

The Lewin Group
Applying Promising Practices to Advance Care of Medicare-Medicaid Enrollees with Dementia
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Caroline Loeser: My name is Caroline Loeser, and I'm with the Lewin Group. This is the first webinar in the 2017 Geriatric-Competent Care webinar series. Today will include a 60-minute presenter led discussion followed by 30 minutes of discussion among the presenters and participants. This session will be recorded in a video replay. The slide presentation, as well as a Q&A, will be available at <https://resourcesforintegratedcare.com/>. If you would like a copy of the slides from today's webinar, a link was provided in the chat box on the left of your screen. This link was also provided to you yesterday via e-mail from webinars at ConferTel.net.

This webinar is presented in conjunction with Community Catalyst and the Lewin Group and supported through the Medicare-Medicaid Coordination Office (MMCO) at the Centers for Medicare and Medicaid Services (CMS). MMCO is developing technical assistance and actionable tools based on successful innovations in care models, such as this webinar series. To learn more about current efforts and resources, please visit our website or follow us on Twitter for more details. Our Twitter handle is @Integrate_Care. Before we get started I would like to remind you all that all microphones will be muted throughout the presentation, but there will be a question and answer opportunity at the end of the presentation. If you do have a question, please use the chat feature on the platform to submit a question at any time during today's event. At this time, I would like to introduce our moderator. Nancy Wilson is an associate professor of geriatric medicine at Baylor College of Medicine. Nancy?

Nancy Wilson: Thank you, Caroline. Good morning and good afternoon, everyone, and welcome. As a social worker here in Houston, Texas and member of Community Catalyst Geriatric- Competent Care Planning Committee, I am honored to introduce this webinar faculty.

Community Catalyst is a national consumer health advocacy organization whose mission is to organize and sustain the consumer voices to ensure all individuals and communities can influence local, state, and national decisions that affect their health. In partnership with the Lewin Group and the American Geriatric Society, Community Catalyst has been hosting the Geriatric-Competent Care series for the past three years, and we are excited that all of this material has been archived. Last year the focus was on the diagnosis and treatment of dementia, and today's webinar is taking us deeper and how state's health plans, providers, and community-based organizations are implementing promising practices for care of those with dementia for enrollees in the financial alignment demonstrations, also known as the duals demonstrations. I think you'll find their content and tools are also relevant to decision makers and providers in other health care settings.

It's my pleasure to introduce our panel of speakers, who will share with you their experience and knowledge, and also direct you to some very practical and valuable tools. First up will be Debra Cherry. Debra is a clinical psychologist and the executive vice president of Alzheimer's Greater Los Angeles. Dr. Cherry received her Ph.D. from the University of Southern California and completed a postdoctoral fellowship in geriatric psychology at UCLA, where she serves on the clinical faculty. Dr. Cherry has participated in the creation of numerous award winning programs for people with dementia and their families. She's had a particular passion and influence for developing programs to increase access to care by ethnically diverse families, you may have heard some of these, such as El Portal, the Latino care network, and its replication in African-American and Asian-American communities. She's also been involved in national health care projects focused on health care quality improvement, such as the Kaiser Permanente dementia care project. At the national level, Debra has served on the American Society on

Aging's board of directors and has been a colleague of mine on the John A. Hartford Foundation's Change AGEnt caregiving network.

Following Debra will be a partner there in California, Linda Wade, a director of care management at Health Net, where she has worked for over a decade. In her current position in this health plan, Ms. Wade is responsible for planning and provision of case management, for MediCal, Medicare, and insurances. Ms. Wade has both a business background, including an MBA from Pepperdine University, and a clinical background as a licensed registered nurse and holds a degree in nursing from Azusa Pacific University. Using these skills, she has 20 years of experience in health care management, leadership including subacute and medical group settings, and we are particularly excited that following Linda we will hear from the most vital part of our workforce, a caregiver. Tracey Brown-Lindsey is a caregiver living in Los Angeles, where she plays a vital role in caring for her mother.

The final speaker is Teeshla Curtis, who works in South Carolina for the South Carolina financial initiative known as Healthy Connections Prime. She is also responsible for the all inclusive program known as Care for the Elderly.

She works as a community relation hospice provider where she assisted in the implementation of a statewide outreach program for assistive caregivers, later joining the South Carolina Department of Health and Human Services, under the Office of Human Behavioral Health. Currently, she works as the program manager for initiatives that seek to improve care for Medicare and Medicaid relatives. Teeshla facilitates caregiver support groups and grief workshops and is a member of South Carolina's coalition for the care of the seriously ill, and along with Debra, a member of the AARP learning collaborative for managed care caregivers and long term support. She is a dementia specialist and is pursuing certification as a Dementia Dialogues trainer.

So you have met our diverse faculty, and now we are eager to meet all of you. So we are going to do that through a process of polling. You're going to have the opportunity to respond to three poll questions, and they are going to be appearing shortly. We ask you to reflect and provide an answer quickly so we can see who's with us today.

So, polling question number one, which of the following best describes your professional area?

I see lots of answers coming in, almost something in every box so far. So take about five more seconds, if you can, and now Christopher if we could close the first poll.

So it looks like we have a nice distribution of individuals with a number of different disciplinary backgrounds, with the largest percentage of people either being involved in the health plan management staff area or as social workers, but we have other medical care providers and some individuals in the other categories, so we are excited to have everyone with us today.

Polling question number two, so you may have a certain disciplinary background but may play another variety of roles with that background, so if you could just kind of identify yourself in that regard?

We'll take a couple of more seconds. And Christopher, if we can close this poll now?

And again, it looks like we have a wonderful distribution, and I see voices of consumer advocacy showing up as well as leadership at the administrative role and also excited to see, Tracey, you have some family caregivers joining, so we have an -- we are going to have all of the stakeholders involved, and that's exciting for this topic.

And our final poll question. So we are interested to know in what setting you work. We recognize that particularly within the financial alignment demonstration there are a lot of different platforms of delivery as well as organization and leadership. So if you could choose which arena you're primarily working out of. Are you in home care, long-term care? Are you at the managed care organization level? And let's close this poll now, Christopher, and see where we are with results.

And on my end, I'm not able to see our distribution, so perhaps because we have -- oh, well, there we are. Okay. So it looks like we have a number of individuals working at the managed care organization level, but we have all settings of delivery represented, which is particularly exciting, from the home, the community, long-term care, and we know that care for persons with dementia needs to be capable in a variety of settings, and a lot of that depends on systems leadership, so it's great to have all of the voices here today.

So at this time we are going to hear from our first presenter, so I would like to turn the webinar over to Debra Cherry.

Debra Cherry: Let me thank all of you for being here today. I'll be speaking about California's Cal MediConnect Project, and the work we are doing within it. That's our state's financial pilot. Let me note that California has 1.1 million dually eligible people, but our pilot operates only in eight counties, eight of the most populous counties within our state, with 11 participating health plans, each of which receives a capitated rate to serve members with Medicare and Medicaid, both through their medical providers and through their long-term care providers. These are usually Medicaid waiver providers, such as nursing homes and adult day care.

Since so much of quality dementia care is delivered in home and community-based long-term care settings, California viewed this pilot as an excellent opportunity to create systems of care with each of the health plans that could serve people with dementia in a more integrated manner and in their setting of choice, which is usually the home.

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This project was supported through a number of funders. Let me particularly call out the Administration for Community Living Alzheimer's Disease Supportive Services program, which has supported the program through the State of California, and the John A. Hartford Change AGENTS Dementia Caregiving Network for its remarkable support.

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The Dementia Cal MediConnect Project had five components. We started with advocacy health plans, and that advocacy was done in stakeholder meetings, advisory committee meetings, and with our state as they planned our duals demonstration. We made the case for focusing on dementia care within this capitated system of care.

Then with ACL support and foundation support, we were enabled to do care manager training and support, to provide caregiver information and respite. Support services for people and their families through referrals to local Alzheimer's organizations, and increasingly we have provided technical assistance to the health plans to help them provide better dementia care.

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So when we started with the advocacy, we had to make a case for improving dementia health care, and one of the first things we pointed out is that the numbers of people with dementia are growing. And while it's estimated that 10-11% of people age 65 and older have dementia, like in Alzheimer's disease or another dementia, the prevalence amongst the dual eligibles is much higher, perhaps as much as 23% of duals age 65 + have dementia, largely we believe caused by their comorbidities that put them at greater risk, and these are expensive people to serve, which is what we pointed out both to our state and to health plans, and if you look at the chart you'll see that they cost Medicare three times more than other beneficiaries. They cost Medicaid 19 times more than other Medicare beneficiaries, and that is primarily driven by nursing home utilization. Sadly, even though they are an expensive population, this group faces many barriers to obtaining quality care. You can see them on my slide. There is very poor detection of dementia. Therefore, people do not get appropriate treatment and management.

This poor recognition of the essential role played by family caregivers, and there is awkward connection to home and community-based services.

The dual eligibles pilot provides us all with policy letters that can help us to move quality care forward. We looked in California at our three-way contracts between the states, CMS and the health plans, to find some of these levers. We also read all plan letters and tried to synchronize the goals of our project with the requirements in those directives.

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So, the project goal is creating a dementia-capable system or multiple systems of care, because each health care plan is different, and to do that we had three goals: one, better detection and documentation of patients with dementia; two, better partnerships with health systems and family, friend, you know, unpaid caregivers; and three, better partnerships with community-based organizations.

Let's review these goals and how we tackled them one by one.

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We are going to start with the first goal, better detection and documentation of patients with dementia. And it has to be noted that only about 50% of people with Alzheimer's disease, a major type of dementia, ever get a diagnosis, and only about half of these have it documented in their medical records. So to achieve better detection and documentation of patients with dementia, members with dementia, we worked with the health plans to include a cognitive assessment question in their health risk assessments to adopt a validated screening tool to document the cognitive assessment in the medical record and to establish a follow-up protocol for diagnosis, if the cognitive screen was positive. And let me note that many times, or several times, health plans believed that they were doing a cognitive screen in their health risk assessments, but on further review it was revealed that they were screening for behavioral health issues, schizophrenia, and other issues, but not really for cognitive impairment.

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So there are challenges to the recognition of dementia. As I mentioned, a lot of health risk assessments don't include screening questions for cognitive impairment. Families in the duals pilot may be less likely to bring dementia to the attention of a physician. They may have a lack of understanding of the condition, may think it's a normal part of aging. There's a lot of stigma attached to this condition. And many times the providers they see, who are from their own communities, may share cultural views about dementia and help families hide or deny the disease. So we need backup ways to identify these individuals.

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One of the ways, as mentioned, was the review of health risk assessment content and within a health plan or within partnership with a local Alzheimer's organization, you can do a review of a health risk assessment and make sure that there is screening provided, a few questions that would then indicate the need for further screening.

We, in our project, trained and provided technical assistance to care managers and others within health plans to encourage them to screen for dementia with a validated tool. This is not simply asking a family member if their relative has Alzheimer's but is actually to use a validated tool. We adopted the AD8, which is an eight-item tool that can be used by telephone, either with a patient or a family member.

And then we developed plans and provided technical assistance to some health plans to develop a follow-up protocol. Each of the tools we'll be mentioning are available on our website, and I'll give you that link later.

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So our next indicator of better quality dementia care was a partnership between health systems and family-friendly caregivers. Now, family caregivers are the backbone of our home and community-based long-term care system for people with dementia.

Families fill in as the person declines, doing all of a wide array of tasks, and it is essential for health plans to recognize the important role that they play in caring for members who have dementia. So we worked with the health plans to help them identify a family caregiver, document it in the chart, and assist that caregiver's needs. But that wasn't enough. They also needed to think about how to provide the caregiver with education and support.

We had trained some dementia care specialists and had hoped that they would use plans that we taught them to adopt, so they could provide more uniform care for these patients, these members as well.

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There were challenges to family caregiver and are challenges to family friend caregiver engagement. Medical providers may not have institutionalized systems that help them identify these systems. They are trained to focus on the patient, not on the family or the caregiver. They may feel bound by HIPAA constraints not to engage with the family caregiver, but as a result of that, as the items on the slide show, they have poorer management of comorbid conditions, especially complex and multiple comorbid conditions, which we often see amongst the duals.

There is apparent noncompliance. Physicians may not understand why the person isn't doing what they told them to do. There can be medication mismanagement, behavioral symptom mismanagement, and this all may result in unnecessary hospitalizations, ER visits, and maybe even in nursing home placement.

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So for those of us working as care managers or health care providers or for those of us who are advocates, working with health plans, we want to encourage that that family friend caregiver or sometimes multiple caregivers be documented in the electronic medical record and/or case management medical record so

that multiple health care providers see who is providing what person is providing what services to the person with dementia. We provide on our website, which is listed on this slide, tools for identifying a caregiver, identifying their needs, and from assessing some of their stress and strain.

We also encourage that specialized or trained care managers provide care to people with dementia and to their families and that they use standardized care plans. Ours were derived from the evidence-based access program.

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We also encourage them to -- health plans to link families to home and community based services that are suitable for lower income people. So most people with dementia do need some financial legal planning, and you have to find no-cost or low-cost planning in order to meet their needs, because they can't afford elder care attorneys, for example.

We also strongly encourage the delivery of education to family caregivers, and within the duals pilot, as you all know, the reading level for this training is supposed to be at 6th grade or lower. And we have developed some plain language fact sheets for a variety of common behavioral issues that come up in dementia.

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These fact sheets are available -- this is an example of one -- in English and in Spanish, and later this year they will also be available in Chinese.

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The third goal or indicator of our dementia capable system was better partnerships with community-based organizations. Many providers believe it is enough to give a family a list of numbers to call or even one number of a community-based organization, but frequently families are so overwhelmed by care that they cannot take the step of making that phone call, so we encourage the adoption of a proactive referral tool that connects families to home and community-based services like respite care support groups, caregiver education, care counseling. Our tool is called ALZ Direct Connect, and it does connect families to local Alzheimer's organizations.

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This is what our tool looks like. It is downloadable from our website and can be adjusted for use in your local community with local resources on it, but the key is that you ask the provider, ask the family if it would be okay if a local Alzheimer's organization gives them a call. And then an organization, such as mine, Alzheimer's Greater Los Angeles, would make the phone call to the family and see what their needs are, try to meet those needs or arrange for those needs, and give feedback to the provider.

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There are challenges to having partnerships between community-based organizations and health care organizations that often involve culture change for both. Managed care organizations often expect you to be timely and provide feedback, and community-based organizations may not be HIPAA compliant. They may not have the capacity for large quantities of referrals. When we started getting referrals from our first

health plan, it set our care counselors back with a waiting list of two weeks, because we got everyone at once.

So people have to consider where additional resources will come from to support the community-based organizations if they take on a large quantity of care for families from managed care organizations, and the partners need to invest some time in order to better understand each other's culture, capacity and services.

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For the materials that we have developed, you can go to our website. Some of the things that we have on that website, which is on this slide, are sample health risk assessment questions and/or training curricula, the ALZ Direct form, a dementia management care toolkit, like contain materials like a dementia screening tool and caregiver identification assessment tools, and a series of tools that can be helpful for you in working with families to better manage some of the behavioral symptoms that we see in dementia.

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We also have a link on our website to three online training modules, which are available for a minimal charge, an hour on fundamentals of Alzheimer's for health care professionals, effective strategies for managing behavioral symptoms of dementia. That's a two-hour module, and caring for the family caregiver. These are set up to provide continuing education units, I believe, for nurses and social workers, possibly for others as well.

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So, with our promising practice, what have we learned so far? And I have to say we are in -- we are going into year-four of what will be at least a five-year intervention. Knowledge gain, which was measured in our care managers from baseline to a six-month period, we saw that our trained care managers showed significant knowledge gain, and that it was maintained through the six-month follow-up.

We measured system change by asking the care managers to self-report how they had changed, how they delivered care in surveys done at pre, post, and six months. And we also kept a system change spreadsheet which was completed by project staff on the word that was obtained of health care health plan staff about improvements in care practices.

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Based on the data collected from the care managers, we believe that the training did have an impact on care management practices. The purple line is baseline, and the six-month follow-up with care managers appears in orange for each of these care practices. And they showed self-reported improvements in encouraging families to get a formal diagnosis, determining whether they have an informal caregiver -- that's an unpaid caregiver -- trying to improve, involve the caregiver in the care planning process, refer the patient to home and community-based services, and their caregiver the same, and referring people to Alzheimer's organizations. All of these improvements were significant, except for a usually involved informal caregiver in the care planning process at the time of this data analysis that had not quite reached significance. But we are still delivering the training and collecting additional data, and we'll probably have final data in about a year to a year and a half.

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Based on our system change spreadsheet, we have seen changes in HRAs in three health plans. Three have adopted the AD8 in their e-recordkeeping systems. All say they are identifying family caregivers, and two have formally adopted a measure of caregiver stress and strain. Five are offering respite, though we still question about how many families are actually getting respite, and seven of the eight we have worked with so far provide caregiver education and referrals to us.

Final slide. I want to give recognition to my wonderful team. I want to encourage all of you -- one more slide, next please, please -- I would encourage all of you to go to our website ALZGLA.org/professionals to get some of these tools. And now let me turn over the presentation to Linda Wade from Health Net health plan.

Linda Wade: Thank you, Debra, and good morning everyone.

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As Debra shared, Health Net, along with other health plans partnered with Alzheimer's Greater Los Angeles to provide tools to our case managers, care members and caregivers to better manage dementia-related diseases. Additionally with the Cal MediConnect health risk assessment, we needed to develop a risk assessment, and we were assisted in the development of that tool and that included draft of screening criteria for cognitive impairment care that was recommended.

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The key components of executing the plan for us, I'll review in more detail as outlined in this one slide below. First, we provided feedback to the Alzheimer's Greater Los Angeles organization in content development and class format for the initial 8-hour dementia training. They came and provided training to our case managers, which was a full-day training for a large group of case managers, and then some of them were selected to go to additional training to become a dementia care specialist.

When the team attended the full day training, so that was the whole team, they had the opportunity to go on a monthly or attend on a monthly basis clinical reviews with experts from UCLA, where we discussed our member concerns and questions, and they had the opportunity to learn strategies to help them better address the members' issues that they were dealing with at the time.

We implemented the AD8 assessment and caregiver assessment, which I'll talk more about later.

The training of our case management team on strategies for member management identified for care planning, such as combativeness, sleep issues, caregiver needs and safety was very helpful, and the training was provided in a manner where the case managers could practically apply the learnings into their conversations with the members, their caregivers, and integrate in a meaningful way to the plan of care.

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As I said, Alzheimer's Greater Los Angeles provided the training of the Health Net case managers, as well as our delegated provider groups, who perform case management, on the best practices for improving dementia care. Health Net delegates case management to 17 provider groups for the Cal MediConnect demonstration, and all of them participated in the training.

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That training was during the summer of 2015. During that time, the groups were provided with an overview of the work and partnership with Health Net. They reviewed best practices for dementia care, including tools that can be used by case managers, and they extended opportunities for the individual medical group pilots for further innovation. And as a result, several medical groups incorporated tools or adjusted their workflows within their electronic medical records to include our enhanced screening tools and interventions.

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The trained dementia care specialists who serve as an internal resource for our care managers at the health plan and delegated provider groups are really important in supporting the ongoing recognition and learning for the team overall in being effective with the members.

The training was, as I said, provided by Alzheimer's Greater Los Angeles. The dementia care specialists attended the monthly huddles for ongoing education in collaboration with other health plans and Alzheimer's Greater Los Angeles, and then they provided ongoing guidance and education to the care managers and members. Specialists also attend interdisciplinary care team meetings to provide consultations to the clinicians on specific member cases.

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Most promising practices that we implemented were the AD8 assessment tool. That tool is used when a member does not have a diagnosis of a dementia-related illness, yet presented with a thinking memory issue during their initial assessment or their health risk assessment. This was integrated into our medical management documentation system. If the AD8 yields a positive result, the care manager works with the primary care provider to make a follow-up appointment for evaluation for Alzheimer's or a dementia-related diseases. The AD8 tool is incorporated as the indicator in our monthly internal health plan audit to ensure our care manager utilization and understanding of the tool, and the caregiver assessment is integrated into our case management process. Health Net recently joined a corporation who owns many health plans across the United States, and as we have moved to our new case management documentation system, the AD8 and caregiver assessments were templated into the assessment for the management team, and the value of the caregiver assessment was recognized and is available to the care managers and case managers at the plans across the United States.

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Other promising practices are listed below. We partnered with, again, with the Alzheimer's Greater Los Angeles community education department to develop a cobranded flier for members in the community.

We partnered to provide community education classes.

We promoted the Alzheimer's Greater Los Angeles 24-hour help line on the Cal MediConnect member newsletter, and between 2014 and 2015, the Health Net Health Education Information Line promoted the Alzheimer's Greater Los Angeles help line upon member request and inquiries.

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I wanted to do a briefcase study that walks us through the different steps that have been integrated from our learnings with the Alzheimer's Greater Los Angeles trainings.

So, initially we have a member, a new member, and we complete their health risk assessment, and we identify a potential cognitive function deficit. The AD8 is complete with the member's grandson, who verified that the member has been positively diagnosed with dementia, but is being treated solely by his primary care physician.

The case manager contacted the primary care physician's office to discuss a neurologist consult. And the member's grandson contacted to schedule appointment as well, and the neurologist referral would be discussed at that appointment.

This member receives in-home support services but it's insufficient to meet the 24-hour care need, and the member and the grandson report issues with frequent caregiver turnover and caregiver burnout.

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The actions that the case manager took were to refer the member to licensed clinical social worker to evaluate psychosocial needs. We also had one of the dementia care specialists review the case, and they provided the following recommendations. During the next follow-up with the grandson, complete the caregiver assessment to identify issues based on a report of caregiver burnout and frequent caregiver turnover, provide education on the regional Alzheimer's Greater Los Angeles -- I'm sorry -- resources, and utilize the dementia care toolkit to resources to provide education on any behavioral issues identified during assessment and incorporate into the care plan.

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The challenges that we experience before, during, and after the implementation were, number one, data access and collection issues to evaluate the effectiveness of the program, and second is access to ongoing education for our new team members. It's such a great program. I really wanted it available to all of the team members, not those -- to those who were solely delivering their case management services to the Cal MediConnect duals demonstration members. Alzheimer's Greater Los Angeles responded to this need, as evidenced in the resources that Debra Cherry already has shared with you.

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The outcomes that we have achieved are early identification and notification to the physician of a member's dementia-related symptoms for further diagnostic testing, continued support and education for care managers, increased caregiver knowledge and skill to better manage members, the ability to help prevent, reduce or delay members' need to be institutionalized, to ensure effective member treatment plan is initiated for better member outcome, the ability to provide appropriate resources for dementia-related care, data used to identify improvement opportunities, and creation of knowledgeable team of care managers to optimally respond to member needs. It has enabled them to reach our goal to positively impact our members.

Now I would like to turn the presentation over to Tracey Brown-Lindsey to talk about her personal caregiver experience.

Tracey Brown-Lindsey: Hi, hello. This is Tracey Brown-Lindsey and thank you for having me, and I'm glad to be here today.

I am the daughter and a full-time caregiver as well as an advocate for my mom, who is 89 years old. She was diagnosed with Alzheimer's disease in September of 2014. I made a choice to basically put my life on hold to be there as a caregiver for her, and I have found that it has been the toughest thing that I have ever had to deal with, but, you know, we are making it happen.

After a couple of years of noticing her cognitive decline in my mom's memory, I decided that she needed to be seen by a physician for an assessment, not knowing what type of assessment or what the procedure was. I just basically depended on what the doctors recommended.

My mom has been up and down, and, you know, it's really hard to determine at the time that she started having these memory issues what was really going on. So at the time the doctor's appointment was made, she was given some screening tests that consisted of being able to remember certain things that were either shown to her or told to her, and with that a diagnosis was made in less than 30 minutes.

Well, I was a little blown away for that, because I really wasn't expecting the type of tests or the type of assessment that was done, but I really -- it was new to me, so all I had was to depend on the doctors and what they determined was the -- what was going on with my mom at that time.

At the end of the assessment, my mom was -- I'm sorry. My mom was prescribed some medication, which was called Namenda. It basically was told to me that it would help slow down the process. It wouldn't stop it, but it would help slow down the process, and that's all I was given at the time. Very few questions were answered. I didn't know what to ask, so I felt like maybe the doctors or the representative for the doctor should have at that point sat me down and described exactly what this medication was going to do, what the long-term condition would lead to, what, you know, exactly what I'm dealing with.

At the time I, in my mind, I thought maybe a brain scan should have been done, just to clarify the fact that she was diagnosed with Alzheimer's dementia, but to date we have never had a brain scan, and it took a lot of phone calls, a lot of time, effort to even get to the point where we are now.

I find it difficult to cope with her diagnosis at times. I don't get very much support from her health care. I -- it's just frustrating, so I have now become her advocate as well as being put on her advanced directives and making sure that things happen for her. But I still find it difficult because her health plan still feels the need to make decisions with her, and she's not in a situation where she can make sound decisions, and I find I spend a lot of time going back and forth with her health plan on establishing my identity and what, you know, what can and cannot be said as far as when I represent her, as far as a phone call or even a letter.

It took a while, but eventually her health care organization social worker referred us to the Alzheimer's Greater Los Angeles, and I tell you, it has been such a relief to have phone counseling, education, chat sessions, and just overall support about her disease. My mom's current situation and her symptoms have started to change, so it's always good to know I have someone I can call, other than her physician or her health plan, that can introduce me to new things, new education, things that will help me.

I have also been and have attended a support group where I'm able to talk to other people and caregivers that are going through the same thing as me. I have learned a lot and feel more at ease when it comes to my mom and her condition.

My current situation was very stressful. My mom had a fall in December. She fractured her hip. She needed surgery ASAP, and it was very frustrating because the whole situation was just -- nothing was explained. Nothing was -- every step of the way, you know, I was there, but they still continued to try to

talk to my mom. They had my mom sign her own surgery paperwork. They just basically acted as if I was not even there or I had nothing to do with her decision-making.

So it's just gotten to a point that, you know, I really need more support from her health care plan, and I would like to stay more involved with the decisions, and I shouldn't have to explain every single time what my position is.

I -- I just find it frustrating, but, again, now that I have more support on the other end, it makes it a little easier to deal with.

In closing, I think it's very important to be connected with support groups and resources from the very beginning of the diagnosis, and as an advocate you must ask a lot of questions and stay on top of your loved one's condition, and at the different phases of the disease so you will be able to handle it as the disease progresses.

Give yourself a break as well and hire someone to come in part-time just so that you can stay right in your mind and don't get overwhelmed.

Thank you for your time and listening to my story.

Now I'm introducing Teeshla Curtis. Thank you.

Teeshla Curtis: Thank you, Tracey. I really appreciate all that you have shared about your support of your mother, and I'm very grateful for this opportunity to share from the South Carolina perspective.

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What I hope to do today is just to give you a brief background and history of South Carolina and our experience in managed care, and then to talk a little bit about how that history and background really has informed our training approach and other requirements of our Medicare-Medicaid plans, and then lastly we will just kind of give an overview of some of the early experience and accomplishments of our health plans and also the lessons learned from the state perspective.

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South Carolina has operated our home and community-based programs for over 30 years, and so we have a very rich history and experience in that realm.

This population primarily serves the elderly and disabled, but our history, in terms of managed care, has been much shorter, with mandatory managed care only being implemented in 2014, and then -- I mean, I'm sorry, in 2010, and then in 2014 the state shifted to a full risk model in 2014, and even under that model some populations remained excluded, including dual eligibles, individuals who are institutionalized are in one of our waiver programs.

So when designing the demonstration model and requirements, thoughtful consideration was really given to kind of our history and our background as we considered oversight of this population, and then also our maturation into managed care.

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While our three-way contract does outline some requirements for health plans in terms of training, it was really our readiness tool that allowed us to assess the overall plan readiness to support older adults and individuals with dementia. The readiness tool kind of, as we modelled it and worked with CMS, really focused on the unique needs of individuals receiving long-term services and support and delivery models that support older adults.

The outcome of the review was really used to help inform ongoing monitoring and training efforts during implementation. During the readiness review process, we did identify some deficiencies among our health plans, and those are related to just simply understanding South Carolina's delivery system in terms of long-term services and support, reporting of critical incidents, and addressing health safety and welfare of enrollees through the individualized care plan.

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And so again, kind of using that information to really inform the next steps, our state, we leveraged our existing partnerships with advocacy groups, academic institutions and other state agencies to develop a series of trainings to help support our health plans.

We worked with the Alzheimer's Association to customize advanced dementia training, and again this training really aligned with some of the areas of concern that were identified through the readiness review. We have listed some of the topics that were covered, and we are very just pleased with that partnership, with the Alzheimer's Association. This training went for about six weeks. It was one-day training each week, but really working I'm not going to partnership with the Alzheimer's Association to develop training that was really specific to the needs of the health plan was very important.

Moving forward, we also have a contract with the University of South Carolina office for the study of aging to facilitate training, including dementia dialogues, and dementia dialogues is a five-session training course designed to educate individuals who care for persons with Alzheimer's disease or related dementias, and this is for individuals who are both professionals and/or caregivers.

This is a program that the state has been supporting for many years, and it's offered free of charge. The focus of the session includes an introduction to dementia, communication skills, safety activities of daily living, quality of life, adjusting challenging behavior, and creative problem solving.

This model, the reason why we chose this model was because it also includes a trainer module in which the health plans could integrate that into their kind of overall training for their staff.

In addition to the dementia training, we also had training related to elder abuse identification and reporting, and this was really to help the health plan to understand their role in the investigative process and to also understand the role of South Carolina Adult Protective Services.

And then lastly, we also provided training related to end-of-life care, and we really looked at the entire continuum from advanced care planning to palliative care to hospice, and how the health plans could help support their members and their caregivers through this process, with an emphasis really on the advanced care planning approach to really help support individuals who still were able to make those types of decisions early on, especially those with a mild cognitive impairment.

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As we move forward in terms of our training, we realize that we needed kind of a more accessible platform for training, and all of the other educational resources for our health plans, and so in 2016 we moved to an e-learning management system, and this really helped us to reduce our training costs. It also provided a centralized platform for learning that included assessment and testing, and so now our health plans have access to this kind of on-demand, and so even as they have new care coordinators come on board, they still have access to this information and training modules.

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In 2016, we also introduced a repository of materials on our website. Again, this is really to enable health plans to have access to this information as their staff continues to grow as the demonstration progresses.

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In addition to the training requirements, our overall program's design also includes other features we believe are very essential to supporting older adults. We have a unified or uniform assessment tool that all of our health plans are required to use, and this was developed by the state. As a component of that tool, each of the plans are required to utilize the St. Louis University Mental Status Examination to identify cognitive impairment, and we chose this as opposed to the many mental state examinations because of the SLUMS ability to identify that mild cognitive impairment, which potentially is biomarker for Alzheimer's disease and may occur in people as they progress from normal aging to Alzheimer's, and again this was simply used as a screening tool, and it's not a substitute for diagnosis, but it helps the health plans to have a better understanding of their members. The tool is also used up front in the assessment process, and so if there is an identification of any sort of impairment that would then kind of inform the care coordinator as to whether or not they should progress with the assessment or involve the caregiver.

And another component of our program design was kind of the testing of a palliative care benefit, and this is a new benefit that's just restricted to the demonstration population. This benefit focuses on pain management and comfort care with the idea of optimizing quality of life for individuals with a serious chronic or a life-limiting illness, including Alzheimer's and/or dementia.

And again, this is a recognition of the -- kind of the financial efficiency of using and leveraging palliative care for individuals with dementia as we look at the cost of those -- of end-of-life services for individuals with dementia, it's almost doubled compared to those individuals without dementia.

And then as part of our quality monitoring, we also recognize that about 30% of elderly patient hospital admissions are linked to some type of drug-related problem or toxic effect, and so we have included an NCQA quality measure to monitor drug disease interactions among the elderly.

And lastly, again, as another requirement in addition to the required reporting outlined in our three-way contract, the state also saw a need to clarify guidance in the role and responsibility of the health plans, and not only reporting but also investigating serious reportable events or critical incidents, and so this guidance really kind of specifies the role of the health plan through the investigation process as well as documenting a detailed resolution, and for us we identified kind of these critical events as falls, pressure ulcers, restraints, including both chemical and physical elopements, suspected abuse, neglect, and exploitation.

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We have just completed our first demonstration year at the end of 2016, and so we are still kind of early in our reflection process, but we have asked our health plans to identify accomplishments, promising practices, and challenges that they have encountered with respect to caring for individuals with dementia, and some of those things that, again, this is feedback, directly from the health plans, they all have staff that have been trained in dementia dialogue. Many of the plans have integrated dementia training into their new employee orientation. They are sponsoring kind of dementia dialogue community sessions, and they've really expanded their resources in terms of care, their focus on caregivers. Health plans have developed tool kits. There's a greater emphasis on respite. We also have one of our health plans that's going to be conducting fall prevention workshops this winter. So again, we have just seen how kind of creating an atmosphere and an environment where the health plans can really leverage their own innovation to take some of the tools that the plan, that the state has given them and then to go on to really expand those into other resources.

Promising practices that have been identified by the health plans include just leveraging the state's dementia dialogue program at the health plan level, and then also educating and supporting caregivers. As an additional requirement, the state also requires that each of the health plans have a quality improvement project related to caregivers, and so I think that too has really helped them to see the need to educate and support those individuals who are helping to care for their members.

Some challenges that they have experienced, access to care. There's some barriers to institutional respite in South Carolina, and then also some limitations on our community mental health centers, in terms of being able to support individuals with dementia.

Some of the health plans have also experienced challenges with working with family members who may also have dementia, and so just again trying to navigate through that, that situation.

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From the state perspective, there have been a number of areas of continuous improvement as well as positive experience or promising practices. I think the first one has been just optimizing existing state resources. Again, based on our kind of limited experience with managed care and with the elderly population being in managed care, it's really important for us to take a look at some of the existing resources in the state, and so we have been able to do that working through the Alzheimer's Association, as well as with the university.

And then in terms of interventions, I think that we still need to make some progress in making sure that there is meaningful care plan development that recognizes dementia or any type of cognitive impairment, and so as we move forward with the demonstration, that is something that the state investigate a little bit more.

And then also identifying caregivers, I think Debra may have mentioned that during her presentation, but even as the health plans are completing their assessments, they are challenged with really being able to identify individuals who may not self-identify as caregivers in that assessment process.

On the clinical side, there's still the issue of the underdiagnosis of dementia. When we take a look at the Medicare claims data for our population, there's only about a 6% rate of dementia diagnosis with that group, but when we look at the results of our assessments, we see a greater incidence of dementia among our members.

And then with care coordination, some of the challenges, you know, for the health plan to figure out how to support individuals who refuse care coordination, and I think Tracey may have alluded to this during her presentation, just, you know, perhaps the frustration with, you know, having a member who may still have some cognitive ability to make decisions for themselves and respecting those choices, even if that means that they refuse help, and so figuring out a way to navigate through that situation, we recently had a -- one of our members who did refuse care coordination, and she was in the midst of a care transition from a hospital back home, ended up stealing her daughter's car and was missing for several hours. And so, again, the health plan has to figure out how to fully support a member during that -- such a complex situation.

One of the things that we have seen that's been very helpful is, again, using the SLUMS assessment early on in the assessment process to be able to identify a mild cognitive impairment that would, you know, again result in perhaps bringing in another individual to help complete the assessment, depending on the results of the SLUMS tool.

And then lastly, what we hope to do moving forward is to really drill down a little bit more on the quality side and to focus on the use of seclusion across all care settings, not just in facilities, and that's going to take some innovation on the part of the state as well as our health plans.

But in general, we have been very pleased just with our health plan's application with some of the tools that we have given them and then how they have also been able to in some respect organically develop their own programs in-house and really leverage some of the work that they have done nationally and in other states.

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And this slide just gives you links to various resources that we have talked about during the presentation, including our readiness review tool and some of the assessment tools that we used in our comprehensive assessments. So thank you again for the opportunity to share today.

Caroline Loeser: All right. Well, thank you so much to all of our speakers. Thank you, Debra, Linda, Teeshla and Tracey for your presentations. This has been incredibly informative. Thanks so much for joining us today. We have a few minutes now for questions from the audience, and I also just want to make one announcement, that the recording of this event, as well as the slides, will be available shortly at www.resourcesforintegratedcare.com.

At this time if you have any questions for our speakers, please submit them using the chat feature on the lower left of the presentation. Type your comment at the bottom of the chat box and press enter to send it.

And just to start off, Debra, we have a few questions that we would like to ask you. Specifically, we have some questions about the standardized care plan, and we have one question about how the standardized care plan compares to a person-centered plan.

Debra Cherry: You know, the standardized care plans can feed into a person-centered plan, and indeed we hope that they would. What they do is they provide suggestions of where the care manager can go for additional resources, what the care manager may want to say to the physician or medical care provider, and also where the care manager might go for materials that they can share with that family, so that they can help with education of the family.

So it is not to take the place of a personalized care plan. It is just recommendations on different issues, like bathing or agitation or combativeness.

Caroline Loeser: All right. Thank you, Debra.

We have another question for you. So for the California project, it was based on increasing capacity for the care managers. So we have a question. They are interested in how many or what percent of duals are served by care managers, and is care management primarily provided by phone or in person too?

Debra Cherry: So, you know, I don't know if I can give you a precise number of people who are duals in the state who are getting care management. The state, much fewer people have signed up for Cal MediConnect than are dual eligibles in the state of California. I could be corrected by Linda, but I believe that the sign-up number is something like about between 250,000 and 300,000. All of these people who are Cal MediConnect are supposed to have access to a care manager if that's what they desire. However, they are actually referred to a care manager when they have indicators of when they are graded in a higher need category, and that often happens because of their use of lots of long-term care services or hospitalizations, emergency rooms and so forth. So we have low, moderate, and high-risk people gradations, and the high-risk people get to care managers pretty much automatically, whereas those at the lower levels have to request care management in order to get that -- get it. Did I miss any other part of that question?

Caroline Loeser: No, that was great, thank you, Debra.

And we do have a few more. So just one more for you.

Can nonclinical staff administer the AD8?

Debra Cherry: Yes, I believe that nonclinical staff can be trained to administer the AD8. It's a fairly straight forward tool, and very flexible.

I believe their other question that someone asked is how is most of this care management delivered, and our experience in California is that most of the care management in Cal MediConnect has been delivered by telephone, but certainly not all of it, and there are situations where care managers can do home visits and go out to the community to see the family, the person with the disease and the family member.

But the great majority of care management, at least in the Cal MediConnect Project, is being done by telephone.

Caroline Loeser: Thank you, Debra.

And Linda, we have a question for you. We were wondering if you could elaborate a bit further on the training of the dementia care specialists.

Linda Wade: Certainly. So, the care specialists, they had a particular toolkit that expanded on the initial one-day training, and Debra, I need you to remind me if it was like two full days of training.

Debra Cherry: It was in addition to the eight hours that was given to all care managers, the dementia care specialists got an additional 12 hours, a day and a half, of training.

Linda Wade: Thank you. And then the materials go through different tools for caregiver identification, care needs assessments, and care plans for challenging behaviors using a particular strategy they call IDEA! Strategy. I think Debra talked about that a little bit earlier, and what was really nice about it is it just talks about, you know, the problems that people have to deal with, sleep disturbance, depression, hallucinations, sundown, suspiciousness, screaming and making noises, how to help someone on a daily basis with their bathing and showering, eating difficulties, toileting safety, and then there was a section on caregiver needs, talking about safe body mechanics, understanding of dementia, legal and financial planning, long-term care planning and end of life planning.

Did I answer the question?

Caroline Loeser: Yes, thank you, Linda.

So we are going to move over to Tracey. Tracey, we were wondering what types of or what kinds or types of support groups exist for family caregivers. What has been your experience with that?

Tracey Brown-Lindsey: Well, after doing a lot of searching on the internet, there is plenty of places that you can call, places that you can access chat groups, but I find Alzheimer's Greater Los Angeles has been the most instrumental in helping get me through some of the toughest times that I have, and most times it's just asking simple questions that can help me, you know, get to the next level.

Caroline Loeser: Thank you, Tracey.

Okay.

Tracey Brown-Lindsey: Did that answer the question? I'm sorry.

Caroline Loeser: No, I think that absolutely did, and if anyone has any follow-up questions, feel free to type that in the chat and we can read that out loud.

Tracey Brown-Lindsey: Okay, great.

Thank you.

Caroline Loeser: Thank you.

All right. And we have some questions for you, Teeshla, as well. How is it the state supports the families for the questions that you find that families need the most?

Teeshla Curtis: We have really given the health plans just kind of simple parameters in terms of how they support families and caregivers. I think for states, we have to balance being very prescriptive and also giving health plans an opportunity to really innovate, and so again a lot of the development, especially on the caregiver support side from the health plans, has really been organic. It has not been anything that's been prescribed or dictated from the state, and at least from South Carolina's perspective we believe that that is the right approach right now, given where the state is with its development of programs to help support individuals with dementia and older adults in a managed care environment, and so that's one of the things that we have done. But we have also helped to connect our health plans to other community-based organizations where, you know, including the Alzheimer's Association, all of our

Triple-As, et cetera, so that they are aware of those resources and can leverage them into their own program model.

Caroline Loeser: Great. Thanks for sharing, Teeshla.

We did have another question come in for you. So in South Carolina, are the care managers interacting via phone or in-person with the health plan members?

Teeshla Curtis: The comprehensive assessment for South Carolina is required to be face-to-face. There are some components that can be conducted telephonically, but for instance the SLUMS is part of the assessment that has to be done face-to-face, and then on an ongoing basis we also have a timeline for interactions with members based on their risk stratification, high-risk members, and those would include individuals who are receiving long-term services and support, have to have interactions, face-to-face interactions, on a monthly basis; and then kind of moderate to low-risk individuals every 90 days, and so we really stress the face-to-face component to not only be able to connect with the members but also to be able to do an environmental scan of the home as a part of our assessment process. Each of the health plans has to conduct a home assessment for their members, and that can address any kind of issues that put members at risk for falls, et cetera, and so that's -- that again was our approach with the program design.

Caroline Loeser: That's great. Thank you, Teeshla.

I'm going to move back up to Tracey. We did have a follow-up question for you. So Tracey, what was the most helpful resource you obtained, and how did you get it? For example, support group versus a telephonic support?

Tracey Brown-Lindsey: Okay. As I indicated, Alzheimer's Greater Los Angeles has been the most instrumental out of all of the referrals or resources that I have been told about and given, and I have had both one-on-one phone conversations as well as group sessions, that both of them are equally important to me. And, you know, it's just the more information I have, the better for me. It helps get me through it. It's just searching, and there's always new information. I keep in close contact with Alzheimer's Greater Los Angeles because there's always something new, and I don't get that much support from my mom's health plan, at all, period.

Caroline Loeser: Okay. Thank you for sharing, Tracey.

Tracey Brown-Lindsey: Okay, thank you. You're welcome.

Caroline Loeser: All right. And Debra, there are a few more questions for you in the cue. So we have one question. What tools or tips do you recommend for health care providers to be aware of community-based dementia services?

Debra Cherry: You know, I think it's pretty easy to find out who is providing dementia care in your area. You can basically go online and put in the word Alzheimer's and put in your area.

There are community-based Alzheimer's organizations all across the country, and then I would say that it would be a good idea to have try to have a meeting if you're from a geriatric clinic or have a number of family members with this disease, have a meeting or two with one or two of your local providers and decide who will provide a good range of services for that family. Then I recommend that people use that ALZ Direct Connect form that I mentioned earlier and individualize it for your local community, getting the family's permission to have the local Alzheimer's organization. Contact them proactively, and that will

help the provider know that they have connected the family with complementary services, like the support groups in disease education. And it also can -- they can express their desire for the community-based organization to provide them with feedback from that family, as a community-based provider we get permission from the family to provide that feedback, just like medical providers get permission from the family for us to call them, and it seems to work well.

Caroline Loeser: Thank you, Debra.

We have another question for you. Do any of the plans or programs you work with allow caregivers to view any of the care plans or medical care plans or health records?

Debra Cherry: Well, the answer is yes. So there are -- some of the health plans are experimenting with having a family member or a paid caregiver on the care team. They have what are called interdisciplinary care teams that develop these care plans, and it varies from plan to plan, but some of them have been taking steps to engage the family in the care plan development and do share the care plan with the family member.

It's a promising practice that is not widespread.

Caroline Loeser: All right. Thank you. And Tracey, we are going to jump back to you. We have two more questions in the chat for you. The first one, what are the expectations from the insurance company as far as information they should provide to you?

Tracey Brown-Lindsey: One of the things, like I said, when my mom was first diagnosed, we left there with a couple of pieces of paper that had a lot of contact information. Me, I'm a hands-on type of person. I would have gladly welcomed someone actually sitting down saying, you know, this is where you need to go; these are different resources, but this is what you need to look for. Because when you're newly diagnosed, you're blown away. You really don't know what's going to be good for you or what type of questions to ask, so I would have appreciated her health plan to be a little bit more compassionate and, you know, try to guide me through the question process, and, you know, helping me decide what I need to ask because you really don't know.

Caroline Loeser: Sure, absolutely.

Our second question for you, Tracey, what was the most surprising information you have learned about caring for Alzheimer's patients?

Tracey Brown-Lindsey: As my mom's condition progresses, I'm finding it a little bit more difficult now, but it's -- it's -- I'm not going to say it's difficult in getting answers, because obviously we have the internet that we can always lean on, but a lot of this information that's on the internet is not as -- I just don't find a lot of it credible. But, you know, I would like to deal with people that are actually going through it, so getting, you know, like with Alzheimer's Greater Los Angeles, you can be put in touch with others, versus just guessing; okay, when you pull up a Google search, you say, okay, I'm going to choose this one. Is this the right person or is this the right group that I really want to be connected with?

So it's just getting information, and, I mean, you have to know where to look, and I think being with an association like Alzheimer's Greater Los Angeles, it helps me. I can't stress enough how their association has helped me through this whole process versus the health plan, which, you know, I could probably, if I push a few buttons with her health plan, which I usually do, but the whole thing is getting returned phone calls. You leave messages. You're transferred to this person, this person transfers you to this person. So

you get frustrated, so you go back to where you know you can get answers, and, you know, I can't stress enough how important it is to have a live person to talk to versus being told here, go to this website, and, you know, so on and so on.

Caroline Loeser: Yeah, absolutely. Thank you for sharing, Tracey

Tracey Brown-Lindsey: Oh, you're welcome.

Caroline Loeser: We just have a few minutes left, so I'm just going to close with some final remarks.

So any questions we did not have time to address will be posted to our website in the form of Q&A, so look out for that.

If you have any additional questions or comments, please feel free to e-mail us at RIC@Lewin.com.

The slides for today's presentation, a recording and a transcript will be available on the Resources for Integrated Care website shortly. Thanks again to all of our speakers. Have a wonderful afternoon, and thank you so much for your participation.