friends and relatives. And back in my social work school days I remember that we referred to this as the theme of recurring loss. I want to give you a quick example of that from my own family. My dad was one of 14 brothers and sisters, and at this point in time out of that original 14 brothers and sisters there are only two of them left. My Uncle Ronnie celebrated his 91st birthday this year. And he and one sister are the only remaining family members of 14, including all of the spouses and significant others as well as the actual siblings. So when we talk about a theme of recurring loss, loss after loss of friends and family and loved ones, think about my Uncle Ronnie and what that means to people.

We also see that the decline in functional abilities has major impact on individuals in terms of their behavioral health, as people find themselves less able to be independent in various activities of their life.

Additionally, our older adults may face stigma, discrimination, and isolation. And to me an interesting example of a stigma, next time you're in a shop where they sell greeting cards, and I know we're sending less greeting cards now, and more online communication, but take a look at the Hallmark section of your pharmacy and look at the cards for kids to send to their grandparents. And after so many years of education regarding elder issues, note how many of those cards are pictures of animals. The elder is a rabbit. The elder is a squirrel with a hat or an apron on the individual. And so we see that that image of elders is not conducive to people feeling like they are active, engaged members of our society.

We also find that there is more and more research and more and more understanding about what is happening regarding social isolation and our elders. And one recent study suggests that the impact of social isolation is every bit as significant and as threatening to health as an individual smoking 15 cigarettes a day. So we have to be sure that we are doing everything we can to help individuals decrease social isolation.

Here is an example of what that would be in the area of transportation. And here again I'm talking about, at this point, more systems issues, not issues related to the individual. So on the systems issues side, transportation interventions are critical to support our elders and to help them to deal with behavioral health consequences. And, again, it's really important, and I know

all of you know this, you are the expert on your own geographic area, your own community. And we're suggesting some best practices, some things that we have seen work.

Obviously it really depends on what is available to you or what you can create in your own community to support older adults. So we're seeing more and more on the horizon regarding what are referred to as ride hailing apps. I saw recently that MIT Age Lab, AARP Foundation and United Health are teaming up to look at how to make these ride-hailing apps more accessible to older adults, so that people are able to maximize the usefulness of these kinds of interventions. Other examples are obviously Lyft, Uber. People are attempting to find ways to connect these new resources to older adults who may not have historically used the iPhone, used the computer in order to track that kind of a connection, and we're trying to do more and more of that.

In some states there is Medicaid coverage for non-emergency medical transportation. Obviously, we know that this this varies state to state, but it's definitely something worth looking into in your state as a way, again, primarily to provide transportation to physicians' appointments, but can be very useful for individuals who are struggling with that transportation.

Moving past transportation, we're also seeing more and more self-management support programs. Just to name two of them, many of you may be aware of the chronic disease self-management programs, which are becoming more and more widespread in many states so that individuals can attend a series of programs and workshops on chronic disease self-management, diabetes self-management, issues that have to do with falls. There are a number of opportunities for older adults to participate in that kind of self-mastery program.

And using the word "mastery" brings us to the Aging Mastery Program, which is also known as "AMP," again, a vetted intervention that covers all aspects of aging and is highly recommended for older adults who are able to participate.

Another issue that we can definitely support our elders with is any number of lifestyle interventions. And we don't have to necessarily be experts in all of these, but we can help our consumers, help our clients to make the appropriate connections.

So what immediately comes to my mind is increasing physical activity. If that literally means walking around your apartment more than you have been doing in the past, then that's an increase in physical activity. Obviously we want people to be checking with their primary care providers when they're increasing physical activity, but these don't have to be getting people ready to run a marathon. It can be very simple, basic increases that could help to enhance behavioral health issues for our clients.

Hobbies and interests are very helpful. Obviously anything we can do to reduce social isolation and help people to visit either telephonically or directly with families and friends.

The role of getting adequate sleep is critical, as well as eating a well-balanced diet.

In addition, again, social engagement is critical. We're reading more and more, seeing more and more about what we're calling warm line calls. And some of you may remember back in the day

we used to refer to this as telephone reassurance. But this is a peer-run listening line for non-urgent calls, and elders are matched with volunteers who make these phone calls in order to offer social engagement. If your community doesn't have such a warm line call, it's something that you and other colleagues in the community might be able to consider in terms of a potential service development.

We know that meals on wheels, also known as home-delivered meals, are critically important for over 2 million, 2.4 million elders, many of whom are socially isolated, are receiving home-delivered meals, and 40 percent of these individuals say that they would have virtually no or little daily contact with other individuals if it were not for the volunteer who delivers those meals.

And, finally, another opportunity is through Experience Core. And again these are best practice examples for you to consider, which is an intergenerational volunteer-based tutoring program, again, matching older adults with children in high need in elementary schools to provide assistance with reading.

Moving on to Slide 31, I do want to talk a little bit about the social worker perspective and the interview process and share with you my commitment, my belief that that interview process involves the physical, the behavioral, and the functional status of the individual. And, as stated by our previous speakers, the role of an interdisciplinary team is critical to this. And when I say that I say I agree that the broader the team the better.

I also want to say that if in your local community you don't have a geriatric psychiatrist, then work with the staff that you do have. Work with the professionals who are available to you: geriatric psychiatrist, primary care physician, community partners, and always, always, caregivers and other family members. And it's important that with the client, not for the client, we identify the interventions and the solutions that are going to help to meet their needs.

What exactly is a comprehensive social work assessment? To me a comprehensive social work assessment aims to understand the current state of the older adult and to identify goals that are meaningful to them. Tools that are commonly used as part of that social work assessment, and note that I'm emphasizing the word "part" because these are by no means comprehensive assessment tools.

The mini-mental state examination and the four-item geriatric depression scale. It's important for us as social workers to recognize that there are many challenges to that assessment process that can compromise the individual's ability to participate in the assessment, including physical and emotional issues. Examples are hearing loss, vision loss, discomfort, pain. Additionally, conversely, it's helpful to realize that older adults can bring unique strength to the assessment process.

The most obvious example of that is strong coping skills. Our elders are survivors. And one way or the other they have survived to a point in life where they are now availing themselves of our assistance. But the coping skills that they developed in the past, some good, some helpful, maybe others not so helpful, they've still had a lifetime of experience with coping skills, and we can

help to support them with good coping skills as they move forward. And when you have an older adult who wants to actively engage in that assessment process you have all that you need in order to move forward.

Therefore, that assessment should include the following. If it's possible, we really would like to see the physical health status provided by a primary care physician, behavioral health information and status provided by, for example, a geriatric psychiatrist, if possible. And in both of those instances we also really do want to know the individual's perception of his or health, because that individual perception is critical to their attitude and their ability to make changes.

We're concerned about their functional status, their activities of daily living, their instrumental activities of daily living, what they can do by themselves, what they need support with, what are they unable to accomplish. Equally important is an assessment of their environment, finances, and their social support kinship system. Critically important that that assessment be person-centered and nonjudgmental. The social workers needs to be skilled in motivational interviewing. And, as mentioned earlier, we want to be sure that we are addressing that individuals' circumstances with an eye towards the person in family, in community, in systems contexts.

Goals and plans of care need to be developed, again, by the individual, not for the individual. We need to understand the client's goals, the client's perspective, and then initiate referrals, provide follow-up, monitoring, and the appropriate documentation to address the individual's ability to meet those goals.

Here again we are looking at possible collaborators. And when I talk about possible collaborators at the moment, I'm talking about them not just in the context of the individual, but in the context of bringing about community change. So, a primary care physician, geriatric psychiatrist or geriatric physician.

A federally qualified health center. Your local hospitals, clinics other local providers, faith-based organizations can work with you in developing new services and new approaches. It's a matter of finding allies. Other obvious examples would be local senior centers and municipal government.

I now want to move on to Slide No. 35, and give a very brief explanation of a case study of an individual who I am going to refer to as Mary. Mary is 65 years old. She is a woman of color who lives in a third floor post-World War II walkup in a poor urban neighborhood, frankly, of any urban area in the United States. Mary is in Philadelphia. Mary is in Baltimore. Mary is in Atlanta. Mary is in Bridgeport, Connecticut. Mary is throughout our country in urban areas.

She is living in an apartment, as I said, a third-floor walkup. It doesn't have an elevator, and the stairwell is very dark. The lightbulbs have burned out on some areas of the stair, and very infrequently does the landlord come and change those lightbulbs.

None of the kitchen appliances or bathroom fixtures have ever been upgraded as far as we know in the 35 years that Mary has lived in this apartment. She does not have air conditioning, and she does not own a car. Mary completed, she thinks, the fifth grade in school in Mobile, Alabama. Her health literacy is poor. She doesn't know her neighbors in her community despite the fact

that she's lived there for 35 years, because she is isolated on that third floor. She fears violence in her community. And so there is much less community interaction among neighbors.

And over the years she has become less involved in her faith community, partly because of her own health, partly because of transportation issues. She raised her two children in this two-bedroom apartment, and now she is raising her two teenage grandsons. She's raising her grandsons because her daughter, the mother of the two grandsons, has been incarcerated for the possession of illegal substances for two years so far. And I assure you that this daughter is going to spend more time in jail than most white-collar criminals spend for their crimes.

Mary's medical history is complicated. She has severe hypertension, debilitating arthritis, morbid obesity, poor vision, diabetes, and frequent urinary tract infections, and her behavioral health history includes depression. Her medical care is provided at the clinic of a local acute-care hospital where she frequently misses appointments, does not refill her prescriptions, and ignores recommendations regarding weight loss. And I don't have to tell you that Mary is labeled by the medical community as being noncompliant.

Moving on to Slide 37, we have taken a number of different approaches with Mary in terms of the healthy idea program, which helps us to identify whether or not a person is suffering from depression and make the appropriate referrals. And we worked very, very hard to be sure that the goals were established by Mary, not for Mary, as I've mentioned before. And the most important goal to Mary is, quote, "keeping the boys safe." So everything that had to do with establishing school and community contacts for her grandsons were her most important goals, and her health needs came well after that.

What had to happen was that the clinic staff, she received most of her care at a local acute care hospital clinic, needed to be educated regarding Mary's challenges, including the medical appointments, refilling the medication. And it was very important that Mary and her community social worker, community staff, provide that education.

Contact was established with the school social worker and guidance counselor regarding the two grandsons. Transportation was arranged. Appropriate referrals were made, including for that transportation, and the social worker saw to it that Mary was referred to any number of programs for which she was eligible. Last slide, No. 39, I don't have to tell anybody on this webinar that progress is often incremental and slow. Mary is now consistently attending her medical appointments, I should say with more consistency than before. She's received diabetic education in her home from a licensed home health nurse, and a local home-delivered meals program is providing a diabetic diet.

She has maintained the connection with the school social worker. We are considering to address challenges regarding access to grocery stores, summer program and after school programming for the grandson, and housing issues. So, this is not a quick fix by any means. You all know that. But this is the route that we have begun with Mary.

And I would like to turn the presentation over to my colleague, Sabrina Wannamaker, from South Carolina, who is going to be talking from the managed care perspective.

Sabrina Wannamaker: Thank you, Molly, and good afternoon, everyone. Definitely excited to be here today.

So we're going to hop right in. Absolute Total Care, we really strive to make a difference in one person at a time by working to improve their health, their well-being, and those overall health outcomes by providing access to quality care as well as those community resources. And in doing such we use a holistic person-centered approach to care management. And so with that we're able to combine and address the physical, the behavioral, and the social determinants of health needs of our members.

We have staff with specialized educational backgrounds, certifications, and actually full independent licensures in these various areas, but more importantly our staff has those hands-on, boots-on-the-ground experience in working with the members prior to coming to working in managed care.

Therefore, the barriers that you are going to see on this slide, they are not necessarily just -- they do not just apply to our older population, but they can often be exacerbated in working with the elderly in our population. And so a lot of times you will find families that are on fixed incomes. The housing may not be substantial as before. Different levels of health literacy. Homelessness has become a big issue, as again income may have dropped and individuals may have been evicted from their homes, or different situations.

Social isolation, as many others before me have mentioned before, but also multiple providers. So as we get older things start to change. Things start to shift, and we may need specialists in different areas. And then that can also lead to polypharmacy, just over the years we're going different places to pick up different information and different medications. And so we'll talk about like how we kind of circumvent some of those barriers within our integrated care management program.

So, our integrated care management program, there are three focuses that we have. The first is going to be that of one central point of contact. We also have assessments and care plans that are individualized, but they're also shared with the primary care physician and our specialists and some of our specialty companies, and where we bring everyone together to manage the care of that member. But also we continuously provide education and self-management training to our staff to help them to be able to give them the right tools to help our members establish not only realistic but achievable goals so that they can get to the best outcomes to improve that quality of life and overall just live their best life that they are able to live.

So one our key components in our care management model is going to be that single point of contact. This single point of contact really helps us to facilitate that true coordination and integration of both the care of the member but also the overall healthcare management system.

And so in this we have a primary case manager that communicates with any secondary case managers from different departments. They communicate with the primary care physician, the community resources, any community providers, but also like different areas for like utilities and

different barriers that our members may face. And so we have that primary point of contact, which really helps to provide just consistent and impactful messaging, so the member's getting the same message constantly on a regular basis and from that same individual, which helps them to build the rapport and relationship.

So some of our strategies for working with our older adults with behavioral health needs, first and foremost we have a person-centered approach to care. So there is not a one-size-fits-all. The same goals are not going to apply the same person. The same approach and even the same type of conversation that may not always work with every individual, and so being able to adjust your approach with that person.

We utilize motivational interviewing, as well, and we have those interdisciplinary care teams that really combine everyone who was on this call before, so the social workers, the family caregivers, our psychiatrist, but also our medical professionals, as well, are also involved.

With this piece we utilize our comprehensive assessments, and we use that we call kind of a let's talk or a conversational approach. So tell me about your day. What was your dinner like last night? Who helped you to prepare that dinner? So person-centered thinking and motivational interviewing really looks at what's really happening in that person's life. And so it becomes more so of a conversation with the individual to find out what's happening. But also, and we use that conversation to develop those individual care plans, and we share those things with providers and the community teams, as well.

So working with our older adults, we try to get to and do face-to-face assessments. The face-to-face assessments gives us a different perspective, where we're actually able to lay eyes on the home. So we go into the home to do a lot of these assessments so that we can see is the home adequate, is it safe, do they have air conditioning, do they have food. So do they have those basic level needs met. So going back to Maslov's hierarchy of needs, so are those things being met, because not having those things can really exacerbate any behavioral health symptoms that they may be experiencing.

And so we also, again, look at the functional status. So everything that Molly was talking about in those comprehensive assessments are taking place. With that, again, we use this to do that person-centered care planning, so getting what's not only important to the member based on their perception, but we also integrate any care gaps into that, so getting also what's important for the member to really be able to thrive in the community.

Another tool that we use is going to be initializing that caregiver involvement. Oftentimes the support system just may be nonexistent. Again, the family members may have passed on. Family members may not know that the person actually needs help, because a lot of times we're very independent people, and so as we get older we don't want to necessarily lose that independence. And so asking for help can be very difficult at times.

And so we try our best to find out who supports you. What do they do for you? When was the last time they did this for you? And how often are they really and truly involved in your care? And so we move forward to getting that person's name and contact information and getting a

release of information from them so that we can start having conversations with those caregivers to find out what else may be going on with the member that we're not able to see in that few hours of the assessment.

So are they having any cognitive deficits that we can't see but that that caregiver may be able to see on a day-to-day basis? So they maybe in a good mood right now, but are they experiencing more depression symptoms when we are not around? And so by getting the release of information to have that conversation we get a clearer picture of what's happening on the day-to-day basis with our members.

And if the support system is just nonexistent at all we do our very best to find those resources to help to build that support system. And we'll talk a little bit more about getting around some of those barriers also.

So when we are doing these assessments, again we utilize motivational interviewing. And it's really about getting that member engaged in the conversation and eliciting the changed thought, so getting them to think differently, or even consider the possibilities of what life could be like and how to move forward, and getting again their own motivation for making that change.

Someone wanting to feel better or kind of manage their depression symptoms, while we may give them all of the medical terminology, and you'll feel better, you'll do this, and it'll increase your energy, they may not really care about that. But being able to really get up and play with their grandchildren, or to get up and go to the grocery store. The things that are important to them are what we're looking for, and so those, when you're using motivational interviewing, you're looking for that client's own motivation to move towards positive change.

And we also, again, just take into consideration the things with aging, so loss of hearing and vision loss, but also decreased mobility. But mainly when you're thinking with adults with behavioral health needs you're looking for those inconsistencies and any deficits in their cognitive functioning so that we may be able to help support them in the best ways that we can.

So what makes motivational interviewing different from that traditional approach is that it is really more so of a conversation and a collaboration. That member is the expert on their self, their life. They know the ins and outs. They know they function throughout the day. As professionals, we may be the expert in the physical and the behavioral health, but that person can give us insight into what really happens in their day.

And so by creating this collaborative conversation we're again able to give the member a sense of autonomy, because they're making decisions. They're giving us input and insight into what's going on in their life. And it really is and truly more member-focused than interviewer focused. It's about what that member needs. It's about what's going to help them, again, to live their best life.

It's not necessarily about the interviewer. It's not about checking boxes and just getting through the assessment to get things done. It's really about finding out what this member needs. Do they have food in the house right now? Are they able to get up and down from the bed? Are there

different stories about what's happening, so are there memory deficits that may be happening right in front of us that we may not be paying attention to? So sometimes even circling back to another question for clarification just to kind of see if we're getting the same types of responses.

So, some additional strategies for caring for individuals with behavioral health needs. So first and foremost in order to get anywhere we have to build that trust. And we build trust by just being consistent with our communication and doing what we said we were going to do when we were going to do it. And so again -- and then just exploring what's important to that member and not casting that to the side.

So if the person wants to be able to go to their grandson's baseball game, that's what's important to that person, so making sure that we just don't cast that aside as being something that's minute, but it's extremely important to them. And by focusing on that with our members we can kind of get them to buy in to the things that they may also need to focus to again be able to get to where they need to be with their physical health and managing their behavioral health diagnosis.

We try to get, again, the provider involvement is going to be one of our second strategies. So our care plans that we create are actually shared with our primary care physicians. The primary care physicians are invited to our integrated care team as well as other providers that are within the community working with the member, and family caregivers are invited, as well.

Our case managers may actually accompany our older adults to their appointments to help them to be able to start those conversations or to gain understanding of what may be happening with their diagnosis and those things in their lives. We again help to develop that support network, and oftentimes that support network, again, doesn't look like just family. It may be a neighbor. It may be Alcoholics Anonymous or Narcotics Anonymous groups within the community, or peer support groups based on specific diagnoses.

Finding appropriate providers. And so with that -- so we're on Slide 51, you're correct. So having lack of immediate support, so, again, getting that family involvement. And also helping to find local wraparound services within the community. So what else does that member need to really kind of envelope them and to kind of surround them with the care that they need to be consistent and to be on top of their care.

And so our overall goal is self-management for the person. We look into home improvement grants, and also our local churches and food banks. And finding out if the local area has utility assistance, so senior protection programs. Here in South Carolina they have something called white flag assistance with different utility companies that prevents the electricity from being turned off in the summertime and in the wintertime and different times of the year because they have different conditions or limited income. So finding out if there are senior protection programs with the utility so again they are able to manage those day-to-day life things and have those basic needs met that can oftentimes, if they're not met, exacerbate their behavioral health.

Health literacy. Do they understand the terminology that is applied to their actual condition, or are they regurgitating terms? So hallucination. Do they really understand what a hallucination is? Not only can you see things that others may not see, but do they know that a hallucination can

also be auditory, or tactile? So do they understand the full terminology, and being able to break it down in a way that they can actually understand those words that may be applied.

So delusions and hallucinations are often times. And suicidality, what does that really mean? I'm not suicidal. I don't have a gun in my hand. But do they understand that also it could mean I just don't want to live anymore. I feel like I'm a burden, and it would be easier if I was not here. So understanding and helping our members to really understand the different terminology associated with their health conditions.

So when overcoming barriers we look at assisting them with finding appropriate providers and specialists. And so do they need a psychiatrist or a therapist? Which one would be best fitting for the situation, and making sure we are getting them to a psychiatrist to be able to manage those medications that they need, but also referrals to home health and community long-term care if they need those things, as well to help support that physical health side.

Again you have the transportation, and a lot of times we help to fund different charts or we create those different charts or checklists when it comes to scheduling transportation. So if I have an appointment on Thursday I need to make sure my transportation is scheduled by Monday or by the previous Friday. And, again our overall goal is just self-management and support. So giving disease-specific information, but helping our members to be able to get to a point where they are able to self-manage their conditions.

Therefore, we are going to kind of talk about Leroy for a second. Leroy is a 72-year-old. He turned 72 recently. And he's a dually eligible adult. He has about 30 years of history of substance use and behavioral health admissions. Initially he was just unresponsive to case management, unresponsive to pretty much anything that was going to intervene in his normal -- what he had created as his normal everyday life.

He had a family friend who manages his finances and allowed him to live in a box truck on the property, but he actually ended up getting evicted by that particular family friend for a while. And the friend has kind of -- he let them kind of go back and forth a little bit. But Leroy had like no coordinated care, no behavioral health providers, no consistent primary care physician, just no overall support system in any area, so dealing with the community supports, family, and provider support. And he was just resistant to kind of moving forward and moving and moving in a positive direction.

So it was extremely hard to get Leroy engaged in case management, but on one of his provider visits he happened to leave that friend's number with the provider. And so when we can't get the member on the number we have outreach to any providers that may have new claims with the member. And so called his provider and they were able to give us the friend's number. And we did a conference call with the friend and Leroy and were able to get him to agree to at least meet with our case managers.

And so they met with him. They actually did a home visit and went out to this site and were able to kind of see the box truck in worse conditions that you can think of, squirrels, different types of animals, the smells. And, again, Leroy is, he's technically homeless, but his friend is able to kind

of keep an eye on him but not allow him to live in the home, but it's just he's really unpredictable with his substance abuse and not wanting to cause danger to other members in his family.

And so we talked with Leroy about what was really important to him, and so being able to just be on his own and stand on his own two feet are some of the things that he has mentioned before. And so we got Leroy on a bus from Charleston, South Carolina up to Columbia and got him into the Transitions Homeless Shelter. And there's a transitional program for substance abuse and also mental health.

Leroy was doing well for a while and then had a disagreement with someone and hopped the bus back to Charleston. And he kind of fell off the grid for a while. And so our case managers started back calling that family friend. And we were able again to contact Leroy. And unfortunately he did relapse. He ended up using cocaine again. And so, but the good thing is Leroy wants better. So his thinking has actually changed. And because of the relationship he's developed with the case managers, he has actually decided to run to Columbia. And our case managers went to go see him today to help to get him a bed in the homeless shelter here but also to help get him back on that transitional program list.

But Leroy is now thinking differently and thinking about what his life really and truly could be. And so I think that's a great success is that his is that his changing -- his thinking is changing about his situation and that he now reaches out to our case managers when he's in trouble and when he needs help.

By utilizing and really implementing the integrated care model, we have actually been able to reduce the duplication of phone calls and follow-up. Leroy has this one -- he has one contact person who is his main point of contact. And so with that we've been able to get better outcomes for him. Being at the shelter he will have access to behavioral health providers that actually have local offices there. There's a drug and alcohol treatment program that is also located there.

So Leroy is getting connected to providers as we speak. And being able again to help with the coordination of services to provide that maximum support for his wellness and his autonomy. And just overall help him to reduce that stigma when it comes to behavioral health, because now he actually wants help. He doesn't feel like he's alone in the situation. And he now knows that there are others who been where he is and are now doing well.

So I am going to turn it over to Evan.

Evan Vahouny: Thank you so much, Sabrina, and thank you to all of our speakers. Dr. Jain, Andrea, Molly, for your very informative presentations. With that we now have a few minutes. We're going to answer some questions from the audience. At this time if you have any questions for our speakers please submit them using the Q&A feature on the lower left of the presentation. Go ahead and type your comment at the bottom of the Q&A box and press Submit.

So the first question that we're going to ask is for Dr. Jain and Andrea. And the question is what were the biggest communication barriers among care providers involved in the care of Andrea's mother, and what are some of the communication strategies that you noticed worked well.

Neha Jain: Andrea, do you want to go first or should I?

Andrea Lovell: You can go so we can piggy back off of each other.

Neha Jain: Okay. So honestly, from my perspective as a physician I think the biggest barrier to communication is time. If I am seeing a patient usually in a 30-minute visit or however much time, and I'm using that time to talk to the patient, to build a treatment plan, to communicate back and forth, there really isn't any time for me or really, I think, for any provider that is specifically assigned for these communication tasks.

So all of the reaching out between different disciplines is really sort of done in our imaginary spare time. And that becomes a challenge. I mean, I'm lucky to be in a practice where I am able to carve time out for these types of interventions, but I think that is what is needed is really for providers across the board, whether it's case managers or social workers or therapists or physicians, to have time that is set aside so that they can make those phone calls, they can send those emails. And I think that becomes a big -- that's probably the biggest barrier I would say.

Andrea Lovell: I agree with that. I think in this role it becomes almost overwhelming trying to coordinate all the care and communication back and forth, and during our presentation Dr. Jain and I both touched on how things can get lost in translation and errors occur. I mean, we're human beings, so errors will occur. But I think the more that the system in itself can create a better form or streamlined or cohesive way of communicating, the less likely obstacles and barriers will occur so frequently, I'll say. Just my perspective on how to -- how some of those things have been challenging.

Neha Jain: Absolutely.

Andrea Lovell: I mean, we are just blessed to have such a great prescriber in Dr. Jain. I can't say that's always been the case until we've met her. I think it's just like she said. Providers don't always, and I understand this, as well, being a provider, you don't always have the time. But I think just making the time where you can and allowing the family to know that there are other -- and Dr. Jain's in a practice where there's other ways to reach her or at least reach her colleagues, and she does a great job of making sure or ensuring that she is not in place that a colleague in her place is well-informed about what's going on.

And that just means a lot and it helps a lot, as well, because it can be taxing trying to regurgitate five years of information to someone that doesn't know my mom. But, for instance, if Dr. Jain's away she does a great job of saying this may be -- this is sort of what's going on now, this is a growing issue. In the event that it manifests into this I just want to let you know this, this, and this. And those things help with the barriers not seeming so overwhelming and creating more obstacles that need to be there.

Neha Jain: Thank you, Andrea. And the one thing I would add to that is I am a big -- again, I'm a big proponent in electronic health record portals, and prior to that we were fortunate enough to have access to a HIPAA-compliant email system. So I think providing both providers and

caregivers a way to communicate electronically actually eases communication a lot, because I may not be able to make a phone call between patients, but I can always answer my emails at some other time. And we've always had that flexibility of being able to communicate electronically, and I think if there is a secure way of doing that, that's a huge strength or a strategy that can be adopted.

Andrea Lovell: I agree with that.

Evan Vahouny: Great. Thank you both so much. So, the next question is for Sabrina, and the question is when deciding that there would be a primary care manager for each member, did you struggle with being able to operationalize that?

Sabrina Wannamaker: So when we think about the primary care managers we are looking at who is going to lead this person. Will it be behavioral health or physical health? And so there are sometimes we use -- we look at what is the most important or what is the most impactful at the time. So what's creating the most physical or the most difficulties for the member at that particular time, and so that's kind of how we decide who's going to be primary, whether it will be a nurse or whether it will be one of our behavioral health case managers.

And then as those needs get managed and taken care of and kind of get those disorders under control we then can shift who's going to lead that case moving forward with the member. But in the integrated care plan both goals are addressed in that care plan, and they collaborate with who's going to do the communication. And, again all of these areas addressed, again, by that one primary person.

Evan Vahouny: Great. Thank you, Sabrina. And so we're going to do one more question here before we wrap up, and this one's for Molly. So, Molly, the question is how do you engage with dually eligible older adults who might be at first resistant to accepting assistance or support?

Molly Rees Gavin: I think that the most important thing to remember is that sometimes people's resistance to our support is exceedingly legitimate, because many of our dually eligible individuals have had bad experiences with medical care systems and bad experiences with the social support system. And sometimes we actually try to point out to individuals that perhaps their -- suspicion isn't the right word, but their questioning of our role and our motivation is actually a coping mechanism and it is a strength for them.

And so it's not something that we should be afraid of. It's not something that we should turn away from. It's something that we should use in our intervention with the person and recognize that it is going to take a long time for some individuals to trust us. And so we start with tiny, tiny interventions, tiny examples of our support. And that might mean, honestly, that if you say you're going to be at the person's house at 10 o'clock tomorrow morning you're going to be there at 10 o'clock in the morning. You may be there at five minutes of ten. If that helps to demonstrate to the person that you are committed to a trusting relationship, that could be the very first step.

Evan Vahouny: Great. Thank you so much. That's great input.

So at this time if you have additional questions or comments, please email RIC@lewin.com. Thank you very much to our speakers. We would also like to invite everyone to visit our website to view recordings of our webinars that aired earlier this year. You can view the topics of these webinars on this slide.

The slides for today's presentation, a recording, and a transcript will be available on the Resources for Integrated Care website, and you can see that URL at the bottom right of your screen.

At this time the post-tests for this webinar are now open. Additional guidance about obtaining credits and accessing the link to the post-test can be found within the continuing education credit guide in the Resource Guide on the left-hand side of your screen or at the Resources for Integrated Care website.

Thank you so much for joining us today. Please complete our brief evaluation of our webinar so that we can continue to deliver high-quality presentations. If you have any questions for us, please email us at RIC@lewin.com.

Thank you again to all of our speakers. Have a wonderful afternoon, and thank you so much for your participation.