Improving Care Coordination for Persons with Dementia: California’s Experience

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Learning Objectives

Participants will gain knowledge of:

• Care manager-focused interventions implemented within a state’s capitated financial alignment demonstration for the dually eligible

• Review of key components of effective care management for people with dementia
  ▪ Workforce preparation
  ▪ Identification and screening of a high-risk population
  ▪ Identification and assessment of family caregivers
  ▪ Collaboration with community-based organizations for patient and caregiver education and support

• Resources for training of care management staff
Cal MediConnect: Overview of California’s Financial Alignment Demonstration

• CMS & CA Dept. of Health Care Services (DHCS) have contracted with the managed care plans to provide Medicare and Medi-Cal services to Dual Eligibles in the 7 largest counties.

• These health plans receive capitated payments to provide Medicare and Medi-Cal services, including many long-term supports and services (LTSS), to enrollees.

• The MOU allows for up to 456,000 enrollees in Cal MediConnect; currently there are 116,000 enrollees.
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.
Care Coordination

• Cal MediConnect health plans must conduct a health risk assessment of all enrollees.
• Plans are required to have interdisciplinary care teams.
• Plans are required to offer care coordination services to all enrollees.
  ▪ This care coordination must incorporate person-centered assessment and care planning, and include both medical and long term supports and services.
Re-Aligning Incentives

• Managed Care - Not Fee-for-Service
• Additional flexibility in services offered
• Shared motivation to control costs, while improving the quality of care

Key Role for Care Managers
An estimated 200,000 dual eligible beneficiaries in CA have ADRD.

By 2030, the number of people with AD in California will increase to 1.1 million.

Generation Alzheimer’s (Alzheimer’s Association 2011)
AD Facts and Figures in CA (Alzheimer’s Association 2009)
Slide courtesy of Cordula Dick-Muehlke, PhD (Adapted)
Caregiving

• Many family and other unpaid caregivers experience high levels of emotional stress, burnout and depression.

• As a result, health plans must assess caregivers’ ability to provide the necessary level of care and identify the education and supportive services the caregivers will need to be able to continue to provide this level of care.

• In cases where caregivers are not able to provide the needed level of care, or where there is no caregiver, plans must develop comprehensive strategies to provide for the safety and well-being of the person with Alzheimer’s.
Why Dementia Cal MediConnect Project?

**Public health crisis**
- Increasing numbers
- Familial impact
- Dual eligible beneficiaries with dementia drive cost of care

**Importance of project**
- Success of CMC health plans depends on dementia-capable system
- Dementia care management improves care & health outcomes
- Potential for cost savings
Project Goals - Creating Dementia Capable Systems of Care Through:

1. Better detection and documentation of patients with dementia
2. Better partnerships between health systems and family/friend caregivers
3. Better partnerships with community-based organizations

Care Management as the Linchpin For Improving Care
Indicators of a Dementia Capable System

1. Better detection and documentation of patients with dementia – largely done by care managers
   - Include cognitive impairment questions in the Health Risk Assessment (HRA) and other assessments
   - Adopt a validated screening tool
   - Document cognitive assessment in the medical management record
   - Establish a follow-up protocol for diagnosis if the cognitive screen is positive
Vignette #1: Incorporating a Cognitive Screening Tool
Indicators of a Dementia Capable System

2. Better partnership between health system and family/friend caregivers

▪ Identify family/friend caregiver and document this in the medical record(s)

▪ Briefly assess family/friend caregiver’s needs

▪ Provide family/friend caregiver with education & supports

▪ Develop a care plan based on person and family-centered needs
Challenges to Family/Friend Caregiver Engagement

Medical providers may not have adopted systems that identify, document, and engage the caregiver. Therefore...

- Poor management of co-morbid conditions
- Apparent non-compliance
- Medication mismanagement
- Behavior symptom mismanagement
- Unnecessary hospital readmissions, ER visits, and possibly even nursing home placement
Better Partnership Between Healthcare System and Informal Caregivers/Families

Vignette #2: Using ICD-9 Codes to Identify Members and Families for Caregiver Education
Indicators of a Dementia Capable System

3. Better partnerships with Community-Based Organizations

Adoption of a proactive referral tool (ALZ Direct Connect) to local organizations with dementia expertise that can connect families to HCBS like:

- Respite care
- Support groups
- Caregiver education
- Care counseling
Vignette #3: ALZ Direct Connect – Linking for Caregiver Education, Support, and Respite
Challenges to Partnerships with Community-Based Organizations

• Involves a culture change for both partners.
  ▪ Health systems timeliness and feedback.
  ▪ CBOs may not be HIPAA-compliant or have capacity to handle increased volume of referrals.

• CBOs may require additional resources to meet increased service volume & respond to other health plan requests.

• Partners involved need to invest time to better understand one another’s cultures and services.
The Dementia Cal MediConnect Project: Key Components

• Advocacy with health plans - Making the case for focusing on dementia care.

• Care manager training and support.

• Support services for patients and caregivers through the health plans and through referrals to Alzheimer’s organizations.

• Technical assistance to create systems change.
Step 1: Identify Champions & Leaders

- Where to meet them
- Who they are
Step 2: Making the Case

- Both cost and quality count
- Data is helpful but so are stories
- Use policy levers
The Case for Improving Dementia Health Care

- Increasing prevalence
- High cost of care
- Multiple quality challenges
  - Poor detection
  - Poor treatment and management
  - Poor recognition of family caregiver’s role
  - Poor access to home-and community-based services

Average Cost of Care for Beneficiaries with Moderate to Severe CI

Average Cost of Care for Beneficiaries without Moderate to Severe CI


Tools for advocacy: www.alzgla.org/professionals
Step 3: Make the Ask

- Provide action steps the health care system can take
- Alert them to the indicators of system change
- Be clear
- Be assertive
Step 4: Implement - Provide Training and Technical Assistance

- Provide to the health care providers so that they can accomplish “The Ask”
- Remember change can be slow; that it is an on-going process
- Be persistent
Tier 1 Care Manager Training Components

- Fundamentals of Cognitive Impairment, Alzheimer’s Disease, and Related Dementias
  - AD8 Screening
- Practical Dementia Care Management
  - IDEA! Behavior Management Approach
  - Plain Language Fact Sheets on Behaviors
- Caring for the Caregiver
- Resources/Support Services
  - ALZ Direct Connect

www.alzgla.org/professionals
IDEA!

IDentify the Behavior
Be specific

Educate Yourself/ Explore
Understand the causes/triggers
Understand the meaning

Adjust
Problem solve
Bathing

People with Alzheimer’s disease or dementia may be afraid of bathing or uneasy with having someone help them with bathing. Sometimes they worry about falling or can have trouble knowing which is the hot versus the cold water faucets.

WHAT CAN YOU DO?

Prepare the Bathroom in Advance
- make sure the room is calm and warm
- run the water so it is not too hot or too cold
- don’t use bright lights if possible

Make the Bathroom Safe
- use a non-slip mat in the tub or shower and as a bath mat
- consider a tub seat
- fill the tub with only 4 inches of water
- remove things that may be dangerous such as razors, nail clippers, hair dryer, etc.
- watch carefully – don’t leave him or her alone

Allow Time & Be Positive
- allow your person to enjoy it... if he or she finds bath time relaxing
- stay calm
- be direct... “Your bath is ready now” instead of “Do you want to take a bath?”
- give one step directions... “Let’s wash your left arm... good!, now your other one”
- be patient... don’t rush

Be Realistic
- don’t argue or get frustrated... a daily bath may be too much
- consider a sponge bath instead of a tub bath
- show what you need from them... pretend to wash your arm so that he or she can copy
Tool to Facilitate Warm Referrals

ALZ DIRECT CONNECT REFFERAL 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) 930-0277

ALZ DIRECT CONNECT does not provide legal or medical advice. Alzheimer’s Greater Los Angeles maintains no therapeutic or clinical relationship with families or individuals referred. The information provided is designed to facilitate referrals to the best possible care and services.

ALZ DIRECT CONNECT REFFERAL FORM
Fax or email this form to Alzheimer’s Greater Los Angeles
Fax # 323.886.5106  Email  alzdirectconnect@alzga.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

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 __________________________ (Patient/Client or Person Authorized/Representative)
Date __________________________

REASON FOR REFERRAL (max. 150 characters)
☐ Social Work Consultation & Support
☐ Support for newly diagnosed
☐ Support for family caregivers
☐ Activities programs
☐ Safety Issues
☐ Housing/Transportation
☐ Other/Medical Alert
☐ Other (specify) __________________________
Additional information

REQUIRED INFORMATION
Referred Provider Name __________________________
Provider Organization __________________________
☐ Non-medical community organization
☐ Healthcare organization
How would you prefer to receive follow-up? ☐ Fax ☐ Email ☐ Follow-up unnecessary

Go to www.aldirect.org for more information

24/7 Helpline—844.HELP.ALZ | 844.433.7299 | alzga.org
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, and Care Needs Assessment tool*, Caregiver Stress & Strain Instrument**)
  - 23 Best practice care suggestions* (sleep disturbances, hallucinations, driving, etc.)
  - Materials to share with caregivers – (plain language fact sheets)

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

# Best Practice Care Suggestions

## Alzheimer’s Greater Los Angeles

### Caregiver Depression/Stress

<table>
<thead>
<tr>
<th>Identify the Problem</th>
<th>PROBLEM: Caregiver Depression/Stress (feeling blue and/or overwhelmed)</th>
<th>GOAL/EXPECTED OUTCOME: To reduce caregiver depression and stress</th>
</tr>
</thead>
</table>

**Educate Yourself**

**ASSESS FURTHER:**

- **Depression**
  - What happens right before the caregiver feels depressed?
  - How does the caregiver know when he/she is depressed? What does it feel like physically and emotionally that lets him/her know?
  - How often does the caregiver feel depressed? How many times per day/week?
  - How does the caregiver act when he/she is feeling depressed?
  - Is there anything the caregiver does that helps to reduce feelings of depression?
  - Is there anyone the caregiver can talk to when he/she is feeling this way?

- **Stress**
  - What happens right before the caregiver feels stressed?
  - How does the caregiver know when he/she is stressed? What does it feel like physically and emotionally that lets him/her know?
  - How often does the caregiver feel stressed? How many times per day/week?
  - How does the caregiver act when he/she is feeling stressed?
  - Is there anything the caregiver does that helps to reduce feelings of stress?
  - Is there anyone the caregiver can talk to when he/she is feeling this way?

- Is the caregiver feeling socially isolated?
- Is the caregiver having increasing family disagreements?
- Is the caregiver having uncomfortable feelings about his/her relationship with the person he/she cares for?
- Does the relationship feel strained?
- Does the caregiver have feelings of guilt?

**Adapt Problem-Solving Strategies to Caregiver:**

- Join a support or education group or identify a trusted friend/family/clergy member you can talk to when you are feeling this way
- Try to stay connected with family and friends
- Focus on what you are able to do as a caregiver, remember that caregiving can be very challenging
- Set realistic goals
- Ask for help with caregiving from others in the family or community
- Try to take a break and do something you enjoy. Consider physical activities when possible, such as taking a walk

### CLINICAL SUPPORT:

- Follow clinical guidelines and procedures for depression screening, intervention and referral
- If abuse and/or neglect is suspected, follow standards of practice, policies, procedures, and reporting mandates
- Encourage caregiver to discuss his/her depression and stress with a social worker/therapist. Direct to PCP for referral as needed
- Review specific questions to help prepare the caregiver for the discussion with PCP
- Coach caregiver on how to talk with PCP
- Consider further screening and assessment as needed

### CAREGIVER SUPPORT AND COMMUNITY RESOURCES:

- Listen empathically to caregiver and evaluate for level of distress
- Refer to respite services
- Refer to IHSS
- Refer to MSSP
- Refer to CBAS
- Refer to Alzheimer’s Greater Los Angeles for support groups, disease education, and care consultation
  - ALZ Direct Connect referral
  - Provide 24/7 Helpline #: 844-HELP-ALZ | 844-435-7259
  - Website: www.alzglia.org
- Local Community Resources:

### FOLLOW UP:

- Schedule a phone call with caregiver to discuss outcomes and provide additional support

### NOTES:
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 90DS0202-01-00, 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.
Care Manager Training: Progress to Date

Care manager trainings – 8 hours

- N = 483 care managers
- 10 health plans plus PPGs, and contracted LTSS agencies

Dementia Care Specialist – 12 hours

- N = 83

Case conferences – monthly for 6 months
Step 5: Evaluate & Provide Feedback
Evaluation Design

• Care manager training outcomes: (pre, post, 6 months)
  ▪ Satisfaction with training
  ▪ Knowledge gained
  ▪ Self-efficacy
  ▪ Practice change, outcomes, systems change,

• Key informants:
  ▪ Practice change
  ▪ Systems change within the health plan

• Systems Change Tracking: Documented by project staff
What Can We Say?

As a result of the training:

• CMs and DCSs were more likely to report conducting formal dementia screening as part of their client’s needs assessment after training.

• CM and DCS knowledge of ADRD, identification, and screening increased after training, and was sustained 6 months after trainings.
What Else Can We Say?

CMs and DCSs report more dementia friendly practices

After training they reported they were more likely to:

- Screen members for dementia
- Encourage a formal diagnosis
- Identify caregivers
- Develop a care plan
- Involve caregivers in care planning
- Provide or arrange for support for caregivers
- Refer to HCBS & Alzheimer’s organizations
Lessons Learned

▪ Staff turnover was a challenge.

▪ Organizational change was challenging.

▪ Variability in the skills of care managers selected to become the Dementia Care Specialists and how they were going to apply those skills within their organization.
Key Informant Feedback on Systems Changes within Health Plans (based on 8 health plans)

Cognitive Screening
• 3+ health plans changed HRAs to include cognitive screening
• 4 health plans adopted AD8 or other validated cognitive screening tool

Partnership with Family Caregivers
• All say they are systematically identifying family caregivers
• 3 adopted a validated measure of caregiver strain
• 5 provide respite under Care Plan Options & 2 refer to CBOs
• 7 offer caregiver education directly or through CBOs

Partnership with CBOs
• 2 formally integrated ALZ Direct Connect/others use it less formally
Online Training Modules

• Fundamentals of Alzheimer’s for Healthcare Professionals (1 hour module)

• Effective Strategies for Managing Behavioral Symptoms of Dementia (2 hour module)

• Caring for Family Caregivers (1 hour module)

Access through: www.alzgla.org/professionals
Resources Available

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

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