Alzheimer's Disease and Related Disorders Commission
Coordinated Care Work Group

Memory and Aging Care Clinic (MACC)
University Hospital
Primary Care Center
Fourth Flour
1221 Lee St.
Charlottesville, VA 22908

Wednesday, June 15, 2016 at 11:00 am

MEETING MINUTES

Members Present:
Lynne Seward, *Chair*
Laura Adkins
Valerie Hopson-Bell
Andrew Heck
Marie Kolendo
Ayn Welleford

Members Absent:
Sharon Davis
Lory Phillippo
Kevin Walsh

Guests:
Debra Cherry, Alzheimer's Greater Los Angeles*
Lora Connolly, California Department of Aging*
Ginger Dillard, Jefferson Area Board for Aging
Carter Harrison, Alzheimer's Association
Marta Keane, Jefferson Area Board for Aging
Tracee Jones, University of Virginia MACC
Carol Manning, University of Virginia MACC
Jennifer Schlesinger, Alzheimer's Greater Los Angeles*
George Worthington, Jefferson Area Board for Aging

Staff:
Devin Bowers, DARS
Amy Marschean, DARS
Mary Strawderman, DARS

*Participated by conference call

Meeting Summary:

Agenda Items:	**Speaker:**
Members Convene at the MACC Members arrived at the MACC around 11:00 and assembled in the conference room.	All
Welcome and Introductions Members and guests made informal introductions prior to the start of the meeting. Dr. Carol Manning, Director of the Memory Disorders Clinic at the University of Virginia, welcomed the group, starting the meeting off at 11:03 am.	Carol Manning

Tour of the MACC Members and guests received a tour of the clinic and an overview of the care provided to patients. The MACC was started in 1997 and has continued to expand. Several hundred patients are seen each year with around 30 seen per day when the clinic is in operation. Currently, the MACC is open on Wednesdays, but hours are being expanded. Patients travel from across Virginia, Maryland, West Virginia, and North Carolina to visit the clinic. In addition to providing interdisciplinary care the clinic enrolls patients in clinical trials. The interdisciplinary team meets in the morning to discuss all patients and caregivers, focusing on their needs. They strive to have every patient get to know all the team members. Patients have an initial visit with a neurologist and either participate in diagnostic testing prior to the appointment or after. After the diagnosis the team develops a treatment plan and provides ongoing clinical and social support as the patient returns for follow-up appointments over the course of the disease progression. All available team members were introduced and briefly described their roles at the clinic. The team consists of four neurologists, three neuropsychologists, a social worker, a nurse practitioner, nurse coordinator, clinical trials coordinator, clinical research coordinator, and a clinical care coordinator (Care Coordination Program). Additional support provided includes speech therapy, physical therapy, and genetic counseling. The clinic serves as both a primary facility for the diagnosis and management of neurodegenerative diseases and as a consultative resource for individuals who will be followed by their primary care physicians. In addition, a brief overview of the Family Access to Memory Impairment and Loss Information, Engagement and Supports (FAMILIES) program, Care Coordination Program, and Effective Strategies Program was provided.	All
Working Lunch: Presentation by the California Coordinated Care Initiative Dr. Debra Cherry, the Executive Vice President at Alzheimer's Greater Los Angeles, and colleagues presented on the California Coordinated Care Initiative: An Opportunity to Improve Access and Services for Persons with Dementia and their Family Caregivers. Please see attached materials and visit the project website for additional information.	Debra Cherry
Reflections and Next Steps Work group members made the following comments following the presentation: • Managed Care Organizations (MCOs) in Virginia should be required to offer dementia case management and should understand the benefit of providing support early in the disease progression to delay institutionalization, which will lead to cost savings. • Individuals need to be reached before they are Medicaid eligible. • State funding supports 40 traumatic brain injury (TBI) case managers statewide who coordinate services for individuals eligible for Medicaid. This type of state support is needed for individuals living with dementia. Work group members did express concern over the Commonwealth's	All

capacity to serve persons with dementia, even if this type of system was in place. • 24/7 case management is needed for when families have emergencies (for example, the caregiver is unsure how to manage difficult behaviors) to provide an adequate avenue of support instead of visiting an emergency department. This type of crisis management also needs to effectively interface with the mental health field. • Many families fall prey to the predatory long-term care industry without being aware of resources such as the Program of All-Inclusive Care for the Elderly (PACE) or short-term home care offered by local Area Agencies on Aging. • Care Coordination for TBI, mental health, and dementia should not be divided in order to share and fully maximize available resources. Next steps: • The work group will stay in regular communication with the Dementia Care Managers to remain apprised of success stories, which can be shared with legislators. • Carter Harrison will request a summary of the services and interdisciplinary care offered by the MACC along with a description of the roles of each team member. • Mr. Harrison will schedule visits with Delegates Landes, O'Bannon, Hanger, and Donovan to inform them about the Care Coordination model and pilot project, in order to gain their support for a future budget amendment. Work group members will accompany Mr. Harrison on these visits. • The Coordinated Care Work Group will meet again prior to the August meeting of the Alzheimer's Disease and Related Disorder Commission.	
Meeting Adjournment The meeting was adjourned at 1:43 pm.	Lynne Seward

Alzheimer's | GREATER LOS ANGELES

Improving Dementia Care in a Dual Eligible Pilot: Dementia Cal MediConnect

Debra Cherry, PhD, Alzheimer's Greater Los Angeles

June 2016

Disclosure Information

Alzheimer's Greater Los Angeles has the following financial relationships/affiliations to disclose:

Grant support from:

- Forest Laboratories/ Actavis/ Allergan
- Eli Lilly

Funding

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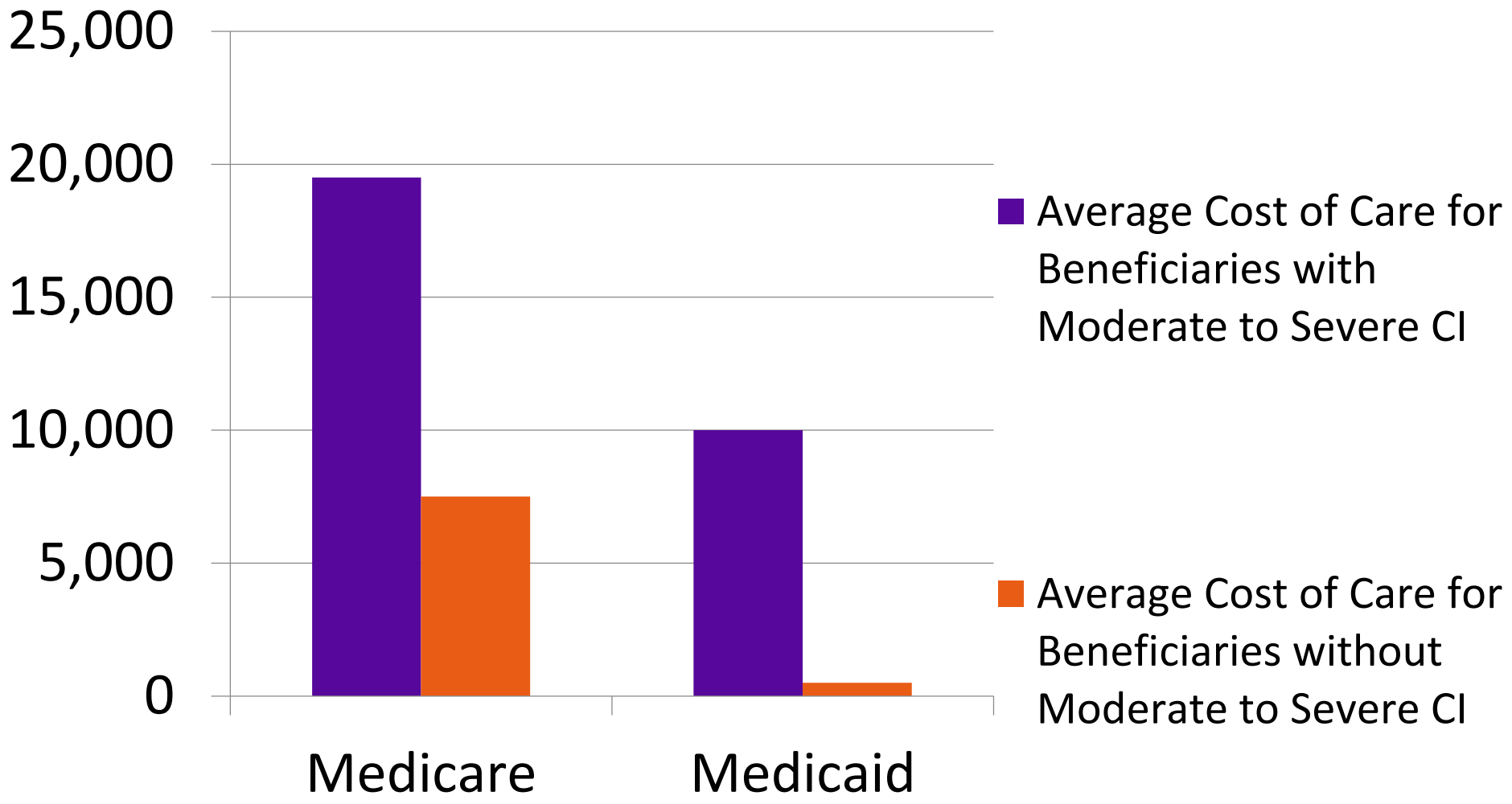
Dementia Cal MediConnect Project Overview

- Advocacy
- Care manager training and support
- Caregiver education and respite
- Support services through referrals to Alzheimer's organizations
- Technical assistance to create systems change

Cost of Care


25,000
20,000
15,000
10,000
5,000
0
Medicare
Medicaid
Average Cost of Care for Beneficiaries with Moderate to Severe CI
Average Cost of Care for Beneficiaries without Moderate to Severe CI

Patients with Dementia

- A population with complex care needs

2.5 chronic conditions (average)

5+ medications (average)

3 times more likely to be hospitalized

Many admissions from preventable conditions, with higher per person costs

- Indisputable correlation between chronic conditions and costs
- Need to identify and engage caregivers to better manage chronic conditions

Adapted with permission from ACT on Alzheimer's

Alzheimer's Association Facts and Figures 2014

Indicators of a Dementia Capable System

1st Better detection of patients with dementia

- Adoption of AD8 screening tool
- Follow-up protocol if cognitive screen is positive

Indicators of a Dementia Capable System

2nd Better partnership between health system and informal caregivers/families

- Ability to identify informal/family caregiver and document this in the chart(s)
- Ability to briefly assess informal/family caregiver's needs
- Integration of informal/family caregiver education
- Assignment to Dementia Care Specialists
- Adoption of standardized care plans

Indicators of a Dementia Capable System

3rd Better partnership with Community-Based Organizations

- Referrals to community-based organizations
- Adoption of direct referral program (*ALZ Direct Connect)*

Tier 1 Care Manager Training Components

- **Fundamentals of Cognitive Impairment, Alzheimer's Disease, and Related Dementias**
  - AD8 Screening
- **Practical Dementia Care Management**
  - Managing co-existing conditions, safety concerns, medications
  - *IDEA!* Behavior Management Approach
  - Plain Language Fact Sheets on Behaviors
- **Caring for the Caregiver**
- **Resources/Support Services**
  - ALZ Direct Connect

www.alzgla.org/professionals

Tier 2 Care Manager Training Components

- **Review of Tier 1 Training**
- **Dementia Care Specialist Toolkit for Dementia Care Management**
  - Assessment tools (AD8 Screen, Family Caregiver Identification Tool, Care Needs Assessment Tool*, Caregiver Stress / Strain Instrument**)
  - 23 Standardized care plans* (sleep disturbances, hallucinations, driving, etc.)
  - Materials to share with caregivers – Plain language fact sheets in English and Spanish

*Adapted from the ACCESS Project. Vickrey, B. et al. (2006)

**Bass, D. et al (1996)

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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

Resources 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

Care Manager Training: Progress to Date

Care manager training (8 hours)

- 15 trainings total
- 9 health plans plus several PPGs, and contracted LTSS agencies
- N = 289 / Original goal was 100 over 3 years

Dementia Care Specialist trainings (12 hours)

- 8 health plans participating plus 1 PPG and contracted LTSS agencies
- N= 44 specialists trained to date

Case conferences

- 5 health plans participating, plus PPGs, and contracted agencies

Sample Technical Assistance Requests To Date

- HRA cognitive screen content
- Tool to determine caregiver need for respite
- How to identify people with dementia through their existing systems
- Content for a physician training event
- How to integrate "caregivers" into the Interdisciplinary Care Teams

L.A. Care Overview

- 1.8 million members
- A leader in safety net support for L.A. County's vulnerable and low-income populations
- 18 years as L.A. County Medicaid provider
- Nation's largest publicly-operated health plan
- Participant in California's Coordinated Care Initiative
  - Cal MediConnect (duals demonstration)
  - Managed Long Term Services and Supports
  - Medicaid for Seniors and Persons with Disabilities

L.A. Care Partnership with Alzheimer's Greater Los Angeles

- Participation in community stakeholder meetings
- Participation on L.A. Care CCI Advisory Committee
- Monthly collaboration meetings
  - Focus on improving service coordination
  - Identification of members with Alzheimer's/dementia
  - Consultation and input on existing processes
  - Discussion of system improvements

L.A. Care Partnership with Alzheimer's Greater Los Angeles

- MOU/contracting opportunities
  - Contracts for staff/physician training
  - MOU development
- Staff education
- Member health education classes
- Caregiver education

L.A. Care System Changes

- Alzheimer's training provided to over 40 Case Management and Social Services staff
- Training of 5 Dementia Care Specialists (more planned for future)
- Developed method to identify members with Alzheimer's/dementia
- Implementing changes to Health Risk Assessment

L.A. Care System Changes

- Incorporating AD8 screening into Case Management Assessment process
- Restructuring Case Management assignments to ensure Dementia Trained Specialist either leads or participates in team
- Developing processes to refer back to PCP for proper diagnoses when needed
- Developed and implemented process to refer members to ALZ Direct Connect Referral Program

L.A. Care System Changes

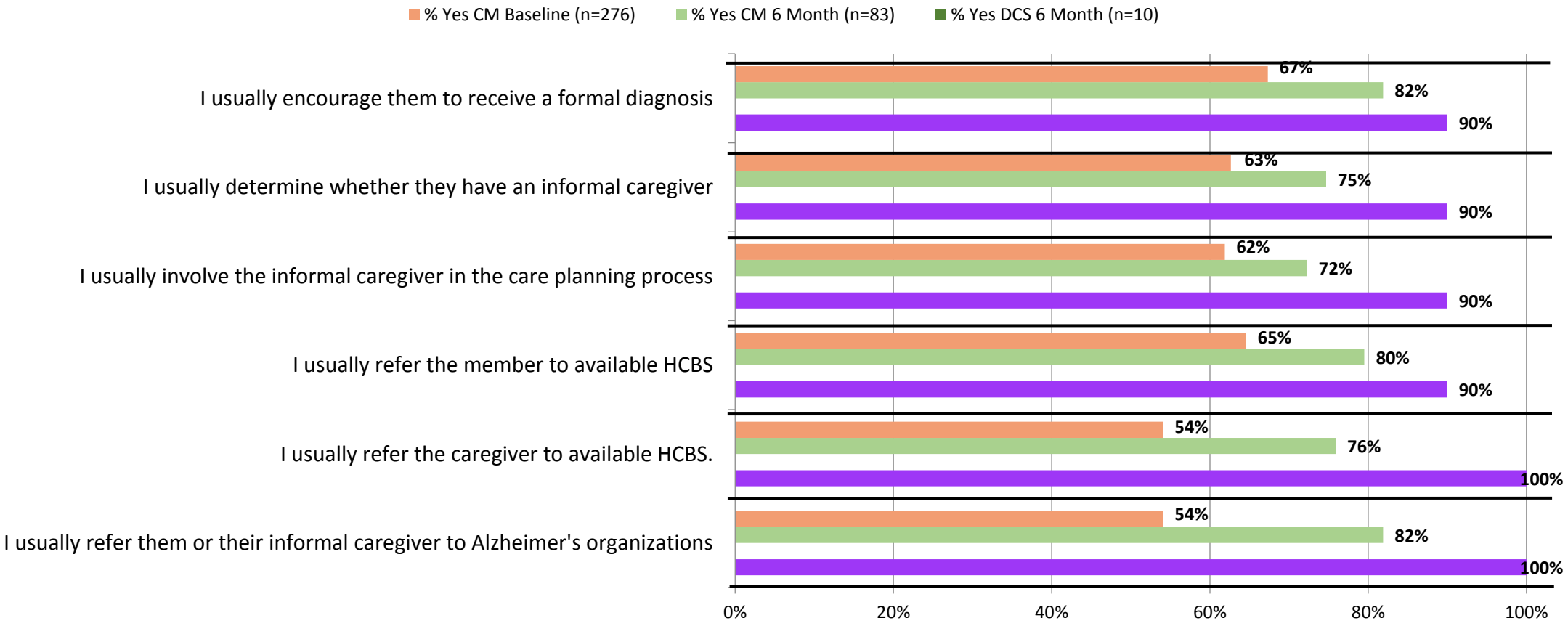
- Implemented process to better monitor referrals to Alzheimer's
- Working to include and track participation of family caregivers in care teams
- Exploration of caregiver support
  - Assessing for and providing respite via Alzheimer's or Care Plan Options
  - Currently researching caregiver needs (phone survey's and focus groups) and developing strategies to better support caregivers

What We've Learned

- The number of members with Alzheimer's or dementia is much higher than anticipated
- This is a population that needs more attention and targeted interventions
- Caregivers must be incorporated in care planning process
- Caregivers must be assessed and supported
- Alzheimer's Greater Los Angeles has been an excellent resource and partner

Care Manager and DCS Practice Change

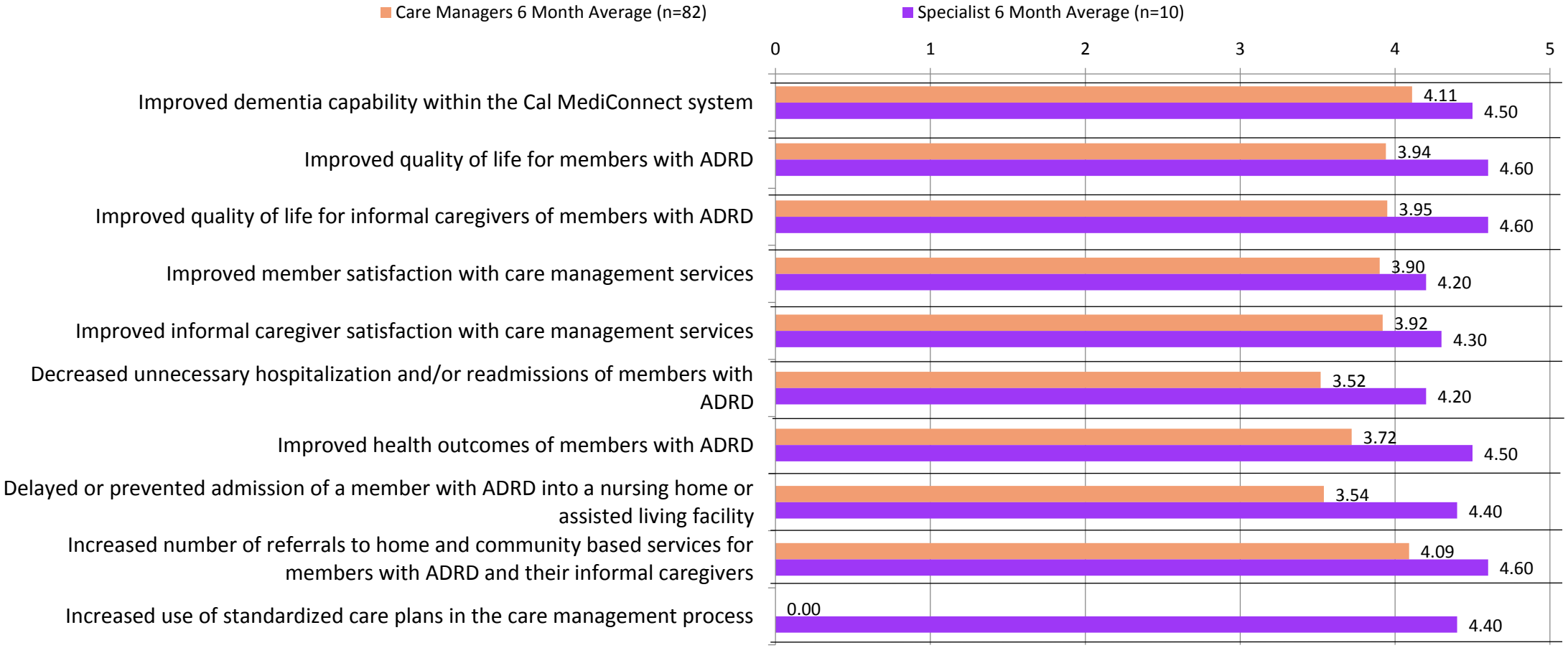
When working with a member who may have ADRD…



March 2016

Dementia Care Perceived Outcomes

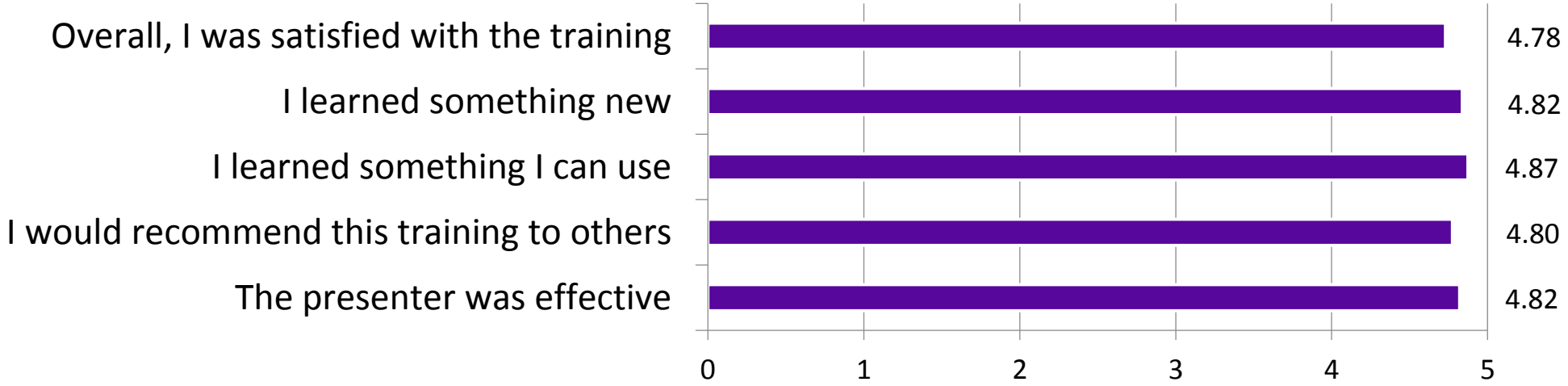
Do you believe the training you have received will result in any of the following outcomes…



March 2016

Satisfaction with Training

Care Manager Post-Training Satisfaction (n=256)



Interactive made it interesting and not just having to listen for 8 hours. Great info for CMs working with Cal MediConnect.

I really enjoyed it and would love to have this training for some of my other team members.

I liked the flow of the training. It was informative, hands-on, and visual.

If we can help at least one person with ADRD and their caregiver, this training and us - we can make a difference.

This training can positively affect the relationship between ADRD members and their caregivers - be able to get along and communicate more effectively.

March 2016

Satisfaction with Training

Presentation was related to my work. Great training, and gave a real great understanding of the disease and components. Enjoyed this training!

I appreciated the many examples and applications. Very thorough for 2-day training. Appreciated it so much, the guests sharing their story.

The DCS Tool Kit is a great resource that I will be able to take and apply to my practice as a case manager.

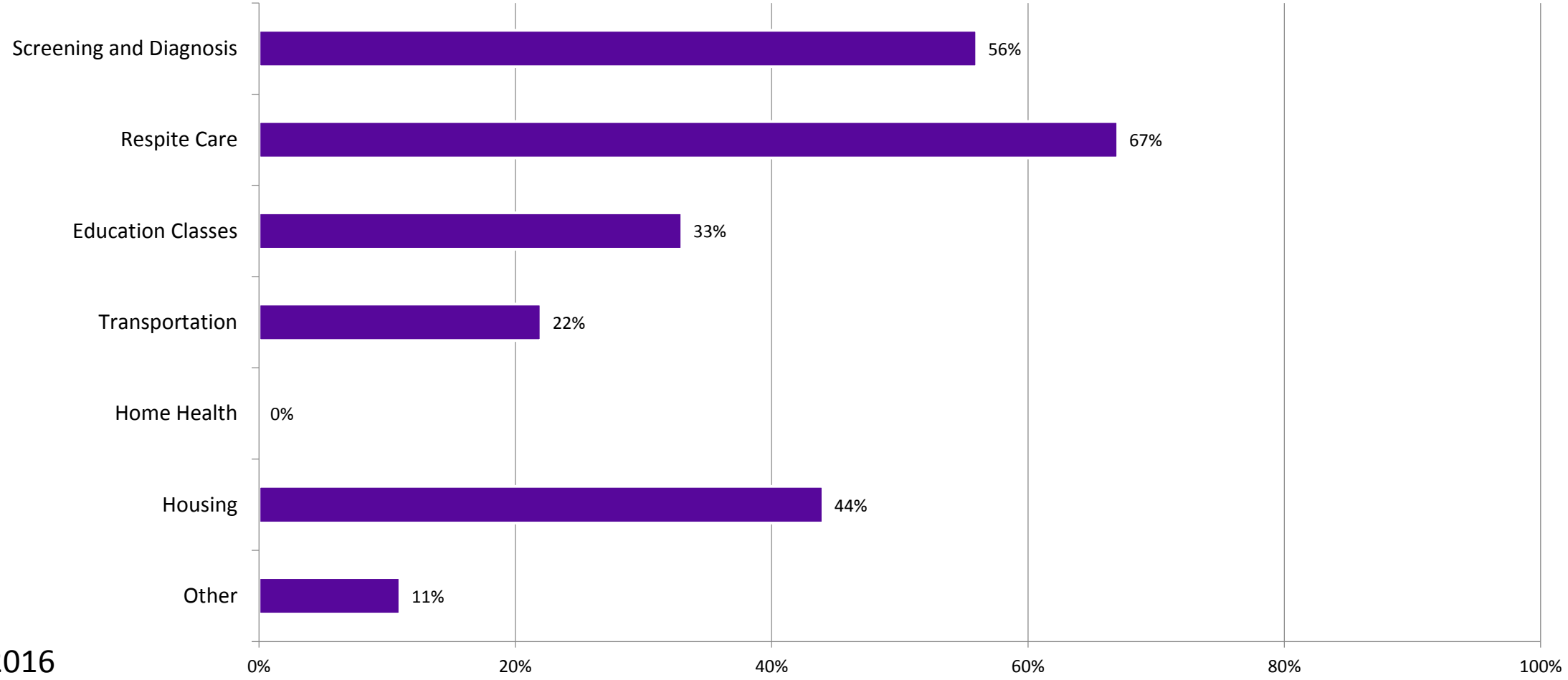
Bring it to all IHSS. Much needed training.

I received lots of tools to use and speaker was engaging and kept information interesting.

March 2016

DCS 6 Month Follow-up (Unmet Needs)

What needs of members with ADRD and their informal caregivers remain unmet… (n=9)



March 2016

DCS 6 Month Follow-up – Systems

	% Yes	% No	% Don't Know
Have screening tools been adopted as part of system protocol? (n=9)	44%	33%	22%
Do members with ADRD and their informal caregivers receive care management from care managers who have received Alzheimer's|Greater Los Angeles Care Manager or Dementia Care Specialist training? (n=9)	88%	22%	NA
Is there a protocol to identify and record the presence of an informal caregiver as part of the member's care plan or medical record? (n=8)	88%	13%	NA
Have protocols been developed to encourage the use of a fax referral form to refer members and informal caregivers to Alzheimer's|Greater Los Angeles? (n=7)	57%	43%	NA

March 2016

Dementia Cal MediConnect 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 Evaluator:

- Brooke Hollister, PhD
  University of California, San Francisco
  Institute for Health and Aging

Alzheimer's Greater Los Angeles Team Members:

- Susan Howland, MSG
- Cora Mahon, MSW, ASW

Alzheimer's Association, Northern California and Northern Nevada Chapter Team Members:

- Bonnie Bollwinkel, LCSW
- Elizabeth Edgerly, PhD
- Ruth Gay, MS, Team Lead
- Pauline Martinez, MA
- Alexandra Morris, MA
- Angie Pratt, MAS

Alzheimer's Association California Council

- Susan DeMarois

CALIFORNIA

Project Title: California Coordinated Care Initiative: An Opportunity to Improve Access and Services for Persons with Dementia and their Family Caregivers

Year grant funded: 2013

Project period: October 1, 2013 to September 30, 2016

Contact Information:

Lora Connolly (Project Director)
Phone: 916-419-7501
Email: lora.connolly@aging.ca.gov

Grantee Agency/Organization: California Department of Aging (CDA)

Partner Organizations:

- California Department of Health Care Services (DHCS)
- Alzheimer's Association California Southland
- Alzheimer's Association Northern California and Northern Nevada
- Health plans involved in state's dual-eligible pilot
    - Years 1 and 2 of program health plans involved include: Los Angeles Care Health Plan, Kaiser, Care 1st Health Plan, San Mateo Health Plan, Santa Clara Family Health Plan, Alameda Alliance Complete Care, and HealthNet.
- University of California- San Francisco's Institute on Health and Aging (UCSF)

Area Covered: California's eight largest counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

Project Summary:

The California Department of Aging (CDA), in partnership with the California Department of Health Care Services (DHCS), Alzheimer's Association chapters in California, health plans participating in the State's dual eligible pilot, and UC San Francisco's Institute on Health and Aging proposes evidence based/informed interventions to improve identification of people with dementia and their access to comprehensive home and community based services (HCBS).

The goal of this 3-year project is to build a dementia capable, integrated system of care for patients with Alzheimer's disease or related disorders (ADRD) enrolled in California's Coordinated Care Initiative (CCI) that is evidence-based or evidence-informed when possible. Working collaboratively, CDA, DHCS, UCSF, the AA chapters, and the health plans will build a dementia capable system of care that assists these patients and their family caregivers in accessing comprehensive, patient and family-centered health care and HCBS services.

Project objectives include:

- Create and sustain increased dementia-capacity within the CCI managed care plans that include a Single Entry Point in accessing health and LTSS that promote community living for people with ADRD. This will be achieved by developing and implementing a training program for health plan care managers derived from the evidence-based ACCESS project;
- Ensure access to a comprehensive, sustainable set of quality, evidence-based or evidence-derived services that are dementia capable and provide innovative services both to California's diverse population with ADRD enrolled in CalMediConnect and their family caregivers.

Target populations will include individuals with ADRC who enroll in CalMediConnect and their family caregivers.

Anticipated outcomes include: increased care manager efficacy and referrals to HCBS; improvements in caregiver depression and self-efficacy; increased health plan dementia capability, quality, and satisfaction; and decreased health care utilization and cost.

- For Care Managers
  - Satisfaction with training and materials;
  - Increased knowledge about dementia signs and symptoms, screening and care, and appropriate referrals to available supports and services;
  - Increased satisfaction with their ability to manage the care for people with ADRD;
  - Increased number of referrals made to the AA; and best practices identified.
- For Caregivers
  - Satisfaction with training and materials;
  - Increase in caregiver knowledge about dementia signs and symptoms, management of challenging behaviors, available HCBS resources;
  - Increased caregiver self-efficacy; and
  - Decreased caregiver depression.
- For Plans
  - Decrease in utilization and cost;
  - Increase in HEDIS quality and satisfaction measures, by plan and ADRD status where possible;
  - Adoption of best practices by plans including: recommendations for factors to include in their Annual Wellness Visit; trainings to additional care managers; pairing of dementia capable care managers with patients with ADRD and their caregivers; institutionalization of ADRD screening and caregiver assessments and referrals; and use of quality measures that track patient and caregiver referrals to HCBS and supports.