A Tale of Two States and the Future of Alzheimer’s Policy

NASUAD HCBS Conference
August 29, 2019
Baltimore, MD
EVERY 65 SECONDS someone in the United States develops the disease

5.8 MILLION Americans are living with Alzheimer’s

BY 2050, this number is projected to rise to nearly 14 MILLION
Between 2000 and 2017 deaths from heart disease have decreased by 9% while deaths from Alzheimer’s disease have increased by 145%.

Alzheimer's disease is the 6th leading cause of death in the United States.
Addressing Alzheimer’s as a Public Health Crisis State-by-State

1. Increase Public Awareness, Early Detection and Diagnosis
2. Build a Dementia-Capable Workforce
3. Increase Access to Home and Community-Based Services
4. Enhance the Quality of Care in Residential Settings
A TALE OF TWO STATES
AND THE FUTURE OF ALZHEIMER’S POLICY
Wisconsin’s Journey with Dementia

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alzheimer’s association
**WISCONSIN STATISTICS**

- Estimated 121,262 people with dementia (2019)
- By 2040, number expected to increase by 72%, to 242,000 people
- Affects 1 in 10 people aged 65+ and 1 in 3 people aged 85+
- Medicaid costs for this population in 2019: $752M
LIVING ARRANGEMENTS

- 92% of people with dementia live in the community (home and assisted living)
- 8% reside in skilled nursing facilities
- ~22% are living alone in their residence
CAREGIVERS

- Family caregivers provide care to ~90% of the long-term care population.
- 195,000 caregivers for people with dementia
- 220 million hours of unpaid care for a total value of $2.8B
HISTORY OF DEMENTIA CARE
SYSTEM REDESIGN IN WISCONSIN
Summits | State Plans | Implementation and Accomplishments
SNAPSHOT OF THE ACCOMPLISHMENTS

Dementia Care Specialists in ADRCs

Dementia Friendly Communities

Family Caregiver Support Programs

Dementia Friendly Employers (on-line toolkit)

WisCaregiver Career Program

Curriculum for Middle and High School Students

Managed Care Dementia Leads and Contract Standards

Music and Memory in the Community and in Nursing Homes
SNAPSHOT OF THE ACCOMPLISHMENTS

On-line Training and “Coupons” for Families

Innovative Programs to Address Health Equity

Dementia-friendly Public Health Mini-Grants

Crisis Innovation Grants

dementia care guiding principles

10+ innovative facility-based dementia pilots/grants
DEMENTIA CARE SPECIALISTS IN ADRCS & TRIBES

- For people with dementia: Information; care planning; memory screening; enrichment opportunities
- For Caregivers: Connections to support groups; evidence-based programming
- For the Community: Dementia-friendly communities/ businesses; memory cafés
- For Key Partners: Aging and Disability Resource Center services; coalitions
Wisconsin Alzheimer’s Awareness Grant and Campaign

alzheimer's association

DAD LEFT THE HOUSE WITH HIS SHOES OFF.
DEMENTIA CRISIS INNOVATION

• Helen EF Decision; Legislative Council Report
• System readiness assessment
• Dementia Crisis Unit Pilot Report
• Dementia Training for Mobile Crisis Teams
• Dementia Chapter 55 Coordinators
• Dementia Innovation Grants
CRISIS INNOVATION GRANTS

- Improved skills of crisis responders
- Clarified protocols
- Expanded the number of facilities willing to accept people with dementia in crisis
- Enhanced caregiver skills to avert crisis by incorporating new care approaches
ALZHEIMER FAMILY CAREGIVER SUPPORT PROGRAM

- State-funded program, began in 1985
- Expansion in 2017: additional funds for respite; and created tribal allocations
- Expanded eligibility requirements
- Broad scope of allowable services
- WI Family and Caregiver Support Alliance
- Caregiver Task Force - 2019
MAKING MEDICAID DEMENTIA-SPECIFIC IN VIRGINIA

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Cognitive Decline in Virginia - Some Statistics

Percent with memory problems who have not talked to a provider about it: 52%

Percent with memory problems who live alone: 69%

Percent with memory problems who have at least one other chronic condition*: 20.1%

*Defined as arthritis, asthma, COPD, cancer, cardiovascular disease, and diabetes

Source: 2015 Behavioral Risk Factor Surveillance System from Virginia Department of Health
Virginia Dementia Specialized Supportive Services Project

University of Virginia School of Medicine

jaba
Live better. Longer.

DARS
Virginia Department for Aging and Rehabilitative Services
Virginia Dementia Specialized Supportive Services Project Objectives
(Initial Phase)

- Develop and pilot an integrated, coordinated care system for PWD (Persons with Dementia)
- Provide a treatment program to newly diagnosed PWD and their caregivers that will include education about dementia, strategies for anticipating and effectively coping with changes, provide emotional support and aid in development of a support system;
- Analyze the efficacy of the system and develop a manual to facilitate replication.
Virginia Dementia Specialized Supportive Services Project Objectives (Second Phase)

• Focus on specialty dementias (Parkinson's Disease Dementia, Frontotemporal Dementia, Lewy Body Dementia), and individuals with moderate to late stage Alzheimer's disease.
• Help PWD maintain their independence, increasing safety within their home environment, and prolonging transitions into higher levels of care.
• Reduce Medicare costs through dementia specific care coordinator designed to decrease the number of unnecessary hospitalizations of PWD.
• Dementia Care Coordinators also help families identify strategies to deal with difficult behaviors and manage other new challenges brought on by disease progression.
BRI CARE CONSULTATION: BASED IN WILLIAMSBURG, VA
Enhancing Family-Centered Approaches to Dementia Care through Wellness and Training (Initial Phase)

- Enrollment through CEALH Geriatric Assessment Clinic and Memory Care Clinic referrals
- Focus on persons with dementia, particularly those who live alone, and their caregivers
- Enrolled first BRI CC client, early May 2019
- Enrollment during first 3 months: 20 caregivers, 4 of which are dyads (where care receiver is able to participate)
- Target of 25 participants in Y1 of grant, and 50 each in Y2 and Y3
- Evaluation: Pre-assessments, interim at 6 months, and post-assessments at 12 months
COMMONWEALTH COORDINATED CARE PLUS

HCBS
August 2019
Medicaid Expenditures

Enrollment vs. Expenditure SFY 2016

- Parents, Caregivers & Pregnant Women: 28%
- Children in Low Income Families: 49%
- Individuals with Disabilities: 17%
- Older Adults: 6%

1.3 million enrolled

$8.41 billion expenditures

23% of the Medicaid population

68% of total expenditures

Drives
Transition from Fee-For-Service to Managed Care

DMAS Pays for Enrollee Health Care Services

25% of Medicaid Enrollees

Fee-For-Service (FFS) Providers Paid Directly

Managed Care: MCO Coordinates Care and Contracts with Providers to Deliver Services

75% of Medicaid Enrollees
Managed Long Term Services and Supports

• Medical, behavioral health and long-term services and supports
• Health Plans cover services within at least equal amount, duration, and scope as Medicaid
• Health Plans provide additional benefits and linkages to resources to address social determinants of health
• Very few carved-out services (e.g., dental, school health, and DD Waiver services)
• Care coordination for all enrollees
Approximately 240,000 individuals, including:

- Adults and children living with disabilities
- Individuals living in Nursing Facilities (NFs)
- Individuals in the CCC Plus Waiver (formerly the Technology Assisted Waiver and Elderly and Disabled with Consumer Direction Waiver)
- Individuals in the 3 waivers serving the Developmental Disabilities populations for their non-waiver services
- Medically complex individuals eligible through Medicaid Expansion
- Governor’s Access Plan members transitioned to CCC Plus on January 1, 2019
Every member is assigned an MCO Care Coordinator who performs the following functions:

**Assess**
- Conduct/coordinate Health Risk Assessment
- Identify barriers to optimal health

**Plan**
- Drive the development of person-centered, individualized care plan
- Include plan to support social determinants of health

**Communicate**
- Establish collaborative relationships that connect the enrollee, MCO, and providers

**Coordinate**
- Help navigate the health care system
- Coordinate team of health care professionals
- Support care transitions

**Monitor**
- Track progress towards goals
- Monitor status to avoid disruption in care
- Update plan of care
## Care Coordinator Ratios and Key Deliverables

<table>
<thead>
<tr>
<th>Sub-Population</th>
<th>Ratio</th>
<th>Initial HRA</th>
<th>HRA Face-To-Face</th>
<th>Minimum Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCC Plus Waiver (with PDN Services)</td>
<td>1:75</td>
<td>60 days (30 days)</td>
<td>Yes</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>1:200</td>
<td>120 days</td>
<td>Yes</td>
<td>Quarterly</td>
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<tr>
<td>Other High Risk (SMI, Complex Conditions, GAP)</td>
<td>1:150</td>
<td>30 days</td>
<td>Yes – SMI</td>
<td>6 months</td>
</tr>
<tr>
<td>Emerging High Risk</td>
<td>1:400</td>
<td>Up to 120 days</td>
<td>No</td>
<td>6 months</td>
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Added Benefits

- Health plans can offer additional supports and training for caregivers for example: extra respite services, community resources
- Some health plans offer memory alarms and devices to members
- Some plans offer environmental or home modifications when needed

Visit: https://www.cccplusva.com/member-materials
For more information about added benefits offered by each health plan.
A Member with Alzheimer’s was cared for by their spouse. The spouse became overwhelmed by the Member’s symptoms. The member was being treated only by a PCP. The Care Coordinator connected the Member with a Neurologist, who altered the Member’s medications. This led to increased appetite, less wandering and better quality of life for the couple, with the member remaining at home.
DMAS Provides Care Coordinator Training and Support

- DMAS has dedicated Care Management Unit that offers weekly trainings and ongoing support to all CCC Plus Care Coordinators.
- DMAS partnered with Alzheimer’s Association staff to host a 4-part training to over 300 health plan Care Coordinators across 6 health plans on dementia specific care to improve competency.
- Topics included – early identification, assessment, approach, and resources.
- Several health plans reached out directly for more information from the Alzheimer’s Association.
UnitedHealthcare Staff Training

UnitedHealthcare has taken a multi pronged approach to dementia care.

1. United identified and trained Care Coordinators to be experts in dementia care that the Alzheimer’s Association provided.

2. United contracted with Alz Better to use their software, assessment tools and trainings. They trained Care Coordinators on the Alz Better program. United reevaluated the caseloads and ratios of the dementia experts to account for the additional assessments, coaching, and tracking with these members.

3. Through Alz Better they also trained caregivers.

Caregivers are trained on techniques to avoid common issues in the dementia population, how to identify possible triggers causing these issues, and incorporates a stress reporting system to alert the Care Coordinator when problems arise.

One example – a granddaughter is taking care of a 100 year old member. The member is agitated and has hallucinations. The Case manager is monitoring the granddaughter’s stress level daily via cell phone and providing tools for her to deescalate the member’s agitation.

United intends to grow the program to about 200 members.
Current Quality Measures

- **Staging of Dementia** - Percentage of members, regardless of age, with a diagnosis of dementia whose severity of dementia was classified as mild, moderate or severe at least once within a 12-month period.

- **Cognitive Assessment** - Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period.

- **Functional Status** - Percentage of patients with dementia for whom an assessment of functional status* was performed at least once in the last 12 months.
Care Coordination

Case Management
- Link to needed resources and services
- Utilize enhanced benefits

Utilization Management
- Understand benefits and application of MNC
- Treatment planning and appropriateness of care

Quality
- Best practices
- Performance improvement and health outcomes

Network
- Assessment and Referrals
- Awareness of specialty providers and shortages

Member Experience
- Understanding and communication
- Provide education and support

Continual Assessment
Future Goals

➢ Continue a strong partnership between Alzheimer’s Association and Medicaid.

➢ Our future Care Management System will be more robust and allow for improved identification of members with dementia and to assist with care coordination. Member specific data elements will be centralized, including LTSS screening, HRA, plan of care and annual level of care review outcomes.

➢ DMAS is partnering with the Center for Healthcare Strategies, health plans, VA state agencies and non profits to support family caregivers. Caregiver Workgroup has been created for ongoing communication and collaboration.

➢ DMAS is implementing a family caregiver survey as part of CCC Plus program evaluation efforts. Goal is to implement a caregiver assessment.

➢ DMAS will continue to train Care Coordinators on specific dementia care and resources to support family caregivers.
Questions?
Want to Learn More?

Visit
alz.org/facts
alzimpact.org/state (re-launch late September)

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