

**Resources for Integrated Care
Innovations in Alzheimer's Disease and Related Dementias (ADRD) Caregiver
Support Programs: Building and Leveraging Support Systems
September 19, 2022**

Katie Palmisano: Thank you. Hello everyone and welcome to the webinar, *Innovations in Alzheimer's Disease and Related Dementias (ADRD) Caregiver Support Programs: Building and Leveraging Support Systems*. My name is Katie Palmisano, and I am with the Lewin Group.

Today's session will include presentations from our esteemed presenters, a panel discussion, and we will close with time for questions and answers. The session will be recorded. The recording and a copy of today's slides will be available at www.resourcesforintegratedcare.com, and the slides are also available to download in the resources pod on your screen.

There are two ways to listen to today's presentation. Audio should automatically stream through your computer speakers. Please make sure that your computer is connected to reliable internet and that the speakers are turned up. If the computer audio option is not working for you, there is a dial in option to access this option at any time. Click on the black phone widget at the bottom of the screen, a phone number and access code will appear. Calling the number will allow you to listen to the presentation through your phone.

Continuing education credits are available at no additional cost to participants. 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.

On this slide, we've laid out the continuing education credit requirements. Social workers may obtain one continuing education CEU through NASW. For those interested in continuing education, you must complete the pre-test at the beginning of the webinar, as well as complete the post-test with a passing score by 11:59pm tomorrow, September 20. Additional information regarding credits is included in the resources pod on your screen.

This webinar is supported through the Medicare-Medicaid Coordination Office at the Centers for Medicare & Medicaid Services. MMCO is helping beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs.

To support providers in their efforts to deliver more integrated, coordinated care to dually eligible beneficiaries, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar.

To learn more about current efforts and resources, please visit our website www.resourcesforintegratedcare.com, or follow us on Twitter. Our handle is @Integrate_Care. You may also find us on LinkedIn.

At this time, I would like to provide introductions for our presenters. Dr. David Reuben is the Chief of the Division of Geriatrics at the University of California Los Angeles. He's the Archstone Foundation Chair and Professor at the David Geffen School of Medicine at UCLA and director of the UCLA Alzheimer's and Dementia Care program. His extensive research in the field of geriatrics includes several prestigious grants. These include a CMMI Innovations Challenge Award and research funding from the Patient-Centered Outcomes Research Institute and the National Institute on Aging which allowed him to investigate innovations in dementia care.

Dr. Debra Cherry is a clinical psychologist and the Executive Vice President of Alzheimer's Los Angeles, a community-based nonprofit dedicated to supporting people living with dementia and their caregivers. Dr. Cherry completed her PhD in Clinical Psychology at the University of Southern California, and her career has focused on improving access to dementia care for underserved communities, and on improving dementia health care.

I would like to introduce our speakers from HealthNet. Our three speakers - Linda Wade, Anita Chacon Terry, and Ed Mariscal - bring a wealth of expertise. Linda Wade is Senior Director of Population Health and Clinical Operations at HealthNet. She has extensive experience in health care management, leadership development, program planning and development, implementation, and evaluation with a focus on care management.

Anita Chacon Terry is currently a Manager in HealthNet Care Management and has been with HealthNet for 12 years. She is a California Registered Nurse, a Public Health Nurse, and a Certified Case Manager.

Ed Mariscal is the Director of Public Programs and Long-Term Services and Supports with HealthNet. He is responsible for the planning, implementation, and oversight of HealthNet's Long-Term Services and Supports program as well as driving HealthNet's Public Programs overall strategy.

Thank you to our presenters for sharing your time with us today.

This event will accomplish the following learning objectives. First:

- Identify unique challenges and needs for caregivers of those living with ADRD.
- Deliver innovative strategies and share examples of programs to support caregivers.
- Provide strategies that support the unique needs of diverse or underserved communities and address health equity.
- Share lessons learned from implementation of caregiver support programs over the last five to ten years.

The roadmap for our time together today is as follows. We will start by collecting some information from the audience via two polls. We will then provide some background information on Alzheimer's Disease and Related dementias or ADRD as well as about caregiving. Then our esteemed presenters will share the following presentations.

First, the *UCLA Alzheimer's and Dementia Care Program - Lessons Learned and Program Expansion*. Second, *Supporting Caregivers of People Living with ADRD who are Dually Eligible*. And finally, *The Benefits of Care Manager Education and the Impact of HCBS Service Referrals on Member Outcomes*.

After these presentations, our panelists will offer their perspective in a guided discussion before we engage in some Q&A, leveraging questions the audience submits throughout today's event. If you have any questions, please type them into the Q&A box as we go, and we will answer as many as we can. We will close by sharing some helpful resources and requesting your feedback on the information shared today.

As noted earlier, we are going to poll the audience before we launch into today's presentation. You should see a pop up on your screen asking which of the following best describes your professional area. The goal of this question is to get a better sense of our audience members today. The options you may select from include Health Plan Case Manager or Care Coordinator; Health Plan Customer Service; Health Plan Administration or Management; Medicine, Nursing, Physician Assistant, or other provider; Pharmacy; Social Work; or Advocacy.

Again, the goal of this question is to get a better sense of our audience members today, so we encourage you to provide your response to this question. We will offer a few additional moments for folks to submit their responses to this question. This is the first of our two polls.

All right. So, in just a moment, we will proceed to review responses to this question so please select the option that best describes your professional area. And we will now move to review our responses. So, it looks like we have quite a number of folks from Health Plans that are in a case management or coordination role. We also have representatives from the field of Social Work, Advocacy, Health Plan Administration and Management, as well as providers. So, thank you to all who responded to that first poll question.

The second asks: In which care setting do you work? The options you may select from include Health Plan, Ambulatory Care Setting, Long-term Care Facility, Homecare Agency, Community Based Organization, Consumer organization, Academic or Research, or other.

We invite folks to please respond to this question. Again, the intent is to get a better understanding or a better sense of our audience members so that we can ensure that we tailor the information that we present to you all today.

So please take a moment to respond to the question, indicating in which care setting you work. And we will provide just a few more moments for folks to submit their responses before we look at our poll results for this second of two poll questions.

All right, and moving to see in which care setting our audience works. It looks like it is most common that our audience members work for Health Plans. So welcome to you all. We also have representatives from community-based organizations and other care

settings, as well as folks across a variety of our other response options. So, thank you all for joining us today.

I'd like to take a few minutes to set the stage by providing a bit of background which will ground our time together. This is a very timely discussion as this month we observe World Alzheimer's Month and every September 21st, just a few days from now, marks World Alzheimer's Day.

ADRD and the dually eligible population: Individuals dually eligible for Medicare and Medicaid are almost three times as likely to have ADRD as people eligible for Medicare only. Twenty percent of all dually eligible individuals aged 65 and over are diagnosed with ADRD, and dually eligible individuals with ADRD are particularly vulnerable to unplanned hospital admissions.

Thinking about the broader impact of ADRD on the general population, social determinants of health are an important factor for health plans to consider when supporting individuals with ADRD. The general population is aging and the older population itself is becoming increasingly older, and over half of persons aged 65 and older live in nine states, with California having the greatest number in 2019.

Moving next to understand caregivers, in 2015, 85% of individuals with ADRD lived in community settings and almost 6 million people were informal caregivers for community-dwelling older adults with dementia. It's common for older adults to have more than one caregiver and most caregivers for community-dwelling older adults with dementia are younger than age 65, and more than half are the child of the person for whom they care.

Passage of the RAISE Family Caregivers Act in 2016...2017, excuse me, directed the development of the National Family Caregiving Strategy, and established a council to identify best practices and recommendations. The Council's August 2019 meeting identified themes emphasizing the recognition of caregivers' diverse needs, supporting the well-being of caregivers, and integrating and empowering caregivers within the health care system.

Specific to caregivers of those with ADRD, the national site Alzheimers.gov shares resources from the National Institute on Aging, the Administration for Community Living, and the Centers for Disease Control and Prevention, among others.

I'm looking forward to some engaging presentations from this impressive group. So, without further ado, I will turn things over to Dr. David Reuben, Chief of the Division of Geriatrics at UCLA and Director of the Alzheimer's and Dementia Care Program to share his insights on UCLA's program as well as lessons learned and thoughts about program expansion. Dr. Reuben?

Dr. David Reuben, MD: Thank you very much. You can hear me?

Katie Palmisano: Yes, we can.

Dr. David Reuben, MD: So that's me. And with a, a little gray now. Next slide, please.

So, in the next 20 minutes, I'm going to tell a story in three chapters. The first is getting started with the UCLA ADC program. The second, to describe the local success. And the third are our efforts going national. Next slide, please.

So, this began in 2011 with philanthropic funds from a patient of one of my partners, and we planned to offer this service for 250 patients. And then we hit the lottery. We applied and were one of the first 26 CMMI Innovation Challenge Awards in 2012. And the purpose of that was to expand the program to 1,000 patients.

That was 10 years ago. Now we are over 3,500 patients. Currently active, a little more than 750. We have a waitlist of almost 350 and approximately 12% are dually eligible. We're seeing about 350 new patients per year.

The mission of this program is to partner with families, physicians, and community organizations to maximize persons living with dementia function, independence, and dignity while minimizing caregiver strain and burnout. Next slide please.

And this follows a pathway. First of all, is the recognition that this care is a long journey. And journey is a really good word when thinking about caring for people with dementia. This is not a curable disease in 2022. It approaches the patient and caregiver as a dyad. Both need support, and programs that focus only on the person living with dementia or only on the caregiver can't get the entire job done.

It uses a co-management model with a UCLA Nurse Practitioner Dementia Care Specialist who does not assume primary care of the patient but works with the primary care provider. And it provides comprehensive care based in the healthcare system that reaches into the community. Next slide please.

Conceptually, the process of the program begins with patient intake. And this is a referral, by either a primary care provider or a specialist physician. Once the patient is confirmed to have dementia, then the initial assessment begins. This tends to be 90 to 120 minutes. It's got patients and their caregivers and sometimes there are half a dozen caregivers in the room.

This is where the Dementia Care Specialist begins to get involved. And with the person living with dementia and caregiver and primary care provider, they create and implement individualized dementia care plans.

The Dementia Care Specialist stays involved, monitoring and revising the care plans, and there's a minimum of a phone call every three to four months. We'll talk about that more in just a moment. We also have access 24 hours a day 365 days a year for assistance. We are fortunate that the division of Geriatrics faculty covers nights and weekends. But obviously during the daytime, the Dementia Care Specialists take their own calls to cover for each other.

And then the final step are referrals to community-based organizations for services, as well as medical specialists such as psychologists, psychiatrists, and neurologists. Next slide, please.

So, the Dementia Care Specialist is really the pivotal person. This is an advanced practice provider, either a Nurse Practitioner, a Clinical Nurse Specialist who has prescribing authority, or a Physician Assistant. This is very important because it was a major decision on our part because we wanted a health care professional who could both do assessment and also prescribe treatments.

The Dementia Care Specialist is based in the healthcare system. Based in the outpatient clinic setting. We are now in five different practice settings in Los Angeles. And they provide Dementia Care co-management. Each Dementia Care Specialist follows roughly 250 patients that's what we budget for. Next slide please.

And they're assisted by Dementia Care Assistants. These can be registered nurses, social workers, or non-licensed trained staff and for the most part we rely on non-licensed staff. The purpose of the Dementia Care Assistant is to reach out to lower acuity persons with dementia and their caregivers. They tend to make the first calls every three months or four months. And we've categorized people as participants in the program as red, yellow, and green. And green are people who are pretty stable, much of their care is managed by the dementia care system. But the yellows are people who were somewhat unstable, recently hospitalized etc. And then the reds are the red hots. Now, these are people who are actively in crisis.

The other thing that the Dementia Care Assistants can do is refer to other resources and provide some reinforcement of non-behavioral and pharmacological behavioral interventions. They help with scheduling, not only scheduling in the dementia care program, but also other scheduling in the health system. And they identify dyads who are in crisis and will triage to the Dementia Care Specialists.

But the most important thing about the Dementia Care Assistants is that they allow the Dementia Care Specialist to work at the top of their license. There's no way they could, the Dementia Care Specialist could care for a caseload of 250 patients without this kind of help. Next slide, please.

So that's the program. Switching to success at UCLA. Next slide please.

So, the first thing we wanted to know is whether the doctors would be willing to accept this kind of program. Shortly after the program began, within the first year, we did an anonymous survey to physicians who have patients in the program. And 61% said that the nurse practitioners provided valuable medical recommendations, 85% valuable behavioral medical recommendations, over two thirds said it enhanced the physician's relationship with their patients, over half said it saved the physicians time, and over 90% that they would recommend this for other patients. And they do, they do. We've stopped any marketing of the program whatsoever. And currently we're getting between 10 and 25 referrals per week. Next slide please.

So, what does this program do? So, we've published some data on patient and caregiver outcomes. So, I'm going to go through this briefly. The top orange bar is functional status. And you see that this rises over one year and actually, unfortunately, rising is worse. Their functional status of the patient actually gets worse. MMSE is a mental status examination, and higher scores are better. So, you see once again, they're declining. The bottom line here is this program does not cure dementia, this disease progresses. On the other hand, the grey bar are the behavioral symptoms. These are the agitation the irritability, the aggression. Those improved significantly and the patient's depression also improved. Next slide.

These are caregiver outcomes and I know this conference is focused on caregivers. So, what you see here are three scales. And the first is distress from behavioral symptoms - How much are these symptoms are really bothering the caregivers? The second is, the green bar is caregiver strain index, which is an overall measure of how disruptive dementia care is for these caregivers. And the third the grey one is the PHQ9 which is the standardized scale measuring depression. And all three get better. This program has a lot of benefit for the caregivers. Next slide, please.

Now, what does this do for health care costs and health care utilization? When we had the CMMI Innovation Challenge Award, an external evaluator, NORC evaluated the program and then we conducted a second internal evaluation. And what we found was what these two evaluations showed that hospitalizations were reduced about 12%. That was not statistically significant. But ED visits were reduced by 20%, which is statistically significant.

ICU stays [decreased] 21%, not statistically significant. Hospital days 26% fewer, statistically significant. Nursing home placement for long term care, reduced by 40%, statistically significant. And hospice use in the last six months increased by 60%.

And when CMS looked at the overall cost savings to Medicare, it found that for each beneficiary, roughly \$601 per quarter was saved - roughly \$2,400 per year. So, this program not only improves outcomes, but it also saves money. Next slide, please.

Going national. So next slide.

In 2019, we received a three-year grant from the John A. Hartford Foundation to implement the program in 8 to 10 health systems outside of UCLA, to work with the Gerontological Advanced Practice Nurses Association, GAPNA, to educate nurses how to fulfil these Dementia Care Specialist roles, and then establish partners to promote payment changes.

To date, and this is how the process works, 80 sites have expressed interest, actually this was as of December 2021. And they fill out a brief interest form just for three or four questions. And then they have a phone call with us. And as of the end of December, there were 58 of these initial phone calls. And they typically include the program manager, a Dementia Care Specialist, and me.

And I would say that I have probably been on another 10 calls since December, I've been on every one of these calls. And if they're interested, we send them what we call a readiness assessment form. The readiness assessment form is about three or four pages and asks what their goals for the program are, what kind of resources they can allocate to the program. And this is going to be filled out in 10 or 15 minutes. But it can't, because this has to be on the basis of discussion with people who are in administration and the C-suites about whether they're willing to commit to this kind of program.

And then finally, the last step is signing a letter of agreement. The letter of agreement is a formal commitment to implement the program and outlines exactly what the adopting site will do and what the UCLA implementation team will provide. And much of that is training. Also adapting the program to local resources and strengths and needs and, and that training of the Dementia Care Specialists and the team and the continual adaptation takes up to two years. Next slide please.

And then, here we are. These are the adopting sites. We've pretty much all over the country and the ones in red are supported by the Hartford Foundation, the ones in purple are part of the randomized clinical trial. And these are our adopting sites. Next slide, please.

So adopting is not the same as creating a program and disseminating is not the same. It takes a lot of work and it's a different kind of work. We recently published on this, what our efforts were, two papers, one from the disseminator side, you know, from us point of view, and they're also from the adopting sites' point of view. But the key lessons were, you need to identify and nurture a product champion. And these typically have been geriatricians or nurse practitioners or neurologists and psychiatrists, they are interested in the program and they're willing to carry the ball.

The business case is critical. You can afford to lose a little bit of money; many institutions are willing to subsidize this. But you can't lose a lot of money on this program. So, we work with them. In fact, we've created an ROI calculator to help the sites go through this and determine how long it's going to take them to come reasonably close to breaking even. Some will not ever break even, and one of the big obstacles to disseminating the program are the current reimbursements.

Training is essential. Just because you are a nurse practitioner or physician assistant doesn't mean you can do this job. There are two kinds of learning you need to have. One is about dementia care, because you don't really learn that much in general, professional training, but the second is about how to use the model.

Local factors are important. Each site is different. And some sites already have certain kinds of professionals who would be good to fit these roles such as the social worker in the dementia care assistant role. But someone has split the dementia care specialists, have them work 50% in this program, and then 50% in palliative care, all sorts of permutations that you have to adapt to.

Be patient. We've had, as you can see, well, as I can tell you it is that we have 14 adopting sites, but only 10 are actively seeing patients. Others are waiting for additional funding; some state programs fell through. It takes a while.

And finally, don't underestimate the time needed for program implementation. You know, everybody talks about toolkits, and you've just pulled the toolkit off the shelf, and you can do it. But, but that's not the case in a program like this. You have to have people trained you have to have measures and fidelity. You have to make sure that the program is working as intended, according to its core pillars if you're going to attain the same results. Next slide.

In 2022, the beginning of this year, we received another grant from the Hartford Foundation to create a Dissemination Center and to create a National Dementia Care Learning Collaborative. We also set a goal of implementing the program and an additional 50 healthcare systems.

The Dissemination Center is local here and what it gives is a menu of options for adopting sites. We focus on the core program with adaptation to local environments. But we also work with them if they want complementary programs such as memory evaluations. And sometimes we talk with these folks and the UCLA ADC program is not the right program for them. And in that case, we refer them to other kinds of models such as the care ecosystem and the Benjamin Rose care collaboration program.

Sometimes they need additional training in geriatrics, and we like to suggest that they attend the UCLA intensive course in geriatrics. We also have an ADC ECHO program, Extension for Community Healthcare Outcomes, which we offer in collaboration with the National Alzheimer's Association. And here, it's kind of distance learning. We present didactics and then case presentation sometimes to as many as 40 or 50 participants from five or six different healthcare system. Next slide, please.

The National Learning Collaborative, I have big smile on my face because the National Learning Collaborative had its first national Summit last week, and it was very well attended by about 100 participants.

And this provides a forum for ongoing peer-to-peer feedback, group learning, also a community of practice. And these include sites that have already adopted and sites that are considering adopting. Our partners in this national dissemination center are the American Geriatric Society, Alzheimer's Association, the Milken Alliance, LEAD Coalition and the Institute for Healthcare Improvement through their age friendly initiative. Next slide, please.

Caregiver support efforts. So, this is also something very interesting, it's very important that we recognize and help the caregivers. So, we've established a voucher system with our CBOs and vendors to provide services such as counselling, education, and support.

And the way this works is that dementia care specialists authorize vouchers that the persons with dementia there and their caregivers can redeem at vetted, community-based organizations. And then when they're redeemed, they bill us, and we pay them.

And initially, this was supported by the CMMI Innovation Challenge Award. But subsequently, we've been able to get philanthropic support for it, so that the families found it, the foundations that have been giving to this to give twice - they give to us, and then they also give to the community-based organization. We've also established seven different support groups: general support groups, Spanish language, frontal temporal degeneration, Lewy-body dementia, early onset, and we pay for the support group leaders and host them. So, we are very committed to helping these caregivers get through this journey. Next slide. And I get to turn it over to Dr. Cherry.

Katie Palmisano: Yes, thank you, Dr. Reuben for describing your ADC program and sharing those insights and lessons learned. If you have any questions for Dr. Reuben, please add it to the Q&A box on the webinar platform. And we will address as many as we can at the end of today's event.

So next I would like to introduce Dr. Cherry, the Executive Vice President of Alzheimer's Los Angeles. Dr. Cherry will share information about supporting caregivers of people living with ADRD who are dually eligible. Dr. Cherry, the floor is yours.

Dr. Debra Cherry, PhD: Thank you and it's a pleasure to be with all of you here today. Much of the material I'm going to describe in this presentation derives from efforts to improve care for people with dementia and California's program for dually eligible adults, it's called Cal MediConnect. We're at an inflection point in our state as this program comes to a close and the state rolls out its new Medicaid waiver program CalAIM.

But the state continues to be a leader in quality dementia care by taking promising practices and lessons learned in the duals demonstration and integrating these into the new CalAIM program through policies and guidance documents. We appreciate the commitment of CMS' Office for Medicare and Medicaid Coordination to educate this community of providers about meeting the unique needs of diverse families who struggle with dementia. Next slide, please.

So, I want to thank the funders of the work. But in particular, I want to make note of the ongoing support of the Administration for Community Living and the Gilbert Foundation. I also have to point out that the views I express do not necessarily represent funders' policies. Next slide.

As Dr. Reuben mentioned, it's really important to make a case for improving dementia care if you're going to want to improve care within your system. And some of the points we make as we create this business case, in a simplistic way, is that rates of dementia are increasing in the United States and around the world, yet still not being well managed.

There's a high cost of caring for this population. And if you look at the graph, you see that people with moderate to severe cognitive impairment cost Medicare an estimated three times more than other Medicare beneficiaries, driven primarily by hospitalizations.

It costs Medicaid an estimated 23 times more than other Medicaid-Medicare beneficiaries, and this is driven by nursing home use. Yet, despite their high costs, they

face many quality challenges. Only about half of people with Alzheimer's disease get a formal diagnosis, and of those that do only a quarter or half of them get it in their medical records. So, if you hear that a health plan has 5% of the population aged 65 and older with, that have been diagnosed with dementia, you can assume that a large undiagnosed population exists within that health plan.

Stigma around the disease further complicates the picture with physicians and other healthcare providers often feeling that they can't do enough for the impacted person. And as a result, we find that only about 45% of people who get a diagnosis are told of that diagnosis. This population often has two to eight other chronic conditions, which means that care is complex, they are vulnerable. And we've especially seen their vulnerability, as shown by their high death rates during the current pandemic. Next slide please.

Improving dementia detection and care is definitely an equity issue. Prevalence rates among the dually eligible are higher than in the general population. Recently released information on this population shows that about 20% of the dually eligible population 65 and older are living with some form of cognitive impairment. And the numbers may be even higher because of non-reporting and non-detection, whereas in the regular, the general population 65 and older, Alzheimer's Association says that prevalence is roughly 10.7%.

When you compare older adults who are White to those from other ethnic groups, you see, you definitely see disparities. Individuals who are Black or African American are twice as likely to have Alzheimer's disease or related dementia than Whites, and they're more likely to be diagnosed later in the disease.

While individuals who are Hispanic or Latinos are about 1.5 times more likely to have Alzheimer's disease or related disorder than Whites, they are also diagnosed later in the disease. And their caregivers report that they can access fewer formal supports and thus face greater care demands. They also experience higher rates of depression. These are startling statistics that need to be attended to. Next slide, please.

There are barriers to accessing culturally appropriate care in this population. There are cultural beliefs about dementia and the role of the family. You probably well know, I see lots of care managers in this audience and social workers, that different cultures view the condition differently, and some it is highly stigmatized and hidden.

I often tell the story of a Chinese family that hid their mother's dementia even after she accidentally set fire to their home. They only sought help after she walked away from their home on the east side of Los Angeles County and was found 10 miles away at LAX airport, wearing only her slippers in a robe. That's what drove them to ask for help. Other than that, no one would have known about her dementia.

Obviously, income can really be a barrier to accessing services and support. But it can be so simple. One Alzheimer's center in Los Angeles County found that a family just never came for its follow up appointments. And after deeper exploration, they realized that that family couldn't afford the transportation costs to get to the clinic. So, they provided them

with vouchers for free ride share, and that's what improved attendance at follow up appointments.

Many people who are dually eligible for Medicare and Medicaid have lower health literacy or lower English comprehension skills, and they need materials and explanations that present information understandably, in written and in oral format. We can't assume that everyone who comes for care is literate. I accompanied one low-income, less-educated African American family to a local academic medical center on the day that the results of the 85-year-old mother's testing for dementia was to be discussed. The medical resident was charged with telling her of the diagnosis. He gave a technical description of the disease, and then asked if they had any questions, and then he left. The family nodded as though they understood everything. But actually, they were completely bewildered. They weren't given any ideas about what to do next. Some kind of care navigation service is necessary for all families, especially these families. And this can be provided by trained social workers, nurses, or even by community health workers, if that's what resources allow you to provide. It's an important but neglected role.

The lack of supportive services is generally the case for the families caring for a person with dementia and for person living with dementia. But it's even more acute if you're seeking culturally and linguistically appropriate services. While health plans may not see it as their role to provide these services, they need to develop systems of referral to community-based organizations that can provide them if they're not willing to provide them. In an ideal world, they'd also pay for those services.

And finally, I must, I need to mention that for some communities, there is a history of discrimination and lack of trust in the healthcare system. Some cultural groups have had long histories of neglect and even abuse by the medical system. You think about widespread forced sterilization of minority women that happened in the 1960s or the Tuskegee Syphilis experiments. Health systems are not necessarily viewed as beneficent, and we have to build trust. Next slide please.

Now family caregivers and whenever I say this, I talk about caregivers of choice. A family caregiver may be a dear friend, a partner, a neighbor. These family caregivers play an essential but often unrecognized role in health care. They can provide complex and intensive medical and nursing tasks and often have very little training to do it, from managing incontinence and prepared special diets, managing pain, and even wound care.

And they do this in addition to helping with activities of daily living like bathing and making medical appointments or managing finances. There's an excellent report published in 2019 by AARP, and if you want to read more about this *Home Alone Revisited* was a great source of insight for me. Next slide, please.

If a family or friend caregiver is not seen as a care partner by the health system, what can result is poor management of coexisting conditions like diabetes, hypertension, poor compliance with medical treatment, medication mismanagement. Often that may cause the system to label the person as non-compliant. It's like blaming the victim there. It can

cause a behavioral symptoms management and all of these together can lead to unnecessary hospital admissions and emergency room visits.

The CARE Act has been adopted in more than half of the states nationwide. It requires hospitals to take certain steps to protect the well-being of cognitively impaired hospital patients, identify a caregiver, document that person on the chart, and provide them with care management and disease education and follow up.

You may want to check to see if the CARE Act has been adopted in your state. Sometimes it's adopted but it takes education to get it implemented. Next slide, please.

So given that we have no medical treatments or cures for dementia at this point, the care is largely social and non-medical, and often provided by family. Yet, there continues to be minimum focus by healthcare professionals on these caregivers. So, they provide the majority of care for people living with dementia. They're the backbone of our nation's long-term services and supports system. They keep people at home, and out of hospitals and out of nursing homes.

I need to note that supporting caregivers not only supports the individuals they care for but could have an impact on the healthcare system's bottom line. Twenty-five percent of family caregivers are estimated to be enrolled in the same health plan as their loved one. Yet they continue not to be identified or adequately supported; they are not given care navigation and disease education services.

Our system of care focuses more and more on social determinants of health yet when it comes to dementia care, a critical social determinant is caregiver support. Caregiver support hasn't made it onto the social determinants of health priority list, and we certainly hope it will. Next slide, please.

Better care relies on support for that caregiver, you need to in your system build a way to identify the caregiver. And I have to note that the person who comes for medical visit is not necessarily the person responsible for the first patient's care. That person may be at work, or that person, primary caregiver may not speak English. So, we can't make assumptions. We have to ask, "Who makes sure that the person's medications are administered correctly? Who tends to the person's other needs?" It can be more than one person and they should be documented in the medical record. Then we want to assess the caregivers' level of distress and the types of support they need. There are some excellent tools for this on the websites of the organizations mentioned on the slide. We want to provide appropriate support. And then, if appropriate, we want to engage the caregiver in development of a care plan and in implementation of that care plan. Next slide, please.

And so again, it's not sufficient to just assess the caregiver. You have to provide assistance that matches their needs. If the caregiver is isolated, you might want to connect them to a support group. If they're depressed, they may need a referral for counselling. If they're physically frail, you may want to set up in-home care. If the caregiver is unable to drive to medical care with the person with the disease, you might want to arrange transportation. If they're unwilling to provide care, sometimes placement is a better

option. And finally, if they're unable to understand the disease symptoms, which is very common, they need to get access to disease education and support. Next slide please.

One best practice from California's dual demonstration comes from the fact that it is required that everyone who entered the program have a health risk assessment and that health risk assessment has one cognitive trigger question. It's called trigger question because it should initiate care, several care processes if someone is noted to have cognitive impairment. In this case, it helps to detect cognitive impairment in a previously undetected patient and can activate a system for further screening, usually by what our system calls a dementia care specialist, nurse or social worker who has some training in dementia. Much of it provided by Alzheimer's LA in this program. Possibly it will trigger a full diagnostic assessment and then documentation of the diagnosis in the medical record. So, hopefully it will mean that the person with dementia gets appropriate care, given their capabilities.

That initial assessment also contains a trigger question to assess whether members rely upon a caregiver for their functional well-being for cooking and bathing and so forth. And that trigger question should activate a system for caregiver identification, assessment, support, and engagement in the care team as appropriate. Next slide, please.

Another best practice that we hope will become a regular component of care for this population has variously been called care navigation, dementia care management, dementia care coordination. The role of the person who does this, this task, be it a social worker, nurse or sometimes even a promotora or health community health worker. Their role is to support the individual and the caregiver through disease education, caregiver training, resources for people who are at risk for walking away, provide psychosocial support, and may be connected to referrals like adult daycare, and in-home respite.

Some of these services are supported or covered by Medicaid and health care organizations should have systems in place to refer patients appropriately for those Medicaid supported long term services and supports. Minimally, you would expect healthcare organizations to connect people to local community-based Alzheimer's organizations. At Alzheimer's LA we have a helpline and a confidential referral program called ALZ Direct Connect, and healthcare systems make referrals to us or many of the services on this list. In an ideal world they would pay for them. Next slide, please.

These are some of the tools, toolkits, and training programs that you can access off of our website. They include sample screening questions for detection of cognitive impairments, a sample training curriculum for dementia care managers, referral forms to help you make referrals to CBOs, validated dementia screening tools and caregiver identification tools, and all the way down to best practice care plans. Next slide, please.

I'd like to highlight our Caregiver Tip sheets. These are plain language tip sheets available on common caregiving issues. They are in the English language on one side, and the other side can be in Spanish, Chinese, Japanese, Vietnamese, or Tagalog. We're always translating into new languages. They were created, when possible, at roughly a

sixth-grade reading level. And with permission, we allow organizations outside of our region to co-brand these tip sheets with us. Next slide, please.

Some of the topics and there are 20 caregiver tip sheets currently available and some of the topics you can see on this slide from anxiety and bathing and eating to hallucinations, keeping homes safe, and so forth. Again, we allow organizations to co-brand these tip sheets. And if you're interested, you can contact us at permission@alzla.org. You'll see that on a later slide as well. Next slide, please.

Community-based organizations also do education for caregivers. You can see here some of the ones that we make available online or in person. We offer them in English and Spanish but other community-based organizations may give preference to other languages. You can see here, our telenovela, a four-part series in Spanish and English that follows the family through the stages of dementia. Again, we're trying to create educational programming that is culturally appropriate. That is literacy appropriate. If people speak at [or] understand things at the sixth-grade reading level, you're not going to provide the material at the college-level. Each of our programs has a facilitator guide. Next slide, please.

For access to tools, toolkits, the trainings, the tip sheets, you can go to our website, you can write to us at permission@alzla.org. I also want to point out that there was a recent website started I guess a couple of years now. Best Practice Caregiving. That website will get you to evidence-supported interventions for your health care system to use for working with people with dementia or for working with their family caregivers. The database is searchable by language and other characteristics. Last slide, please.

This is some additional resources sources if you want to learn more about what we have done in California to improve health care. The most recent one at the Journal of the American Geriatric Society emphasizes the advocacy model and can be helpful to others who are trying to do something similar. Thank you for attending today and I certainly hope you found this presentation helpful.

Katie Palmisano: Thank you for sharing your knowledge and so many valuable resources, Dr. Cherry. As a reminder, if you have a question, please submit them into the Q&A box and it is now my pleasure to introduce our presenters from Health Net. These include Linda Wade, Senior Director of Population Health and Clinical Operations, Ed Mariscal, Director of Public Programs and Long-Term Services and Supports, and Anita Chacon Terry, Manager of Care Management for Health Net. Linda, I'll turn to you to tell us a little bit about Health Net's approach.

Linda Wade-Bickel: Great, thank you so much. Next slide, please.

Health Net is one of the many health plans owned by Centene Corporation. Centene was founded as a single local health plan in 1984. And now it is a diversified enterprise with multiple health plans across the United States, serving the commercial marketplace, Medicare, and Medicaid members. Health Net was founded in 1977. And currently 85% of our members are in government sponsored programs with 2 million members in our

Medicaid program. And moving on to our next slide, I'll share some information regarding our dual demonstration program entitled Cal MediConnect. Our dually eligible population is in the Los Angeles and San Diego counties. Currently there are approximately 7,000 members enrolled in the program, and about half of these are 75 years old or older. The chart on the right shows the age breakdown with quite a wide range. The race and ethnicity distribution from 2021 shows 83% of this population are in the Hispanic, White, Asian/Pacific Islander, and Black/African American groupings.

A few details most applicable today to today's topic, are an average of 98 Cal MediConnect members are utilizing adult day care health services per month, and approximately 4.5% of this Cal MediConnect population has a diagnosis of Alzheimer's disease and related dementia. Next slide, please.

Health Net's approach to supporting the ADRD caregiver is integrated into our overall structure and process. Each dually eligible member is assigned a care manager upon enrollment into the program. And this care manager completes a comprehensive assessment for each member that includes cognitive capabilities, activities of daily living, caregiver medical and psychosocial status and needs. The care manager will work with the member, caregiver, and care team to address any areas of actual need and potential risks. Actions the care manager may take include making referrals to our licensed clinical social workers who will assist with connecting the member and their caregiver to community resources, our internal public programs and Long-Term Support Services Department that I will share more information about and organizations such as Alzheimer's, Los Angeles. Next slide, and to Anita.

Anita Chacon Terry: Thank you, Linda. I'll be discussing the care manager's role in the caregiver assessment and the benefits of care manager education. When our care managers connect with our members, they complete a comprehensive assessment of the members' medical and psychosocial needs. We look for any indications of memory or cognitive impairment and identify if the member has a diagnosis of Alzheimer's or dementia.

In addition, we will also complete an assessment with the caregiver. The caregiver's stress strain assessment evaluates how the caregiver feels and behaves as a result of providing care. Often the member's primary caregiver is a family member, not a trained professional. Therefore, it's important for the care manager to have a good understanding of their ability to care for the member and the impact that caregiving may have on their own activities and relationships.

We assess whether the caregiver feels prepared and able to provide care. If they are experiencing any resentment or anger towards the member due to the change in their relationship with caregiver and if they are experiencing any changes with their own mental and physical health as a result of becoming a caregiver. This gives us a deeper understanding of any potential issues with caregiver mastery, relationship strain or help strain which we can then use to develop an effective care plan to manage the members and caregivers needs. Next slide, please.

Having care managers who are trained in dementia care is an important part of a comprehensive care management program. We are able to start supporting the member and their caregiver from the first call by identifying needs, issues, and barriers and implementing interventions right away. For example, if a member is diagnosed with dementia and during our assessment, the caregiver reports that the member has been displaying challenging behaviors such as sundowning, we would utilize the care needs assessment tool resource we received from our training to further assess challenging behaviors experienced. This assessment will also give the care manager insight into any ADL, functional, safety, and caregiver needs. Once the specific behaviors and needs are identified, the care manager will then utilize information from the appropriate Best Practices Care Plans provided in the dementia care toolkit from Alzheimer's Los Angeles to develop a plan of care that will help the caregiver to understand the possible meaning and triggers of the behavior.

In the example of sundowning behaviors, the care manager will ask questions to further understand the possible triggers for the behaviors such as, does the member feel fatigue? Is there a lot of noise in the environment? Or is the member in a room that is very dark and might have shadows? They will help the caregiver to understand the possible meanings of the behaviors. Is the member feeling frightened? Are they experiencing anxiety from too much noise or stimulation?

And the care manager will also help the caregiver to understand their own feelings towards the member's behaviors. Does the caregiver feel frustrated? Is the caregiver tired. We then teach the caregiver problem-solving strategies and interventions that may help to decrease the behaviors. Strategies such as increasing illumination in the home before the sundowning behaviors occur. Lower the noise level, use a calm and reassuring voice. And we also mail tip sheets specific to the identified behavior that the caregiver can use as a reference for the problem-solving strategies we discussed.

In addition to working with the caregiver. The care manager will also collaborate with the PCP for further evaluation of possible medication interactions or other medical concerns that may be impacting the behavior. Dementia care training has armed our care managers with the knowledge to effectively collaborate with their health care team, provide appropriate referrals for support, and most importantly, advocate for the member. And now Ed will talk about health equity.

Ed Mariscal: Thank you, Anita. And again, good morning, slash afternoon, everybody. The CDC says that health equity is achieved when every person has the opportunity to attain his or her full health potential. And no one, no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. Health inequities are reflected in differences in length of life, quality of life, rates of disease, disability and death, severity of disease, and access to treatment.

Dr. Cherry spoke about the Latino population in particular, accessing fewer supports. Our goal here is to achieve health equity by eliminating these health disparities and achieving optimal health for all people. We at Health Net are the equity in the system and our responsibility is to ensure our members do not face these health inequities.

To achieve this health equity, it's vital that we acknowledge cultural differences in caregiving. To achieve health equity, we must ensure that cultural competence is foundational. If we're going to transform the health of our communities, we must ensure that our health plan resources, our teams supporting our very vulnerable members are able to navigate this cultural landscape.

They must understand and emphasize with values, customs, and traditions of the very diverse populations we serve. Additionally, we must understand generational differences as people of different generations will have unique needs and insight into the care they receive. An effective health equity program must have immediate access to interpreter services. An effective health equity program has a large network of community-based organizations with culturally appropriate services. And to repeat my earlier statement for an effective health equity program, the health plan must engage in regular and consistent training of our staff. Next slide, please.

Dr. Cherry earlier gave some great examples on barriers accessing care. Let me share with you a couple of case studies where we at the health plan intervened to eliminate some of these barriers. Back in 2020, Health Net had maybe a little over 10,000 members institutionalized in long term care. About 10 to 15% were enrolled in our MMP, what we call our Cal MediConnect plan, our dual demonstration. A nursing facility had reached out to us asking for support in training a member and transitioning a member home at his request. This member had been institutionalized for a little over three years; he had a wife and two kids at home.

The nursing facility had not made any previous attempts to transition the member home, and they had come to the conclusion that that was not a viable or safe option for him. The wife had indicated that she did not have any resources or support at home to take care of her kids plus her husband, who still required quite a bit of support. She also worked full time.

When this member was, when the nursing facility and the member reached out to us for support, we immediately gathered a team of resources to support this member and the family. It included care management, and a social worker from the public programs team of specialists. Together we engaged in a conversation with the member's wife. We worked with the apartment landlord to add her to a first-floor apartment waitlist. Unusual for health plans to deal with directly with landlords, but we did. We thought it was important. We made a referral to the county in-home supportive services program to initiate and schedule an assessment. Understanding that in LA County, that assessment can sometimes take up to 90 days. We identified a local, community-based adult service center that caters to the member's cultural and language needs. Additionally, and equally important, the wife's needs were top of mind. As the primary caregiver for her husband, she needed her own supports. We offered her the respite care benefit as she was, and she was given the information on how to access this particular benefit. And we also ensured constant communication to ensure that she was aware every step of the way because we knew it was going to be a long process.

When this first-floor apartment became available, the member was transitioned from his institutionalized setting back home with his wife and kids after about three and a half years. On the day of the transition, DME was in place, IHSS was in place, a CBAS center was available, and he began participating five days a week. Health Net's public programs team, as well as care managers followed him and his wife for the next six months. We're very, very proud of the safe and successful transition. Next slide, please.

The second case study also focuses on the transition of a member from an institutionalized setting. This time the member was previously experiencing homelessness and had high ADL and IADL needs. She was also blind and experiencing dementia. The case management team together with the public programs team partnered to support the member. She had been found unconscious on the streets. After a short acute hospital stay, she was transitioned to a skilled nursing facility where she expected to remain for the remainder of her life. However, the team at Health Net immediately jumped into to action here, and we began working on a safe discharge plan for her at the time of admission. For all nursing home admissions, our team reviews the MDS assessment that's completed by the nursing facility, more specifically Section Q, which members, which identifies the member's desire to transition home or to the community.

In this case, while she was still a patient with high acuity needs in the nursing facility, she did express a desire to transition, and we sprang into action. We identified a boarding care in the community of her choice that had other residents experiencing vision loss and were previously experiencing homelessness. We identified a mental health provider in her community to support her upon discharge.

We partnered with a community-based organization to help the member with general relief fund, SSI, obtaining identification. We connected the member to a CBAS center that specialized in dementia care too. This member eventually transitioned to this supporting care. And two years after this transition, the member had no hospital readmissions. We're incredibly proud of that. These are just a couple of examples of our responsibility to help transform the health of our communities, one person at a time. Next slide, please.

You've heard me speak about the impact of these community programs. Let me just spend a little bit more time a couple more minutes on them. HCBS waiver programs, long term services and supports, and other community-based organizations exist to help reduce avoidable emergency department utilization and hospital admissions which oftentimes lead to institutionalization.

They exist to support the family caregivers as well. In some cases, providing safety evaluations in the home, family caregiver training, and many additional supports. HCBS waiver programs, long term services and supports and community-based organizations have specialized care programs, services and supports to care for the member in the family and they're incredibly effective, and we need to continue to utilize these very, very valuable programs in our communities.

You heard me say earlier that the managed care plan is the equity in our systems. We can only be the equity in in our systems if we have a vast partnership with these HCBS and LTSS and CBOs in our communities. Together we improve access to care and continuity of care. Together we ensure culturally appropriate care. Together we advocate for our members through the services we provide, language and interpreter services, medically tailored meals, which are very often delivered to our members' doorstep.

Additionally, on the health plan side, we can leverage a lot of data available to us to create what we call report cards that will call out specific quality metrics and key performance indicators. Our data analytics can trend issues before they can negatively impact our members. And our data analytics can help risk stratify our members, to direct specific resources to them and their family caregiver sometimes even before they ask for those supports.

We can look at historical trends on hospital admissions and readmissions, and direct resources specific to those historical trends. We can look at CBOs and other providers with successful rates of interventions to ensure members remain safe in the community. We can make the appropriate referral specific to the CBOs depending on their successful outcomes.

Ultimately, no one entity can do this alone. Through the examples shared in the community partnerships, together we can continue to transform the health of our communities, one person at a time. Thank you for your time. Next slide, please.

Katie Palmisano: Thank you so much to the Health Net team and to all of our speakers for sharing your thoughts on supporting caregivers of individuals with ADRD. We will now move into our panel discussion.

The first question is for Dr. Reuben, Dr. Cherry, and Linda. Starting with Dr. Reuben, based on your program or experience, what are the innovations or opportunities that could be implemented within health plans for addressing health equity when supporting caregivers for persons with ADRD?

Dr. David Reuben, MD: Yes, thank you. I think one of the major things is linking persons living with dementia and their caregivers to community-based resources. They have much better context in terms of understanding the patient and her or his environment and can tailor resources. The healthcare system is kind of a monolith. And the community-based organizations are much more personalized and much more fitting with the community.

Katie Palmisano: Thank you, Dr. Reuben. Dr. Cherry, do you mind providing your perspective?

Dr. Debra Cherry, PhD: Sure. No, I agree with Dr. Reuben that there has to be an emphasis on collaboration with community-based organizations. You know, they're embedded in the community, they're embedded into the culture. There are also, however, current opportunities due to the recent emphasis on population health. For example, as I've mentioned in my presentation, you can use the health risk assessments that are

becoming more common to identify caregivers. These are people with living with dementia and who were often invisible in the past. Also, the emphasis on dementia care management, where dementia care coordination provides opportunities to identify and address caregiver needs within the health plan with a culturally matched eye. So that the care manager can connect families from different backgrounds to culturally appropriate services.

Katie Palmisano: Thank you, Dr. Cherry. Linda, could you share your thoughts in response to this question?

Linda Wade-Bickel: Hi. Similarly, we have the opportunity to discuss the member and understand the member and caregiver needs and integrate this with the knowledge of the community to best align with and meet the needs of the member and the caregiver. Ed discussed an example of this earlier and matching the member needs to take services at the CBAS site. And also, we take the opportunity to provide a training to our health plan staff, medical groups, and community-based organizations on health equity issues, to enable effectuation of the best solutions for specific member needs and their caregivers.

Katie Palmisano: Thank you, Linda. And the second question is for Dr. Cherry, Ed, and Dr. Reuben. Dr. Cherry, how do you suggest health plans or providers customize caregiver support programs based on population characteristics?

Dr. Debra Cherry, PhD: Well, first, you want to customize the caregiver support to the needs of caregivers of people living with dementia specifically. Because these caregivers frequently have higher needs than people who are caring for people with many other conditions. The second level of customization would be by language and culture and literacy level. And that needs to be prioritized. And that means use of linguistically and culturally competent dementia care managers. And development of relationships with community-based organizations that are linguistically and culturally capable of collaborating with your caregivers and families.

You want to make sure that you can access disease education that is matched linguistically, culturally, health literacy level to the members in your health plan. Some people, again, are able to read at only a sixth-grade reading level or are not literate at all. You don't want to be providing them with regular college level disease education materials. You have to cater and bring what's needed by the people served by your health plan.

Katie Palmisano: Thank you, Dr. Cherry. Ed, do you mind offering your perspective?

Ed Mariscal: Sure, thank you. So here at the health plan, we must have systems in place to understand first what our member population characteristics are because this isn't a guess. This isn't a wait and see situation. We engage in welcome calls and new member outreach. And during those opportunities to speak to our members, we identify the member's population characteristics, but also their caregiver support, and support programs that they might need.

Of course, it's super important to hire and train the right resources to support this population based on the information we have available to us. And at the same time, it's incredibly important that we work closely with our CBOs, LTSS, and HCBS programs to ensure what we understand what their strengths and challenges are to ensure proper and timely and appropriate referrals and partnerships.

Oftentimes when speaking to our members, they wish to receive services from a CBO that either a friend went to or someplace that is closest to their home. It's across the street or around the corner they often say. What they don't know or at least not initially is that the CBO may cater to a different kind of population. And while close is good, they may not be the most culturally appropriate for them or their family. So, we speak to them, we listen to them, we understand them, and together we make the decision of what is best for them. Thank you.

Katie Palmisano: Thank you, Ed. Dr. Reuben, do you mind providing the final response to this question?

Dr. David Reuben, MD: Glad to. So, customization really depends upon how you define the population. What characteristics are you defining it on? Is it what disease they have? It is the person's income, socio-demographic factors, utilization, other ethnic differences? So, think of it this way, if you take the entire population and make a triangle, and at the top of that triangle, the triangle has a bunch of tiers, the top is the top 1%, and two to 5%, 6 to 20%, 20 to 60%, and 60 to 100%. The needs of that population will differ depending upon where they fit in that triangle, which tier. So, for example, at our institution, that 60 to 100%, they have very little need, because the disease is not so severe, and they don't have high utilization. They're plugged into an information referral system. But as the needs get greater, they're either it's either a dementia care assistant or dementia care specialist. So, it's defining it, it is making sure to get it right, getting the right care for the right person. And that's the best not only for the person, but also for the health system.

Katie Palmisano: Thank you, Dr. Reuben. And our third and final panel question is for Anita, Dr. Reuben and Dr. Cherry, Anita perhaps you can start. What strategies would you suggest care managers employ to build and sustain connections with caregivers of persons with ADRD?

Anita Chacon Terry: Yes, thank you. The most important thing to build and sustain connections with caregivers is listening to them, asking them about how their caregiving is impacting them. So often, our focus is on the member and the caregiver is forgotten. Caregivers themselves often forget about their own needs. Taking the time to talk to them, identifying what they need, and connecting them to resources, and letting them know that you're there for them too can really help make that connection.

Katie Palmisano: Thank you, Anita. Dr. Reuben, do you mind sharing your thoughts on these strategies?

Dr. David Reuben, MD: Sure. In our approach, we actually think of it as a dyad, the person living with dementia and the caregiver. And you have to meet the needs of both.

And interestingly enough, our Dementia Care Specialists don't like to be called care managers, because they do much more than care management. They build relationships. And that's really the key because living with dementia is a journey that has twists and turns and having somebody who knows you, knows your values, and knows your situation, and having them being available are key.

Katie Palmisano: Thank you, Dr. Reuben. And Dr. Cherry, I'll turn to you for the final response to this question.

Dr. Debra Cherry, PhD: First, let me say that I agree with everything my co-panelists have said so far. I think the key question is how do you build trust and enhance communication? I know it does go a long way to be able to speak to people in their language, and to have staff available to work with members who come from a similar culture, it's not absolutely necessary, but it is beneficial.

Also important is for that individual to be an active listener and learn where needs are, to be prepared to meet those needs in a way that's responsive to the members socioeconomic status, their culture, and their educational status. So, you need to have resources that are low cost, that are accessible in many ways. Probably not an elder law attorney, but perhaps a legal clinic that caters to low-income older adults.

You want to let people know that you're available as the disease progresses, and they can come back to you as new needs arise, which they will. And then finally, because there's so much stigma attached to these conditions, we have to recognize that family caregivers may be reluctant to speak about all that they need. You have to build trust in order to give them a safe environment so that they can speak frankly.

Katie Palmisano: Thank you, Dr. Cherry. And a big thank you to all of our presenters, all of our panelists for your engaging presentations, as well as that thoughtful panel discussion.

With that we now have a few moments for questions from the audience. If you have any questions for our speakers, please continue to submit them using the Q&A box on the lower left side of your presentation. Please type your comment at the bottom of the Q&A box and then press Submit to send. So given the time that we'd like to ask this question to all of our panelists.

So, the question is, from your perspective, what role may Medicare-Medicaid health plans have in supporting patients living with ADRD and their family caregivers? So, kind of final thoughts and perspectives on the role that Medicaid and Medicare plans have in supporting these patients and family caregivers? And perhaps we can start at the top of the list and Dr. Reuben, you can respond first?

Dr. David Reuben, MD: Yes, I think that health plans have a unique opportunity, because they can mobilize these kinds of resources immediately. They don't have to worry about payment codes, etc. And they have the privilege of actually contracting with community-based services and paying for that. So, realizing that these kinds of services can actually save health plans money, there is no barrier other than inertia.

Katie Palmisano: Thank you. Thank you, Dr. Reuben, and Dr. Cherry to you.

Dr. Debra Cherry, PhD: You know, the duals demonstration on health plans have had some really wonderful tools at their disposal, because they oversee Medicare, which is primarily the medical payer for many of these members, and also Medicaid, which pays for some long-term services and supports in some states. So, it does, it does give you tools to increase the chance that the member will get the best quality of care available, and the best environment. And all those conversations, you know, the case examples from Health Net of moving people out of a less preferred nursing home into community-based settings. That is something that would be hard to do in other systems of care.

Katie Palmisano: Thank you, Dr. Cherry. And I'll pose the same question to our Health Net team, and I'll invite one of you to respond.

Linda Wade-Bickel: This is Linda. I think that the opportunity to have an integral, you know, integrated system where we can work across so many internal and external entities to achieve what's needed for the member and then look at each member individually. That's really our goal at this company is to help each person and their caregiver meet their overall health care needs.

Katie Palmisano: Thank you so much, Linda. At this time, if you have any additional questions or comments, please email RIC@lewin.com. The slides for today's presentation, the recording, and a transcript will be available on the resources for Integrated Care website shortly. Additional resources referenced during today's presentation are included at the end of this presentation and these references are available to you upon downloading the slides.

As a reminder, please take the post-test if you're interested in earning NASW CEUs. You must take the post-test by 11:59pm on Tuesday, September 20th with a passing score. You can take the post-test multiple times to earn this score.

Please complete our brief evaluation of this webinar so that we can continue to deliver high quality presentations. We would also like to invite you to provide feedback on other RIC products as well as suggestions to inform the development of potential new resources by using the link included on this slide.

Our speakers also wanted to highlight a few key resources for you all today. And those are listed here. Thank you again to all of our speakers for sharing these resources and for your engaging and informative presentations. Thank you also to all of our audience members for your participation in our polls and our questions. I hope that you all have a wonderful day.