

A Tale of Two *States* and the Future of Alzheimer's Policy

**NASUAD HCBS Conference
August 29, 2019
Baltimore, MD**

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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

9% 

while deaths from
Alzheimer's disease
have increased

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

CARRIE MOLKE, Director
WI Department of Health Services
Bureau of Aging and
Disability Resources



MICHAEL BRUHN, Director of Public Policy
Alzheimer's Association - Wisconsin

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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



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HISTORY OF DEMENTIA CARE SYSTEM REDESIGN IN WISCONSIN

Summits | State Plans | Implementation and Accomplishments



Wisconsin Dementia System Redesign

A Plan for a Dementia-Capable



February 2014



Wisconsin Department of Health Services
Division of Long Term Care
P-00586

Wisconsin Dementia System Redesign Reflecting on the Journey



Wisconsin Department of Health Services
Division of Long Term Care
P-01355 (06/2018)



Wisconsin State
JUL 10, 1902

TO: SPEAKER JOHN VOISARD

FROM: Members of the Assembly Speaker's Task Force on

RE: Report of the Speaker's Task Force on Alzheimer's

DATE: June 14, 2016

This memorandum summarizes the work of the Speaker's Task Force on Alzheimer's and dementia, including a description of the public hearings held by the Task Force, and recommendations for future action.

INTRODUCTION

The Task Force was created by Assembly Speaker Rob Roth and make recommendations on policy initiatives to improve Alzheimer's and dementia. Specifically, the Speaker presents goals, including identifying ways to improve and sustain promoting community-based resources for those suffering continuing raising individual and community awareness in determining ways to ensure future quality of care while lowering costs.

Representative Mike Huberke served as Task Force Chair. Dianne Hesselbein served as Task Force Vice-Chairperson. Representatives Kathy Bernier, John Jagler, Terry Katana, Tom Beth Meyers, Jonathan Brostoff, and Debra Koloski.

Based on information and recommendations received and tours, members of the Task Force and other legislators referred to as the "Wisconsin Care Legislative Package." The Task Force, relating to funding for caregiver respite, funding, developing a pilot program to ensure individuals with dementia are placed in an appropriate setting, were enacted into law.

Throughout this memorandum, the term "dementia" refers to Alzheimer's disease and related dementias.

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<http://www.wisconsin.gov>

Wisconsin Dementia Care System Redesign ACCOMPLISHMENTS

ACCOMPLISHMENTS



Wisconsin Department of Health Services
Division of Public Health
P-02092 (02/2018)



Wisconsin State Dementia Plan: 2019-2023



Wisconsin Department of Health Services
Division of Public Health
P-02241 (09/2018)

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

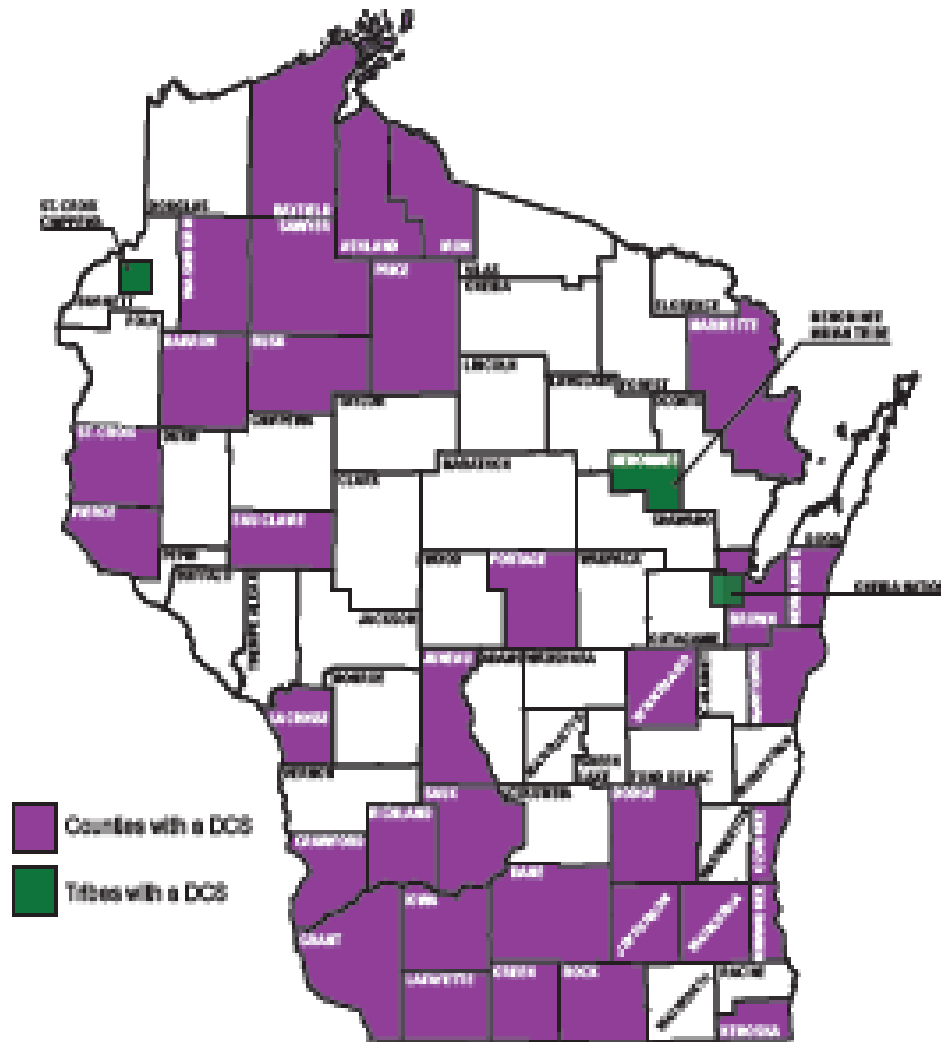
Dementia-friendly Public Health Mini-Grants

Crisis Innovation Grants

dementia care guiding principles

10+ innovative facility-based dementia pilots/grants

Aging and Disability Resource Center
Dementia Care Specialists (DCS)–2018



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

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DAD LEFT THE HOUSE WITH HIS SHOES OFF.

 ADRC
Aging & Disability Resource Center

alzheimer's  association®



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

SANDRA BROWN

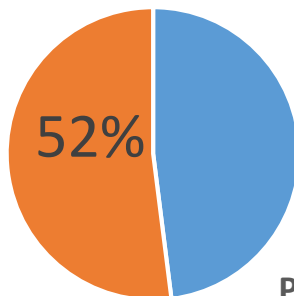
**Care Management Manager, Division of Integrated Care
Virginia Department of Medical Assistance Services**

CARTER HARRISON

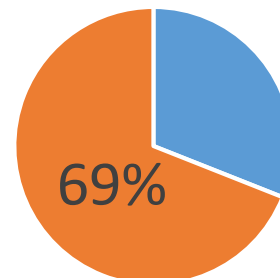
**Sr. Director of Government Affairs
Alzheimer's Association – Virginia**

Cognitive Decline in Virginia - Some Statistics

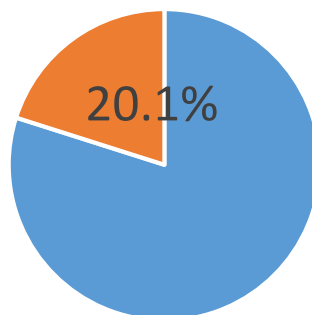
Percent with memory problems who have not talked to a provider about it



Percent with memory problems who live alone



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



*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



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



BENJAMIN ROSE
INSTITUTE ON AGING
SERVICE • RESEARCH • ADVOCACY



Rosalynn Carter
I N S T I T U T E
F O R C A R E G I V I N G



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

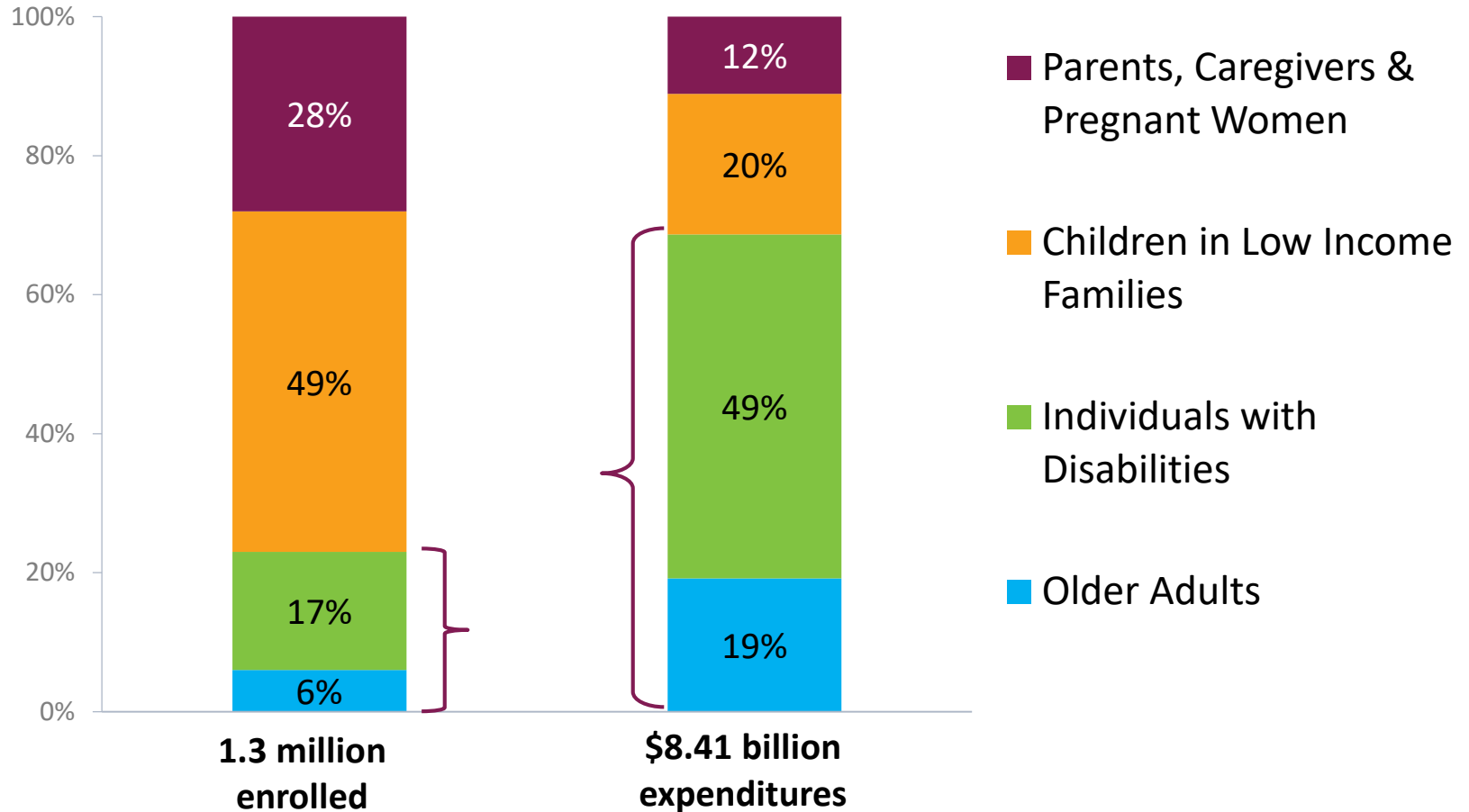
COMMONWEALTH COORDINATED CARE PLUS

HCBS

August 2019

Medicaid Expenditures

Enrollment vs. Expenditure SFY 2016

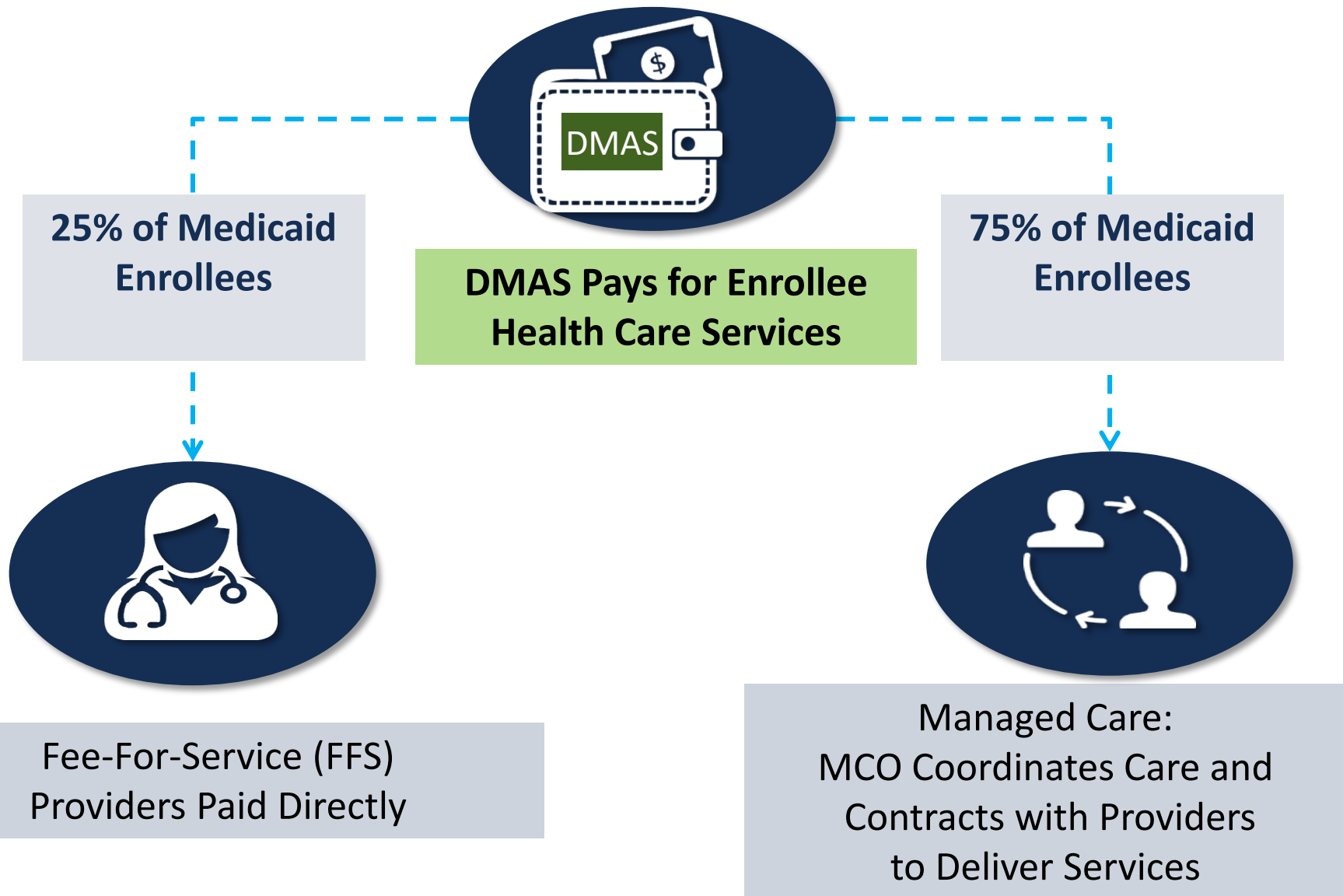


**23% of the
Medicaid population**

Drives

**68% of total
expenditures**

Transition from Fee-For-Service to Managed Care



Commonwealth Coordinated Care Plus

Program launched on 8/1/2017 and phased in by region across Virginia.

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

CCC Plus Populations



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

Care Coordinator Role

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

Sub-Population	Ratio	Initial HRA	HRA Face-To-Face	Minimum Contacts
CCC Plus Waiver (with PDN Services)	1:75	60 days (30 days)	Yes	Quarterly
Nursing Facility	1:200	120 days	Yes	Quarterly
Other High Risk (SMI, Complex Conditions, GAP)	1:150	30 days	Yes – SMI Others as needed or requested	6 months
Emerging High Risk	1:400	Up to 120 days	No Except as needed or requested	6 months

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.

Care Coordination in Action

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 Management

Care Coordination

Continual Assessment

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

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)

Reach out

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