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

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CALIFORNIA DEPARTMENT OF AGING

MARCH 2016
Dementia Cal MediConnect
Grant Overview

• Three year Administration on Aging grant to the CA Department of Aging, in partnership with the Alzheimer’s/Greater Los Angeles, the Alzheimer’s Association of No. California, and the CA Department of Health Services (DHCS)

• Federal grant goal: “create sustainable home and community based services system that meets the unique needs of persons with dementia and their family caregivers.”

• Total grant amount: $744,000

• Grant period: Sept. 2013 – 2016
CA Focus—Cal MediConnect

- Strategic focus on health plans participating in the CA Coordinated Care Initiative (CCI) working to develop integrated care delivery systems.

- A major component of CCI is to align the fiscal incentives and care delivery within managed care model that combine all Medicare and Medi-Cal benefits and services into a single health plan.

- These plans are referred to as Cal MediConnect health plans and are being offered to individuals dually eligible for Medicare and Medi-Cal in 7 counties.
These health plans must have a system of care with care managers that assist individuals in obtaining the care they need (acute, primary, behavioral health and long term services and supports).

The three-way contact contract between the Centers for Medicare and Medicaid (CMS), the CA DHCS, and the participating health plans requires Plans to have Dementia Care Specialist.
## CCI Participating Counties & Health Plans

<table>
<thead>
<tr>
<th>County</th>
<th>Cal MediConnect Health Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Los Angeles</strong></td>
<td>Care 1⁰ - Care More - Healthnet - LA Care - Molina</td>
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<tr>
<td>Orange</td>
<td>CalOptima</td>
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<tr>
<td><strong>Riverside/San Bernardino</strong></td>
<td>Inland Empire Health Plan - Molina</td>
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<tr>
<td><strong>Santa Clara</strong></td>
<td>Anthem - Santa Clara Family Health Plan</td>
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<tr>
<td>San Diego</td>
<td>Care 1⁰ - Community Health Group - Healthnet - Molina</td>
</tr>
<tr>
<td><strong>San Mateo</strong></td>
<td>Health Plan of San Mateo</td>
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CCI Dementia Grant Year 1-3    CCI Dementia Grant Year 2-3
Need for Care Manager Dementia Expertise

- About 13% of individuals who will be passively enrolled in Cal MediConnect will have been diagnosed with Alzheimer’s disease or a related dementia
- An additional 13% likely have undiagnosed dementia
- Per capita health care costs for those with Alzheimer’s & related dementias rank in the Top 5
- Complex care needs, social supports & high risk for institutionalization
Dementia Cal MediConnect Strategy

- Focus on health plan care managers who have the most direct contact with the individuals and their families
- Tier 1 - basic dementia training for care managers in participating health plans (8 hours)
- Monthly case conference calls for 6 months to reinforce training content & assist in handling more complex situations CMs are experiencing
- Tier 2 - Dementia Care Specialist training (12 hours)
- Provide family caregiver education & support
Tier 1 Care Manager Training

• 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
Train the Trainer took place in May 2015

Dementia Care Specialist Toolkit for Dementia Care Management developed

- Assessment tools (AD8 screening tool, family caregiver identification tool, and care needs assessment tool)
- Standardized care plans (adapted from ACCESS Project)

Training began in late Summer 2015
### Dementia Cal MediConnect Grant

<table>
<thead>
<tr>
<th></th>
<th>Grant Goal</th>
<th>Accomplishments to Date</th>
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<tbody>
<tr>
<td>8 Hour CM Training</td>
<td>100 CM trained</td>
<td>264 from 7 health plans + several PPGs + contracted LTSS agencies</td>
</tr>
<tr>
<td>Dementia Care Specialist Training</td>
<td>8 CMs from health plans</td>
<td>44 CMs from 8 health plans + 1 PPG</td>
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<tr>
<td>Case Conferences</td>
<td></td>
<td>8 health plans + 1 PPG</td>
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<tr>
<td>Family Caregiver Support Training</td>
<td>200 family caregivers</td>
<td>Almost 500 caregivers attending training events</td>
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<tr>
<td>On Line Dementia Care Specialist Training</td>
<td></td>
<td>Coming Soon!</td>
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Evaluation & Data: Progress to Date

• Care Manager Surveys Response Rate:
  --135 baseline
  --113 post-training
  -- 20 six month 😞

• Caregiver Surveys N=96

• Key informant interviews to start in early 2016
Evaluation:
Care Manager Measures

- High level of satisfaction with training & materials
- Increased knowledge about dementia and home and community-based services
- Increased satisfaction with their ability to coordinate the care for persons with dementia (CM self-efficacy)
- Increased number of referrals to HCBS providers, including the Alzheimer’s Association
Care Manager Practice Change

When working with a member who may have ADRD...

- I usually encourage them to receive a formal diagnosis
  - % yes at baseline (n=135): 70%
  - % yes at 6 month (n=13): 77%

- I usually determine whether they have an informal caregiver
  - % yes at baseline (n=135): 67%
  - % yes at 6 month (n=13): 85%

- I usually involve the informal caregiver in the care planning process
  - % yes at baseline (n=135): 63%
  - % yes at 6 month (n=13): 92%

- I usually refer the member to available HCBS
  - % yes at baseline (n=135): 67%
  - % yes at 6 month (n=13): 92%

- I usually refer the caregiver to available HCBS
  - % yes at baseline (n=135): 55%
  - % yes at 6 month (n=13): 85%

- I usually refer them or their informal caregiver to the Alzheimer's care manager
  - % yes at baseline (n=135): 53%
  - % yes at 6 month (n=13): 92%
Evaluation: Family Caregiver Measures

- Very satisfaction with training and/or services
- Increased knowledge about dementia and HCBS resources
- Increased caregiver self-efficacy
System of Care Measures

- Adapting Health Risk Assessment to include dementia screening questions
- Including cognitive assessment into e-medical record for care manager & clinicians
- Protocol if cognitive screen is positive
- Ability to identify informal/family caregiver
- Integration of informal/family caregiver education
- Adoption of standardized care plans
- Referral to community resources, including Alzheimer’s organizations
What We Know to Date…

• Health Plans & care managers eager to engage
• Health Plans have sought technical assistance in a number of areas (HRA, respite criteria, developing their own physician & caregiver training, etc.)
• Health Plans want Alzheimer’s organizations at their county stakeholder meetings & events
• Health Plans have been willing to pay for additional training & consultation
• Has led to the first low literacy dementia education materials in the county
Work in Progress: Challenges

- No cookie cutter approach—each health plan is structured differently & has their own care management model. Must adapt to those differences.

- Even modified Health Risk and Annual Wellness Assessment and e-Medical Record will still miss individuals with dementia.

- Role of Dementia Care Specialist is new and evolving. How to direct persons with dementia to this specialist? How do other care managers learn about and access this specialist?

- Identifying family caregivers, their specific role and their needs.

- Getting family caregivers to education & support programs.
Dementia Cal MediConnect Team

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