Improving Health Care for People Living with Dementia

Debra Cherry, PhD

Lora Connolly, MSG

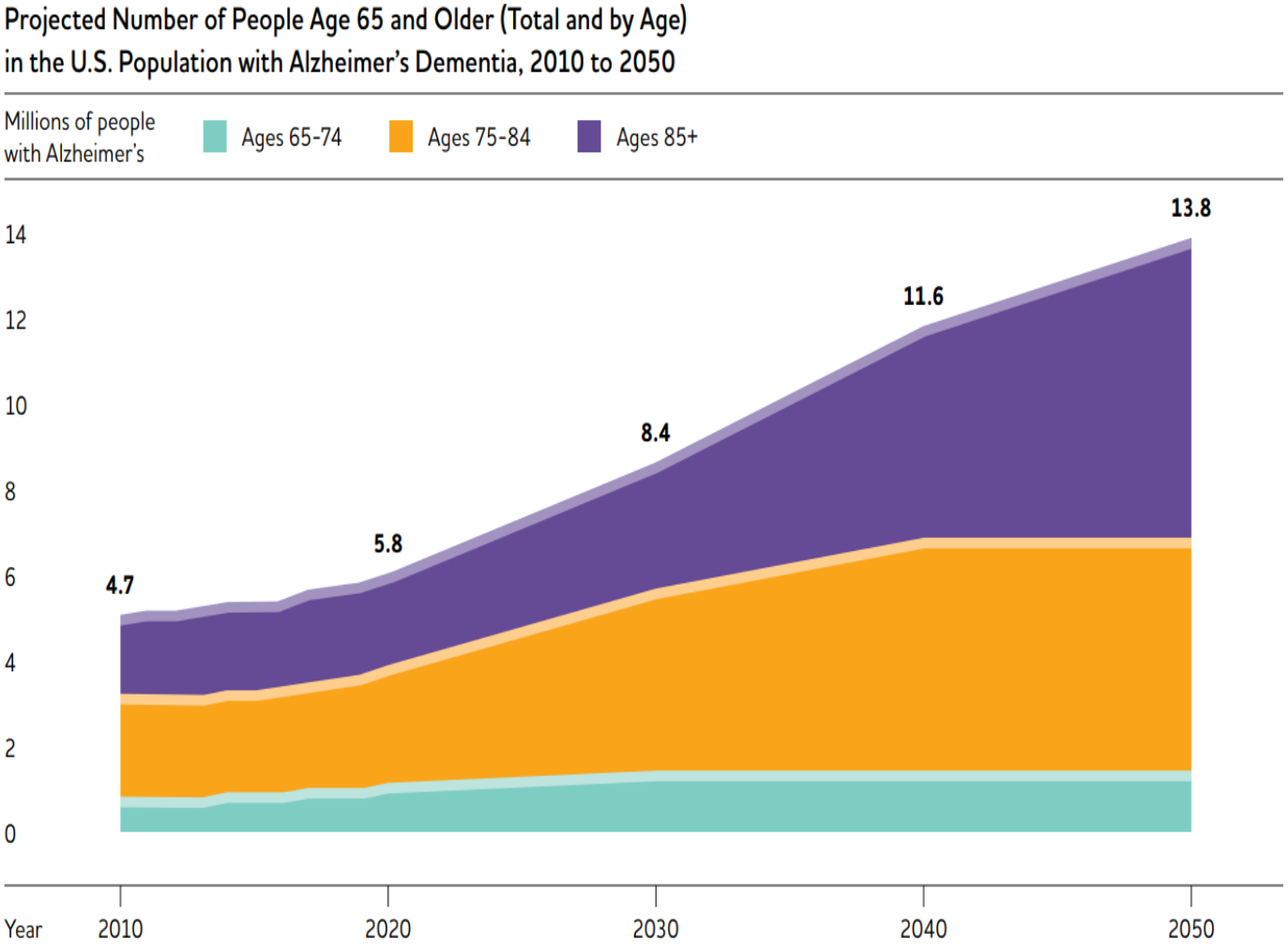
Katie Scott, MPH

NADRC
National Alzheimer's and Dementia Resource Center

ACL
Administration for Community Living

Part of the National Alzheimer's and Dementia Resource Center webinar series sponsored by the Administration for Community Living.

Prevalence of Dementia



From Herbert et al data as presented in Alzheimer's Association. 2017 AD Facts and Figures. Alzheimer's Dementia 2017:13:325-373.

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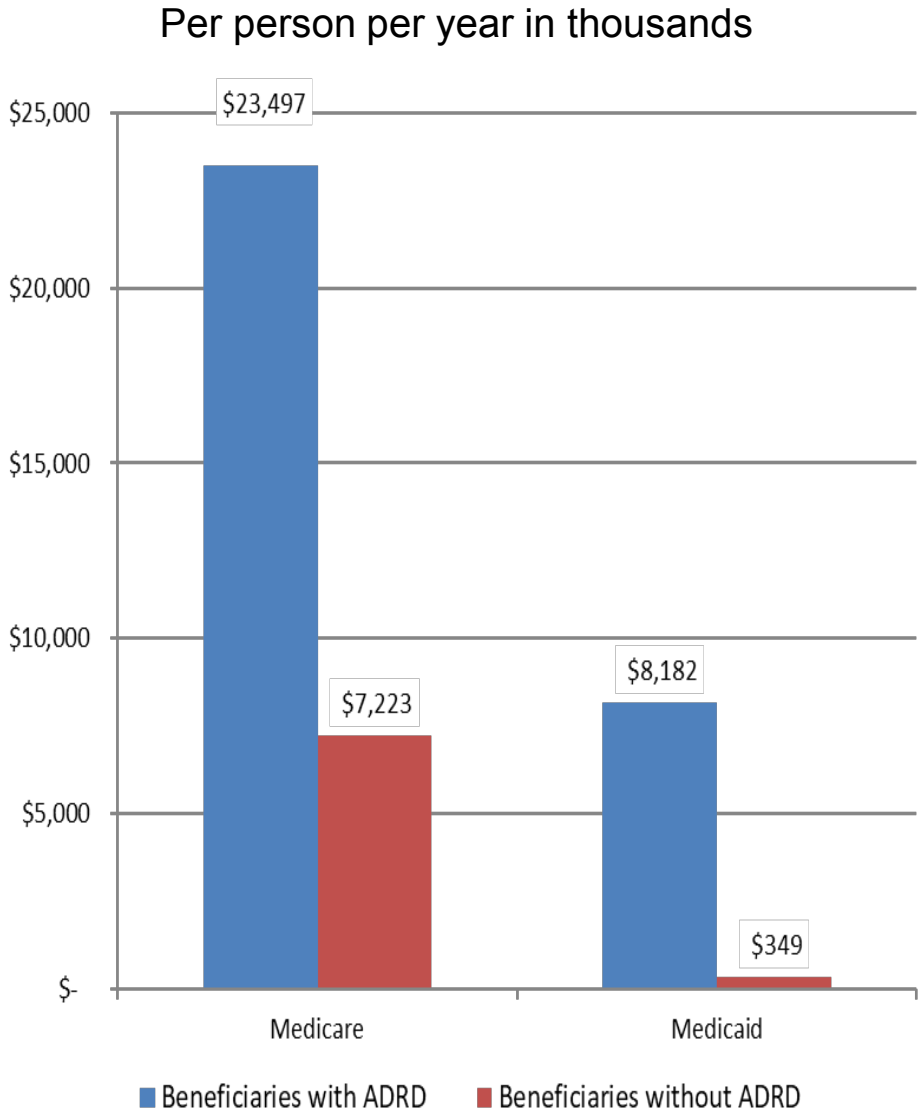
Cost of Care

Patients with dementia cost Medicare **3X** more than other beneficiaries in the same age group, primarily because of hospitalizations.

They cost Medicaid **23X** more, primarily because of nursing home placement.



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Quality Challenges

- Poor detection of people with Alzheimer's disease and related disorders (ADRD)
- Limited recognition of the caregiver's role
- Limited use of home and community-based services (HCBS) and long-term services and supports (LTSS)

Indicators of a Dementia Capable System

Indicator #1

Better detection of patients with dementia

- Include cognitive impairment questions in the health risk assessment (HRA) and other assessments
- Adopt a validated screening tool
- Document cognitive assessment in the electronic medical record (e-MR)
- Establish a follow-up protocol if the cognitive screen is positive

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Indicators of a Dementia Capable System

Indicator #2

Caregiver identification and support

- Identify caregiver and document him/her in the medical record(s)
- Assess the caregiver's needs
- Provide the caregiver with education & supports
- Engage the patient, as appropriate, and the caregiver in care planning
- Develop a care plan based on person and family-centered needs

Indicators of a Dementia Capable System

Indicator #3

Connect to home and community-based services

- Dementia education
- Meals on Wheels
- Support groups
- Caregiver education
- Adult day services
- Care counseling and care management
- In-home services
- Engagement programs
- Caregiver education

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California CalMedi Connect Dementia Initiative

Grant Funding

This project was supported, in part by grant numbers 90DS2002-01-00 and 90DS2017-01-00, from the Administration on Aging, U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201 and the California Department of Aging.

Additional funding was provided by:

- The Change AGEnts Initiative Dementia Caregiving Network, funded by The John A. Hartford Foundation through a multi-year grant to The Gerontological Society of America
- The Allergan Foundation
- The Rosalinde and Arthur Gilbert Foundation
- Anthem Blue Cross Foundation


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Administration for Community Living
CDPH
California Department of PublicHealth
California Department of Aging
DHCS
California Department of HealthCareServices
University of California San Francisco
Institute for Health & Aging
Alzheimer's GREATER LOS ANGELES
alzheimer's association
Northern California & Northern Nevada Chapter
Alzheimer's SAN DIEGO
IEHP
Inland Empire Health Plan
Health Net
MOLINA HEALTHCARE
Anthem BlueCross
HealthPlan OF SAN MATEO
CareMore
It's what we do.
Community Health Group
Care1st HEALTH PLAN
An affiliate of Blue Shield of California
L.A. Care HEALTH PLAN
Santa Clara Family Health Plan
The Spirit of Care

Cal MediConnect Health Plan Benefits

Participating plans must provide:

- All Medicare and Medi-Cal services: primary and acute care, prescription drugs, & most behavioral health and LTSS.
- Supplemental benefits not otherwise available under Medi-Cal: dental care, vision care, and non-emergency medical transportation.
- Care management services.

Plans have discretion to provide:

- Other home and community-based services – like respite, non-medical transportation, Medic Alert bracelets, etc.

Policy Levers for Dementia Cal MediConnect (DCMC) Project

- Financial & Administrative Alignment
  - Emphasis on coordination of care
  - Quality improvement targets
  - Partnerships with CBOs encouraged
  - Caregivers' roles acknowledged
- Informational Bulletin on Dementia
- Health Risk Assessment Changes

DCMC Project: Components

- Advocacy with health plans, state and Center for Medicare & Medicaid Services (CMS) - Making the case for focusing on dementia care
- Care manager training and support
- Health plan technical assistance from Alzheimer's organizations
- Support services and disease education for patients and caregivers through the health plans and/or through referrals to Alzheimer's organizations for: caregiver supports, care planning information & referral, respite, etc.

Key Steps of Partnership

Step 1: Identify Champions & Leaders

Step 2: Make the Case

- Value Proposition
- Highlight Policy Levers

Step 3: Make the Ask

- Propose Clear & Realistic Goals
- Evidence to Support these Goals
- Preliminary Plan for Achievement

Step 4: Implement the Plan

Step 5: Evaluate & Provide Feedback

Dementia Care Manager Training Components

- Fundamentals of Cognitive Impairment, Alzheimer's Disease and Related Dementias
  - **AD8™ Screening**
- Practical Behavioral Symptom Management
  - **IDEA! Behavior Management Approach**
  - **Caregiver Tip Sheets on Behaviors**
- Caring for the Caregiver
- Home & Community-Based Support Services

www.alzgla.org/professionals

Keeping Home Safe

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

WHY DOES THIS HAPPEN?

People with Alzheimer's or dementia might:

- trip because of changes in balance or trouble walking
- have problems seeing clearly due to poor eyesight
- forget to turn off water, burners, ovens
- forget how to use knives, etc. or where to safely place burning objects

WHAT CAN YOU DO?

Keep Things Simple

- make sure rooms are neat
- place "often used" items in the same place
- remove things that might break and aren't needed

Look at the Floor

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

Remove Dangerous Items

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

Don't Leave Him or Her Alone

- in the kitchen with the stove or oven on
- in the bathroom with water running
- anywhere with burning cigarettes, cigars, or pipes
- near an open or unlocked door or gate

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...also serving San Bernardino & Riverside Counties

24/7 Helpline
844.HELP.ALZ
alzgla.org

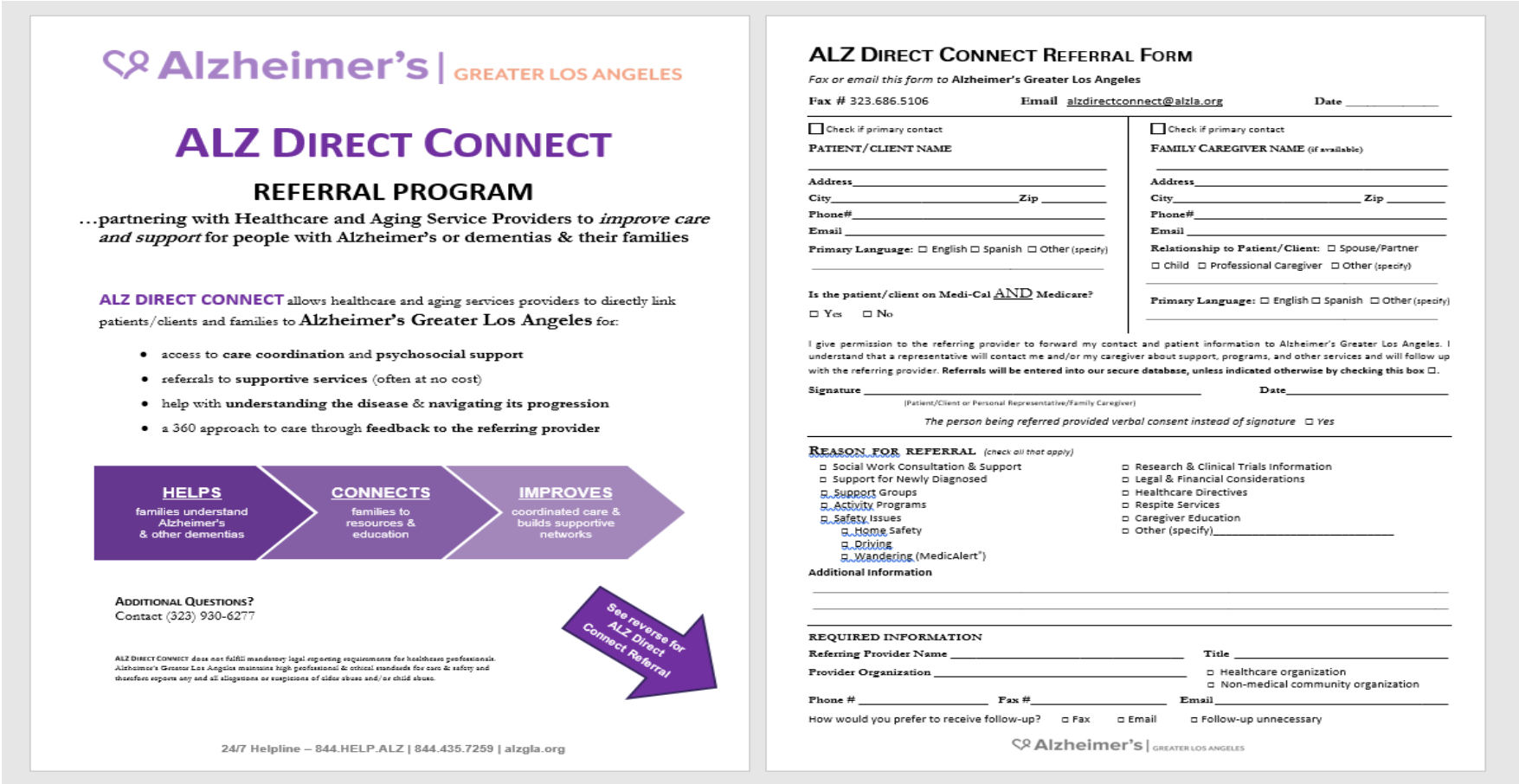
Supported by DHHS, ACL (#90ALL0002-01-00)

Plain Language Caregiver Tip Sheets

- **Anger and Fighting**
- **Bathing**
- **Getting Lost**
- **Medications**
- **Hallucinations**
- **Paranoia**
- **Sundowning**

- **And more…at www.alzgla.org/professionals**

Tool to Facilitate Warm Referrals



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ALZ DIRECT CONNECT

REFERRAL PROGRAM

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

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

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

HELPS families understand Alzheimer's & other dementias

CONNECTS families to resources & education

IMPROVES coordinated care & builds supportive networks

ADDITIONAL QUESTIONS?
Contact (323) 930-6277

See reverse for ALZ Direct Connect Referral

ALZ DIRECT CONNECT does not fulfill mandatory legal reporting requirements for healthcare professionals. Alzheimer's Greater Los Angeles maintains high professional & ethical standards for care & safety and therefore reports any and all allegations or suspicions of elder abuse and/or child abuse.

24/7 Helpline – 844.HELP.ALZ | 844.435.7259 | alzgla.org

ALZ DIRECT CONNECT REFERRAL FORM

Fax or email this form to **Alzheimer's Greater Los Angeles**

Fax # 323.686.5106 **Email** alzdirectconnect@alzla.org **Date** _____

☐ Check if primary contact

PATIENT/CLIENT NAME

Address_____
City_____ **Zip** _____
Phone#_____
Email _____
Primary Language: ☐ English ☐ Spanish ☐ Other (specify)
_____

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

☐ Check if primary contact

FAMILY CAREGIVER NAME (if available)

Address_____
City_____ **Zip** _____
Phone#_____
Email _____
Relationship to Patient/Client: ☐ Spouse/Partner
☐ Child ☐ Professional Caregiver ☐ Other (specify)
_____
Primary Language: ☐ English ☐ Spanish ☐ Other (specify)
_____

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

Signature _____ **Date**_____
(Patient/Client or Personal Representative/Family Caregiver)

The person being referred provided verbal consent instead of signature ☐ *Yes*

REASON FOR REFERRAL *(check all that apply)*

- ☐ Social Work Consultation & Support
- ☐ Support for Newly Diagnosed
- ☐ Support Groups
- ☐ Activity Programs
- ☐ Safety Issues
  - ☐ Home Safety
  - ☐ Driving
  - ☐ Wandering (MedicAlert®)
- ☐ Research & Clinical Trials Information
- ☐ Legal & Financial Considerations
- ☐ Healthcare Directives
- ☐ Respite Services
- ☐ Caregiver Education
- ☐ Other (specify)_____

Additional Information
_____
_____

REQUIRED INFORMATION

Referring Provider Name _____ **Title** _____
Provider Organization _____
☐ Healthcare organization
☐ Non-medical community organization
Phone # _____ **Fax #**_____ **Email**_____
How would you prefer to receive follow-up? ☐ Fax ☐ Email ☐ Follow-up unnecessary

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Dementia Care Management Toolkit

The Dementia Care Management Toolkit provides healthcare professionals with tools to support dementia care management. It includes assessment instruments to help identify people with dementia and their family, and to assess their needs. The contents of this toolkit are not all-inclusive and are meant to complement and enhance existing care management tools and practices. Clinical judgement should be used when working with individuals and families, and procedures, policies, regulations, laws, and mandates should always be followed.

- The AD8 Dementia Screening Interview
- Caregiver Stress/Strain Instrument
- Tool for Identifying an Informal or Family Caregiver
- Care Needs Assessment Tool
- IDEA! Strategy for Managing Challenging Behavioral Symptoms
- Standardized Care Plans
- Plain Language Fact Sheets

Available for download at:
www.alzgla.org/professionals

This toolkit was created by Alzheimer's Greater Los Angeles. Financial assistance for this project was provided, in part by grant number 90DS2002-01-00, from the Administration on Aging, U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201, and from the California Department of Aging. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.

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

Tools Available

Download at: www.alzgla.org/professionals

Care Manager Training: Progress to Date

Care manager training (8 hours)

- 10 health plans
- Nearly 500 care managers

Dementia Care Specialist trainings (12 hours)

- 9 health plans
- 109 specialists trained

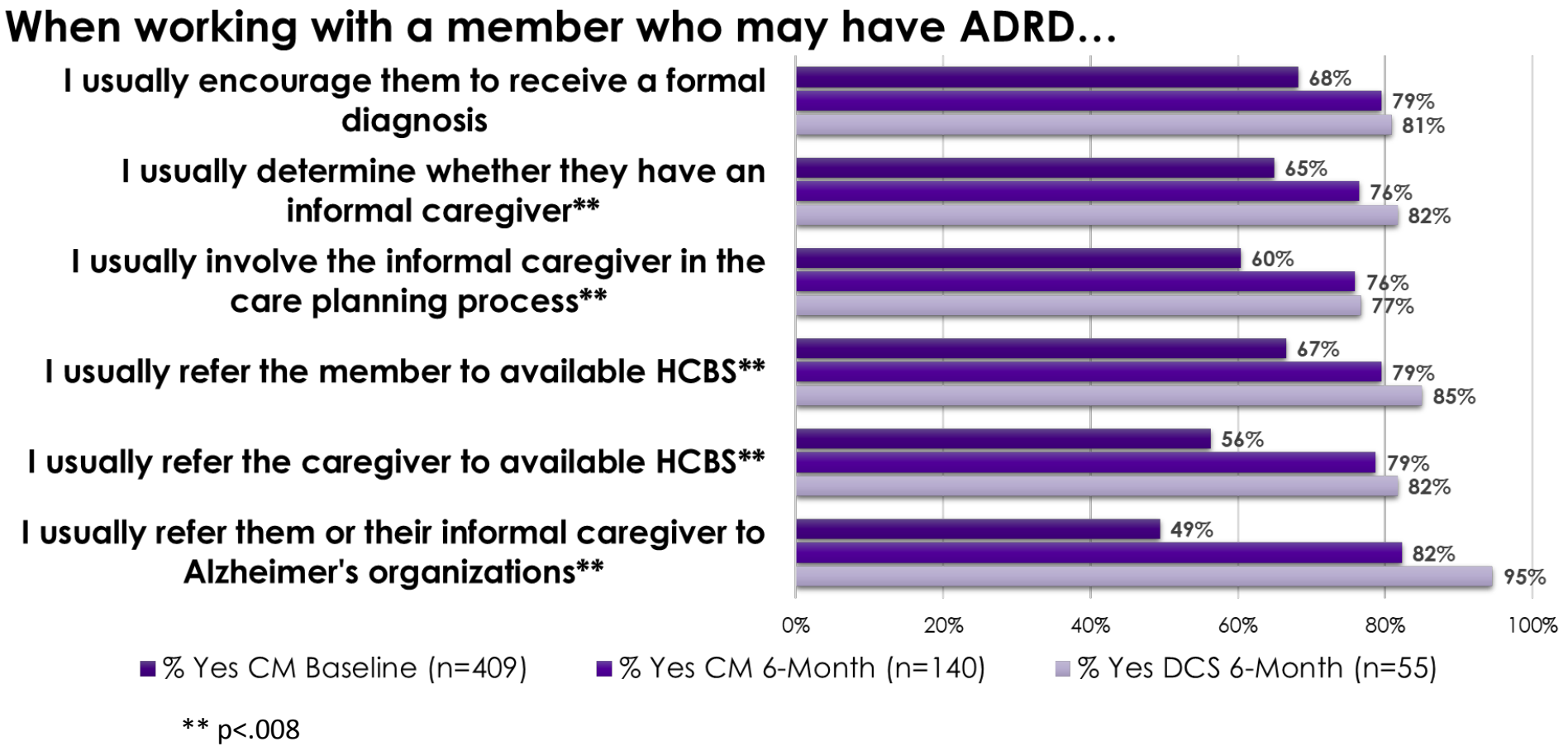
Step 5: Evaluate & Provide Feedback

Evaluations provide evidence and talking points to promote systems change

Evaluation Design

- Care Manager training outcomes
  - Knowledge of ADRD
  - Practice change, outcomes
  - Systems change
  - Pre-, post- and 6 months post surveys
- Systems Change Tracking
  - Tracking indicators of dementia capable systems of care.
  - Staff report and key informant validation

Care Manager Practice Change results



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Health Plan Systems Change Results (n=10)

Screening and Diagnosis

- All have at least one question in HRA regarding cognitive issues
- 6 have adopted a validated screening tool and integrated results into their electronic health records (EHR)
- 5 have protocol to refer members for a diagnostic evaluation if screen is positive

Caregiver Identification, Assessment, and Involvement

- 9 report documentation of caregivers
- 4 plans report engaging caregivers in care planning and Interdisciplinary Care Team
- 2 adopted validated measure of caregiver stress and strain and integrated into EHR
- 6 offered respite as a Care Plan Option, 1 offered other non-covered LTSS services
- 6 plans offer or arrange for caregiver education

Referrals to HCBS

- 4 plans have formally adopted *ALZ Direct Connect*
- All plans make referrals to the Alzheimer's organizations

Case Example: Molina Healthcare

Cognitive Screening and Diagnosis

- Molina changed their HRA to better identify members with memory concerns / recent changes in cognition
- Molina added a validated tool into the clinical software to screen members for dementia- AD8™
- Creation of primary care physician (PCP) Notification of AD8™ score

Case Example: Molina Healthcare

Caregiver Screenings

- HRA and other methods identify caregivers of those with dementia
- American Medical Associations Caregiver Self-Assessment tool was added to the clinical system as a method to assess the needs of family caregivers
- Case Managers assist to link caregivers to appropriate resources based on identified needs

Dementia Cal MediConnect Project Team

Project Co-Directors

- Lora Connolly, MSG
  Director
  California Department of Aging
- Debra Cherry, PhD
  Executive Vice President
  Alzheimer's Greater Los Angeles

Project Manager

- Jennifer Schlesinger, MPH, CHES
  Director, Professional Training and Healthcare Services
  Alzheimer's Greater Los Angeles

Project Evaluators

- Brooke Hollister, PhD
- Leslie Ross, PhD
- Jarmin Yeh, PhD
  University of California, SF
  Institute for Health and Aging

Alzheimer's Greater Los Angeles

- Barbra McLendon, MSW
- Kelly Honda
- Sergio Calderon
- Terry Garay

Alzheimer's Association

- Elizabeth Edgerly, PhD
- Ruth Gay, MS, Team Lead
- Pauline Martinez, MA
- Alexandra Morris, MA
- Angie Pratt, MAS
- Susan DeMarois

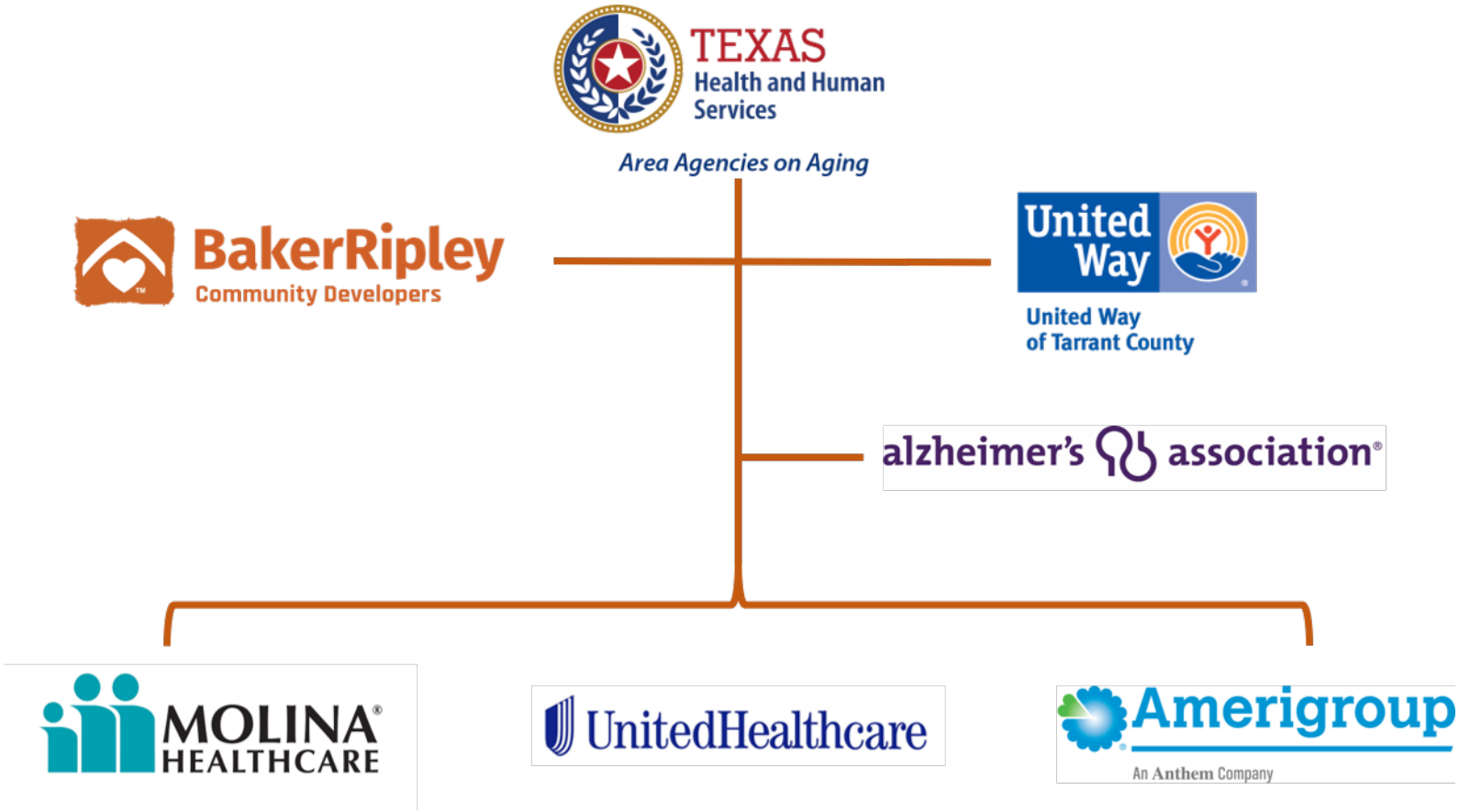
Alzheimer's San Diego

- Jessica Empeño, MSW
- Amy Abrams, MSW, MPH

Texas Takes on Dementia

This presentation was supported in part by a cooperative agreement (No. 90DS2023) from the Administration on Aging (AoA), Administration for Community Living (ACL), U.S. Department of Health and Human Services (DHHS). Grantees carrying out projects under government sponsorship are encouraged to express freely their findings and conclusions. Therefore, points of view or opinions do not necessarily represent official AoA, ACL, or DHHS policy

Texas Takes on Dementia



Advisors: Baylor Scott & White; Texas Department of State Health Services, Baylor College of Medicine, Alzheimer's, Greater Los Angeles

How does it work?

Texas Takes on Dementia

- Education and Training
- Screening Identification Tools
- Referral Procedures

Health Plans

- Identify PWDs and CGs
- Provide and refer to resources

Community Resource Providers

- Provide Direct Services

People with Dementia and Caregivers

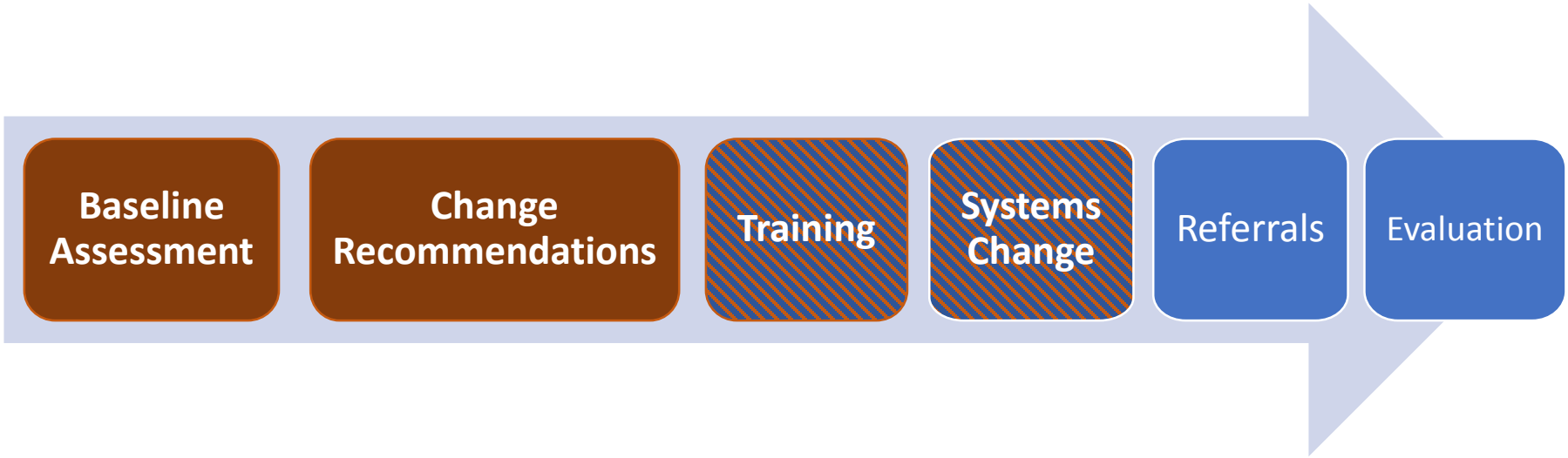
Everything's "Different" in Texas

Frame work already established

Health plan support from onset

Minimal policy drivers

Progress to Date



TEXAS Health and Human Services
Area Agencies on Aging

United Way
United Way of Tarrant County

What we have learned…

- Service Coordinators want:
  - Screening tools
  - Knowledge of community resources
  - Easy referral system
  - Coordination of care

- What plan members need:
  - Dementia specific services
  - Dementia specific adult day centers
  - Caregiver education
  - Respite

Challenges and Lessons Learned

- Making dementia care a priority
- Turn-over of champions
- Lack of access to meaningful data
- Detection of dementia
- Caregiver identification, assessment & support
- Connecting to community based organizations
- Overcoming the lack of policy drivers

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Contact information

Katie Scott, MPH
Sr. Director of Dementia and Caregiver Support Services
Sheltering Arms Senior Services Division
713.558.6306
kscott@bakerripley.org

Debra Cherry, PhD
Executive Vice President
Alzheimer's Greater Los Angeles
323.930.6225
dcherry@alzgla.org