Aging and Disability BUSINESS INSTITUTE

Connecting Communities and Health Care

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Leaders in Aging Well at Home

American Society on Aging

The Role of CBOs and CBO Networks in Comprehensive Dementia Care Models

March 24, 2022

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Aging and Disability BUSINESS INSTITUTE
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American Society on Aging

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Alliance to Improve Dementia Care

Recommendations for Scaling Comprehensive Dementia-Care Models

About the Milken Institute

Our Mission

The Milken Institute is a nonprofit, nonpartisan think tank that helps people build meaningful lives, in which they can experience health and well-being, pursue effective education and gainful employment, and access the resources required to create ever-expanding opportunities for themselves and their broader communities.

Center for the Future of Aging

What We Do

The Milken Institute Center for the Future of Aging elevates awareness, advances solutions, and catalyzes action to promote healthy longevity and financial wellness. Through research, convening, advocacy, and partnership with leaders across key sectors, the Center works to improve lives and build a better future for all ages.

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Alliance to Improve Dementia Care

Cross-Sector Collaborative

90+ leading organizations across eight key stakeholder groups

Areas of Focus/Working Groups

- Health and Economic Disparities
- Workforce Development and System Capacity
- Comprehensive Dementia-Care Models

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https://milkeninstitute.org/centers/center-for-the-future-of-aging/alliance-to-improve-dementia-care

Alliance to Improve Dementia Care Steering Committee

Alzheimer's
Drug Discovery
Foundation

The
John A. Hartford
Foundation

Scaling Comprehensive Dementia-Care Models

The Milken Institute Alliance to Improve Dementia Care convened fifty-one leaders across industry, government, research, advocacy, philanthropy, health systems, and community-based organizations to explore ways to improve and pay for comprehensive dementia care.

Barriers

- Wide-ranging needs of people living with dementia
- Need for robust workforce training
- Inequitable access to health care and long-term services and supports
- Misaligned incentives
- Inadequate payment structures

Advantages

- Matches needs to services by following a population-health approach
- Supports training for all workers involved in dementia care
- Coordinates care across health- and long-term care settings
- Reflects diverse community needs and preferences
- Advances value-based care
- Promotes alternative payment structures to reimburse providers for comprehensive dementia care

https://milkeninstitute.org/report/dementia-care-models-scaling-comprehensive

*See Appendix slides 24-27 for a full list of roundtable working group members and attendees

Why Comprehensive Dementia Care?

- Improves Quality of Life
- Better Supports Caregivers
- Delays Transitions from Home to Nursing Homes
- Reduces Total Cost of Care

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Develop a structured framework to test, implement, and scale comprehensive dementia-care models

Ensure all models contain eight core elements for comprehensive care & follow a population-health approach that matches services to need.

- There are **eight essential elements** of comprehensive dementia care that improve outcomes and lower costs
- A **structured framework** can reduce variations in care, align incentives, and improve care coordination
- A **population-health approach** can help clinicians adapt the core elements of comprehensive dementia care to the unique needs of individuals and their caregivers across stages of dementia

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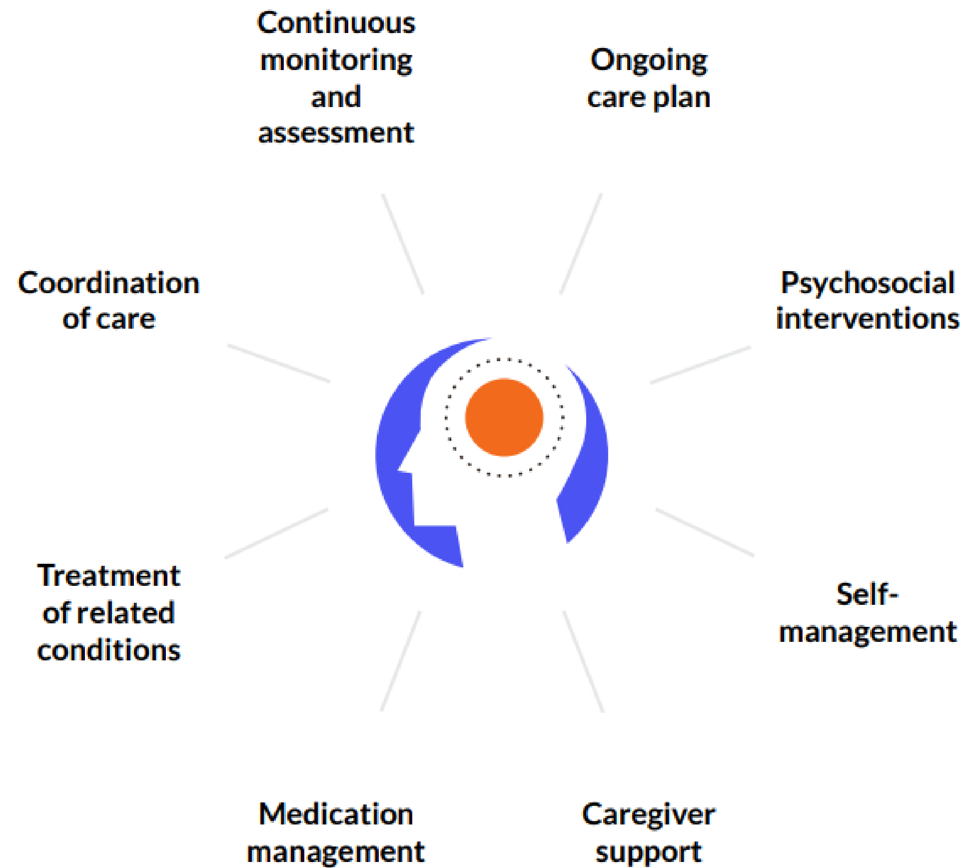
Eight Core Elements for Comprehensive Dementia Care



*See Appendix slide 22 for definitions of each core element

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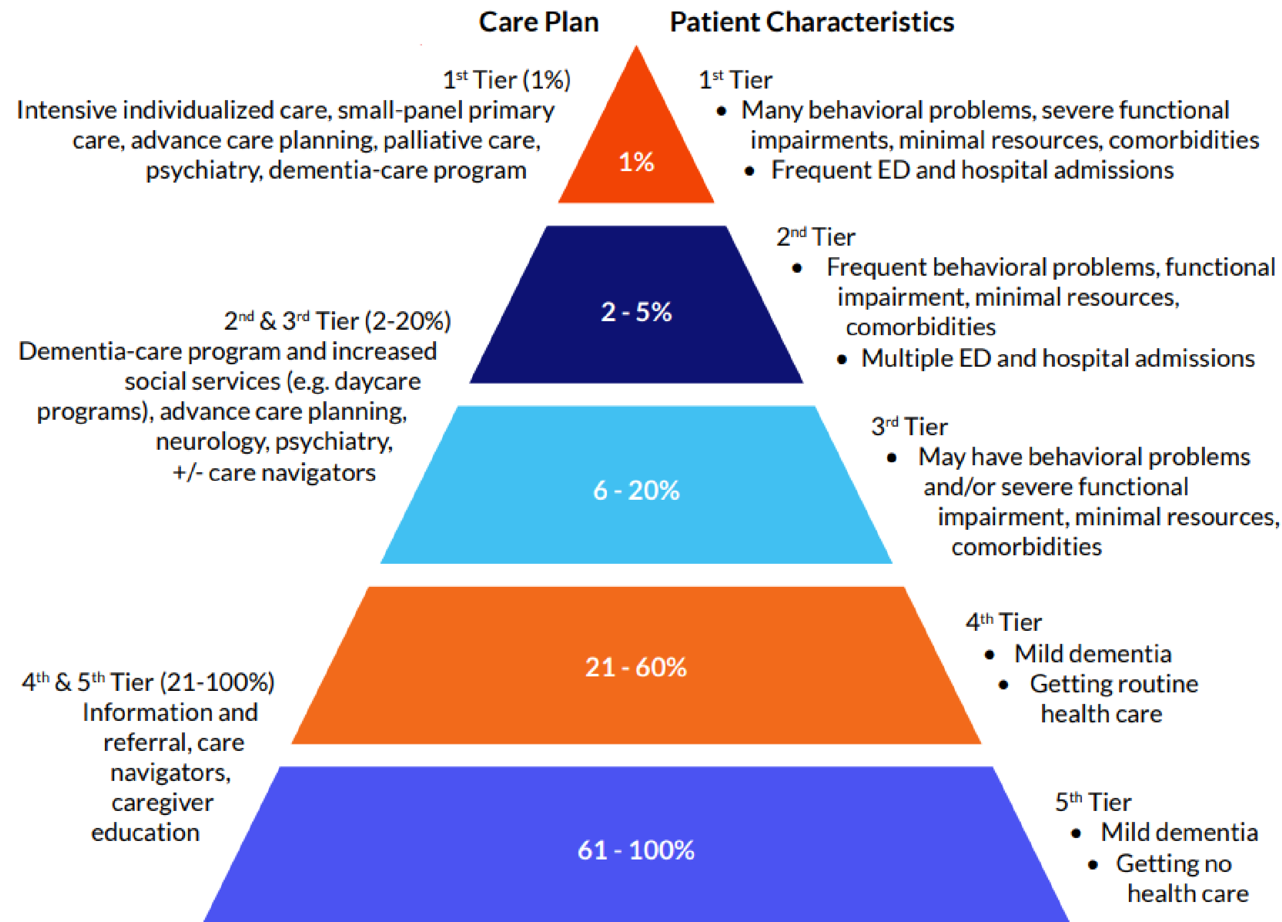
Adapted from Kristen Lees Haggerty et al., “Recommendations to Improve Payment Policies for Comprehensive Dementia Care,” *Journal of the American Geriatrics Society* 68, no. 11 (November 2020): 2478-2485, https://doi.org/10.1111/jgs.16807.

Population-Based Approach to Improve Dementia Care



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Source: David B. Reuben, Reshma Gupta, & Samuel A. Skootsky, "How A Population-Based Approach Can Improve Dementia Care," https://www.healthaffairs.org/do/10.1377/hblog20190506.543619/full/.

Implement quality measures to evaluate access, utilization, and outcomes of care models, particularly for diverse communities disproportionately impacted by dementia.

- **Measuring and tracking health system and person-centered outcomes** may help:
  - Create the evidence to scale high-performing innovations, replicate them across care settings, and ensure that providers consistently deliver high-quality care
  - Promote continuous evaluation of resources
  - Yield greater trust in the health- and long-term care systems and improve patient and family satisfaction
  - Increase enrollment in future comprehensive dementia care demonstration projects
- **Expressly linking equity measures to outcome measures** will help hold providers accountable for racial, ethnic, and geographic disparities

https://milkeninstitute.org/report/dementia-care-models-scaling-comprehensive

Expand dementia-specific training beyond physicians and nurses to increase interprofessional coordination, provide continuous monitoring and assessment, and expand access.

- Models that **support the training needs of all workers** involved in dementia-care teams can better scale services across communities and care settings
- A workforce model that elevates the role of care navigators, community health workers, and social workers
- Supporting both paid and unpaid caregivers is essential to **expand workforce and system capacity**:
  - Family caregivers should be considered members of the care team
  - Training direct-care workers on dementia care best practices can help clinicians focus on treating more complex patients
  - Certain care team members can provide care coordination navigation services

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Theme 2

Implement effective payment policies to incentivize adoption and participation in comprehensive dementia-care models

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Test implementation of payment models for comprehensive dementia care in traditional Medicare, especially in underserved communities.

- The bipartisan Comprehensive Care for Alzheimer's Act (S. 1125; H.R. 2517) calls on CMMI to **test an alternative payment methodology for dementia-care management**
- **Proposed alternative payment models (APMs)** move from Medicare's traditional fee-for-service payment structure toward capitated payment
- A dementia-care model can be **incorporated into CMMI's Primary Care First Model**, or a direct contracting approach, with an emphasis on dementia care
- **Other existing complex disease models,** such as the Comprehensive ESRD Care Model or Serious Illness Payment Model, may be adapted to manage the complexities of dementia care

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A Range of Comprehensive Dementia-Care Models

Structure and Process	Benjamin Rose Institute Care Consultation	Care Ecosystem	Maximizing Independence at Home	Eskenazi Healthy Aging Brain Center	UCLA Alzheimer's and Dementia Care	Integrated Memory Care Clinic
Key Personnel	SW, RN, MFT	Non-licensed care navigator, CNS, SW, Pharmacist	Non-licensed staff, RN, MD	Non-licensed staff, MD, SW, RN, psychologist	NP, PA, MD	APN
Face-to-Face Visits	No	No	Yes	Yes	Yes	Yes
Access 24/7/365	No	No	No	Yes	Yes	Yes
Patient Benefit	Yes	Yes	Yes	Yes	Yes	Non-significant findings but positive direction
Caregiver Benefit	Yes	Yes	Yes	Yes	Yes	Non-significant findings but positive direction
Cost Savings (gross)	$	$	None	$	$$$	$$$

Abbreviations: APN: advanced practice nurse; CNS: clinical nurse specialist; MD: medical doctor; MFT: marriage and family therapist; NP: nurse practitioner; PA: physician assistant; SW: social worker; RN: registered nurse; $: least cost savings; $$$: most cost savings

Adapted from Kristen Lees Haggerty et al., "Recommendations to Improve Payment Policies for Comprehensive Dementia Care," *Journal of the American Geriatrics Society* 68, no. 11 (November 2020): 2478-2485, https://doi.org/10.1111/jgs.16807.

Develop mechanisms to pay community-based organizations for services provided to individuals living with dementia and their caregivers.

- Under the capitated payment structure, **health systems should identify and pay CBOs that can deliver services** outside clinical settings
- Care models should **include home and community-based services** to assist individuals with dementia living at home, support caregivers, and address inequities affecting access to care
- Technology infrastructure that collects data and automates referrals and claims processes can help **integrate care**
- Showcasing how CBOs can help avoid or reduce high-cost services, decrease provider workload, improve patient outcomes, and reduce caregiver stress can help **create the business case for health systems**

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Paying CBOs for Dementia-Care Services

In December 2021, the Alliance conducted research in partnership with AARP to understand the barriers and opportunities for paying CBOs to deliver dementia-care services.

Barriers

- Delayed diagnosis of dementia
- Most people don't self-identify and seek out caregiver support services
- Complex and unsustainable funding sources
- Fragmentation of health- and long-term care systems
- Capacity and infrastructure constraints

Opportunities

- Alternative payment models (APMs)
- Medicare Advantage coverage options
- Community-based integrated care networks (CBICNs)
- The Program for All-Inclusive Care for the Elderly (PACE)
- Adult Day Care Centers
- Meals on Wheels America (MOWA)

Recommendations

For a pilot project for dementia-care services to be successful, it is important to identify these key elements to be tested:

- Dementia-specific services: Tailor services to meet the needs of people living with dementia and their caregivers across disease stages.
- Target population: Target interventions to Latino and Black populations who are disproportionately impacted by dementia.
- Geographic locations: Choose a program site with willing partners from health-care and CBO sectors.
- Payment method: Build upon an existing, evidence-based model of care.
- Evaluation: Utilize a third-party evaluator to measure outcomes and program success metrics.
- Funding: Partner with federal or state government, private foundations, or Medicare Advantage plans to fund the pilot project.

Pilot Project Location Opportunity: California

- Large state budget + Governor Advisory Council priorities
  - Timely detection, diagnosis, and care planning
  - Enhance access to home, hospital, and community-based services
  - Address barriers to affordability
- USAging and SCAN Foundation collaboration on CBO network development
- Ten Alzheimer's Disease Centers (CADCs) in university medical centers throughout state
- State initiatives to build upon (e.g., implementation of Dementia Aware (SB48), expanded access to the Alzheimer's Day Care Resource Centers)
- 211 Caregiver Identification and Referral initiative
- Large private foundation presence

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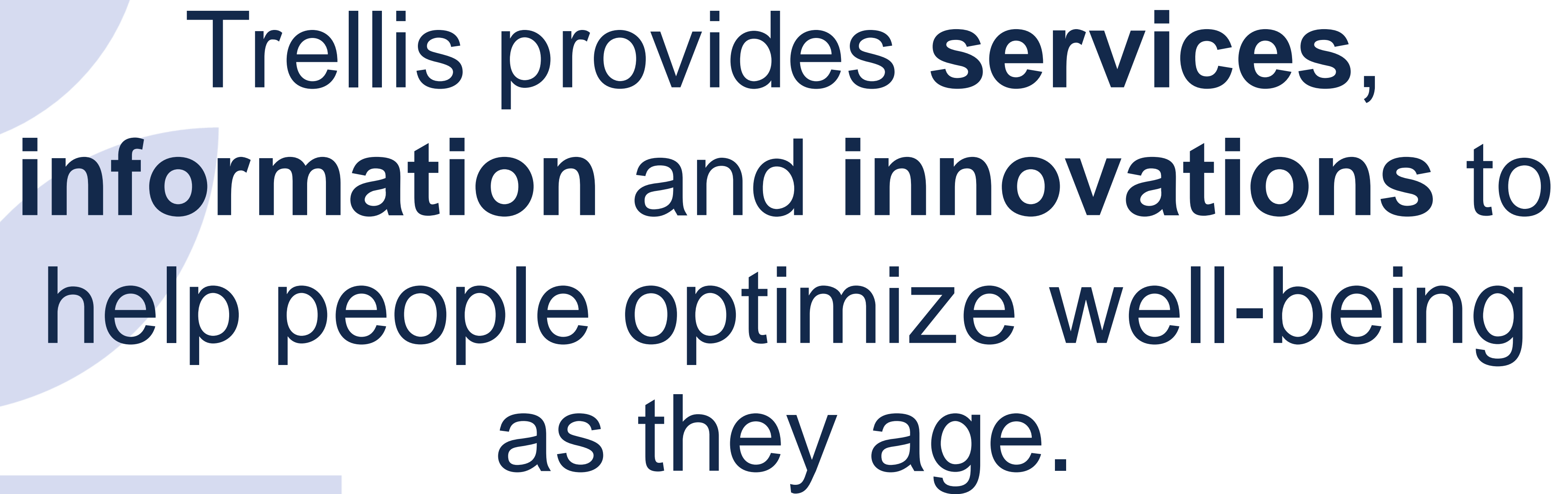
Benefits and Challenges of a CBO Network

Trellis

Dawn Simonson, President and CEO

Mark Cullen, VP of Strategy and Business Development



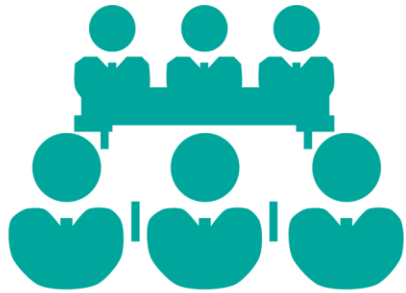
Trellis provides **services**, **information** and **innovations** to help people optimize well-being as they age.

JUNIPER STARTED WITH

Evidence-based health promotion classes

Now offered in every MN county, with online and in-person options

Juniper: Gaining Momentum



27,364
Participants
Since 2016

1,814
Classes

70
Providers

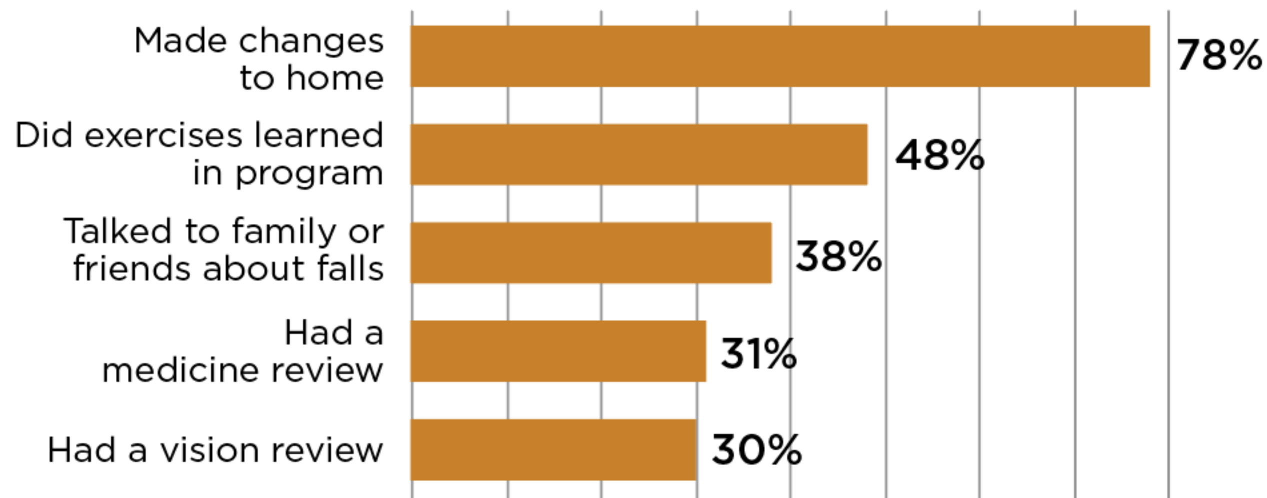
375
Class leaders

Participant Results

After taking a Juniper chronic disease self-management class, participants:

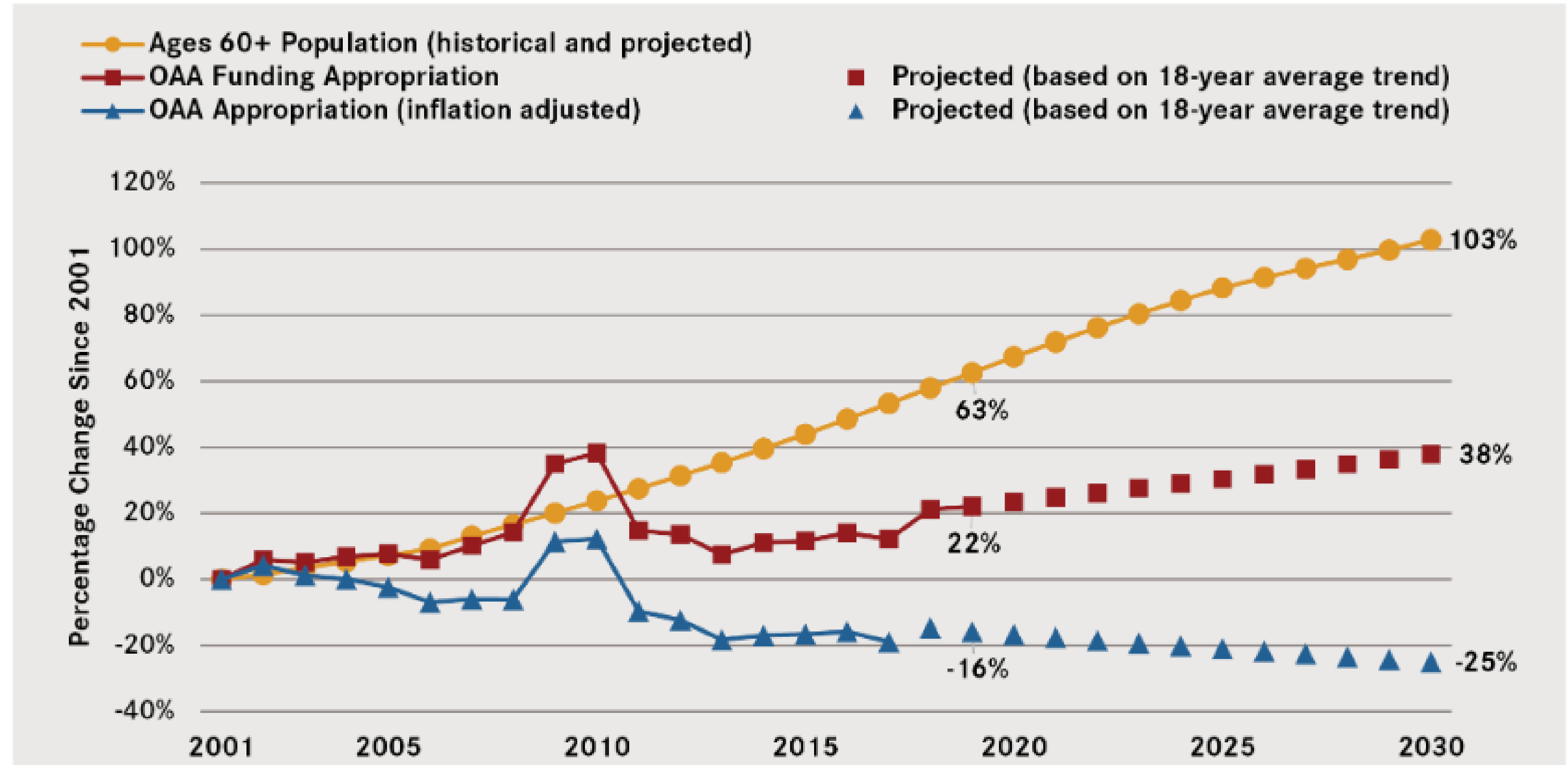
98%	Feel more confident managing their condition
92%	Increase physical activity
89%	Have a sense of well-being
87%	Socialize more with others

n=886



Regional
Hubs
Juniper
Network

Older Americans Act funding isn't keeping up with growing needs



Source: AARP

Our Business Model

Juniper Network

Administrative Support
Marketing
Technology
Centralized Contracts
Data Management

External Partnerships

“Partnering with the existing infrastructure of community-based organizations [...] in the aging and disability network [...] is the more cost-effective strategy for delivering . . . support for their most high-risk and high-need patient populations.”

— Lance Robertson, Former HHS Assistant Secretary for Aging

“Addressing Social Determinants: Scaling Up Partnerships With Community-Based Organization Networks ” Health Affairs

Savings from Falls Prevention

- Preventing just one fall that results in severe injury has significant savings
- Our MIS system makes this analysis possible

Participants in Juniper classes report up to 20% fewer falls.

With significant average cost savings per participant*

A Matter of Balance	Stepping On	Tai Ji Quan	Stay Active and Independent for Life
$6,391	$6,508	$4,488	$2,144

*Data from January 2019 through January 2020, based on self-reported falls; assumes program completion, and using an estimate of cost-savings per fall avoided.

Cost Savings Associated with Preventing Falls in Older Minnesotans, Trellis,

Partnering with Health Plans

- Four health plan contracts covering 27,000 dually eligible members for Juniper evidence-based health promotion classes
- Blue Cross and Blue Shield of Minnesota, HealthPartners, UCare, Itasca Medical Care (IMCare)

Weaving Networks for Greater Impact

[ACT on Alzheimer's]
60+ action communities

[Dementia Friends]
22,000 friends

[The Remember Project]
Theater-based awareness building in Minnesota, Wisconsin and Michigan

“Given the lack of effective treatment for dementia […] finding targets for prevention of dementia is imperative.

Source: [Association between age at onset of multimorbidity and incidence of dementia, The BJM]

By 2060, Alzheimer’s cases for Hispanic individuals are projected to increase **seven times** over today’s estimates; for African Americans **four times**

Disparities and discrimination remain at alarming levels

Source: CDC

Broadening to Dementia-focused Services

- Partnering to bridge clinical care with social care prior to diagnosis
- Including Powerful Tools for Caregivers and telephone reassurance to support caregivers
- Using community health workers to conduct SDoH assessments and help people navigate services
- Training CHWs to be dementia-capable, recognizing that dementia is a triggering factor and people with dementia/care partners are often at greater need for services

Benefits of a CBO Network

- Allows services to be deeply embedded in local communities
- Makes service delivery at scale possible
- Strengthens the aging network for everyone (Juniper has distributed $3.5 million into community-based organizations)
- Leverages existing networks

Challenges Juniper Has Faced

- Producing evidence of ROI (which is hard to get without claims information)
- Recruiting strong partners across the service region
- Access to sufficient investment of financial and human resources for backbone services
- Building brand identity and maintaining brand integrity among multiple partners

Thank you!

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Questions & Answers:
Please Submit Using the "Questions" Box

Appendix A

Definitions of Comprehensive Dementia-Care Elements

Caregiver support—Identify one or more caregivers to include in evaluation, decision making, and care planning; provide culturally sensitive support and assistance designed to help the caregiver(s)

Continuous monitoring and assessment—Continuously monitor and assess cognitive, functional, behavioral, and psychological needs and safety and the level of caregiver stress

Coordination of care—Coordinate transitional and other health-care services across hospitals, nursing homes, ambulatory care, and community-based settings

Medication management—Use evidence-based medication management, including deprescribing medications with adverse cognitive effects; includes efforts to increase medication adherence and education about opportunities for participation in research

Ongoing care plan—Develop and implement a care plan that is regularly evaluated and modified as needed, including advance care planning, wishes about the place of residence, and attention to end-of-life care

Psychosocial interventions—Implement interventions to prevent or reduce the burden of cognitive, functional, behavioral, and psychological challenges and caregiver stress, including care practices from innovative technology solutions

Self-management—Provide self-management tools to enhance the skills of the person living with dementia and caregiver in managing Alzheimer's disease and related dementias, navigating the health-care system, and engaging in activities related to person-centered goals

Treatment of related conditions—Take steps to prevent and treat conditions related to Alzheimer's disease and related dementias, such as depression, falls, and delirium

Adapted from Kristen Lees Haggerty et al., "Recommendations to Improve Payment Policies for Comprehensive Dementia Care," *Journal of the American Geriatrics Society* 68, no. 11 (November 2020): 2478-2485, https://doi.org/10.1111/jgs.16807.

Appendix B

Descriptions of Six Comprehensive Dementia-Care Models

The Benjamin Rose Institute Care Consultation model is a telephone-based program utilizing bachelor's or master's degree-level social workers or nurses for individuals living with dementia and their caregivers. This model has demonstrated beneficial changes in psychosocial outcomes for both patients and caregivers (e.g., reduced symptoms of depression, embarrassment about memory problems, care and caregiving strains, and social isolation).

The Care Ecosystem utilizes a team of non-licensed Care Team Navigators as well as advanced practice nurses, social workers, and pharmacists to implement care plan protocols via telephone and internet. In a clinical trial, the Care Ecosystem model improved the quality of life of individuals living with dementia as well as reduced emergency department utilization and caregiver depression and burden.

The Eskenazi Healthy Aging Brain Center initially employed a nurse practitioner dementia-care manager for delivery of nonpharmacological and pharmacological care to patients in collaboration with their primary care provider. This program demonstrated effectiveness on quality measures and patient outcomes (reduced behavioral symptoms and caregiver stress by half at 12 months). Most care within the program is provided by non-licensed staff.

The Integrated Memory Care Clinic is a patient-centered medical home providing comprehensive primary and dementia care led by advance practice nurses for individuals with dementia and mild cognitive impairment. It demonstrated success in delivering high-quality care and is associated with reduced emergency department utilization and rates of ambulatory-sensitive hospitalizations.

The Maximizing Independence at Home program is a comprehensive home-based care coordination intervention provided by non-licensed personnel, registered nurses, and physicians. The program demonstrated success in delaying transitions from home to residential care and reducing caregiver burden.

The University of California, Los Angeles (UCLA) Alzheimer's and Dementia Care (ADC) program uses a co-management model with nurse practitioner dementia-care specialists and primary care and specialty physicians. In a large case series and cost comparisons with a matched control group, the program demonstrated reduced total Medicare costs, decreased nursing home placement compared with matched patients, and improved end-of-life care and patient and caregiver outcomes.

Adapted from Kristen Lees Haggerty et al., "Recommendations to Improve Payment Policies for Comprehensive Dementia Care," *Journal of the American Geriatrics Society* 68, no. 11 (November 2020): 2478-2485, https://doi.org/10.1111/jgs.16807.

Appendix C

Scaling Comprehensive Dementia-Care Models Working Group Members

- Chris Badgley, Senior Director, Head of Government Affairs and Policy, Eisai
- Matthew Baumgart, Vice President, Health Policy, Alzheimer's Association
- Laura Chaise, Vice President, Long-Term Services and Supports and Medicare-Medicaid Plans, Centene
- Debra Cherry, PhD, Executive Vice President, Alzheimer's Los Angeles
- Gary Epstein-Lubow, MD, Associate Professor of Psychiatry and Human Behavior and Associate Professor of Medical Science, Brown University
- Aaron Greenstein, MD, Chief Resident of Geriatric Psychiatry, McLean Hospital
- George Hennawi, MD, Director, Department of Geriatrics, MedStar Health
- Scott Kaiser, MD, Director, Geriatric Cognitive Health, Brain Health Center, Geriatric Family Medicine, Pacific Neuroscience Institute
- Kathleen Kelly, Executive Director, Family Caregiver Alliance
- Sarah Lenz Lock, Senior Vice President, Policy & Brain Health and Executive Director, Global Council on Brain Health, AARP
- Erin Long, Team Lead, Alzheimer's Disease Programs Initiative, Office of Supportive and Caregiver Services, Administration for Community Living
- Soeren Mattke, MD, Research Professor of Economics and Director, Center for Improving Chronic Illness Care, University of Southern California Dornsife
- Diane Meier, MD, Director Emerita and Strategic Medical Advisor, Center to Advance Palliative Care
- Jim Murray, PhD, Research Fellow, Eli Lilly & Company
- David Reuben, MD, Director, Alzheimer's and Dementia Care Program, University of California Los Angeles School of Medicine
- Allison Silvers, Vice President, Payment and Policy, Center to Advance Palliative Care
- Katie Sloan, President and CEO, LeadingAge; Executive Director, Global Ageing Network
- George Vradenburg, Chairman, UsAgainstAlzheimer's

Appendix C

Scaling Comprehensive Dementia-Care Models Roundtable Participants

- Rajiv Ahuja, Associate Director, Center for the Future of Aging, Milken Institute
- Carrie Amero, Director, Long-Term Services and Supports, AARP
- Lauren Anderson, Social Science Analyst, Office of the Assistant Secretary for Planning and Evaluation
- Gary Bacher, Chief Officer for Strategy, Policy, and Legal Affairs, Capital Caring Health
- Chris Badgley, Senior Director, Head of Government Affairs and Policy, Eisai
- Matthew Baumgart, Vice President, Health Policy, Alzheimer's Association
- Eric Beane, Vice President, Regulatory and Government Affairs, Unite Us
- Ellen Blackwell, Senior Advisor, Centers for Medicare & Medicaid Services
- Alice Bonner, PhD, RN, Director of Strategic Partnerships, CAPABLE Program, Johns Hopkins University School of Nursing; Senior Advisor for Aging, Institute for Healthcare Improvement
- Malaz Boustani, MD, Richard M. Fairbanks Professor of Aging Research, Center for Health Innovation and Implementation Science, Indiana University
- Katie Brandt, Director of Caregiver Support Services, Massachusetts General Hospital; National Alzheimer's Project Act Non-Federal Advisory Council Co-Chair
- Shelby Brown, Intern, Center for the Future of Aging, Milken Institute
- Arthena Caston, Advocate Living with Early-Onset Alzheimer's; Early-Stage Advisor, Alzheimer's Association Board of Directors
- Laura Chaise, Vice President, Long-Term Services and Supports and Medicare- Medicaid Plans, Centene
- Debra Cherry, PhD, Executive Vice President, Alzheimer's Los Angeles
- Kelly Cronin, Deputy Administrator, Center for Innovation and Partnership, Administration for Community Living
- Lenise Cummings-Vaughn, MD, Associate Professor of Internal Medicine, Division of Geriatrics and Nutritional Science, Washington University in Saint Louis
- Peggye Dilworth-Anderson, PhD, Professor, Health Policy and Management, Gillings School of Global Public Health, University of North Carolina
- Lauren Dunning, Director, Center for the Future of Aging, Milken Institute

Appendix C

Scaling Comprehensive Dementia-Care Models Roundtable Participants

- Gary Epstein-Lubow, MD, Associate Professor of Psychiatry and Human Behavior, and Associate Professor of Medical Science, Brown University
- Phyllis Barkman Ferrell, Global Head, External Engagement, Alzheimer's Disease and Neurodegeneration, Lilly BioMedicines, Eli Lilly & Company
- Sarah Fogler, PhD, Deputy Director, Patient Care Models Group, Center for Medicare & Medicaid Innovation
- Terry Fulmer, PhD, RN, President, The John A. Hartford Foundation
- George Hennawi, MD, Director, Department of Geriatrics, MedStar Health
- Peggy Jacober, Senior Strategist, Reputation Management—Corporate Citizenship, Edward Jones
- Scott Kaiser, MD, Director, Geriatric Cognitive Health, Brain Health Center, Geriatric Family Medicine, Pacific Neuroscience Institute
- Kathleen Kelly, Executive Director, Family Caregiver Alliance
- Helen Lamont, PhD, Senior Analyst, Office of Disability, Aging, and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation
- Allan Levey, MD, PhD, Director of the Alzheimer's Disease Research Center, Emory University; Co-Chair, NAPA Non-Federal Advisory Council
- Cara Levy, Senior Associate, Center for the Future of Aging, Milken Institute
- Shari Ling, Deputy Chief Medical Officer, Centers for Medicare & Medicaid Services
- Sarah Lenz Lock, Senior Vice President, Policy & Brain Health and Executive Director, Global Council on Brain Health, AARP
- Erin Long, Team Lead, Alzheimer's Disease Programs Initiative, Office of Supportive and Caregiver Services, Administration for Community Living
- Soeren Mattke, MD, Research Professor of Economics and Director, Center for Improving Chronic Illness Care, University of Southern California Dornsife
- Mac McDermott, Associate, Center for the Future of Aging, Milken Institute
- Diane Meier, MD, Director Emerita and Strategic Medical Advisor, Center to Advance Palliative Care
- Jim Murray, PhD, Research Fellow, Eli Lilly & Company
- Kelly O'Brien, Executive Director, Brain Health Partnership, UsAgainstAlzheimer's
- Leslie Pelton, Senior Director, Institute for Healthcare Improvement

Appendix C

Scaling Comprehensive Dementia-Care Models Roundtable Participants

- Andrew Renda, MD, Associate Vice President, Bold Goal and Population Health Strategy, Office of Health Affairs and Advocacy, Humana
- David Reuben, MD, Director, Alzheimer's and Dementia Care Program, University of California Los Angeles School of Medicine
- Allison Silvers, Vice President, Payment and Policy, Center to Advance Palliative Care
- June Simmons, CEO, Partners in Care Foundation
- Dawn Simonson, Executive Director, Metropolitan Area Agency on Aging; President, Innovations for Aging, LLC
- Katie Sloan, President and CEO, LeadingAge; Executive Director, Global Ageing Network
- Scott St. Germain, Vice President, Access & Policy Strategy, Genentech
- Nora Super, Executive Director, Milken Institute Alliance to Improve Dementia Care and Senior Director, Center for the Future of Aging, Milken Institute
- Laura Thornhill, Senior Associate Director, Regulatory Affairs, Alzheimer's Association
- Diane Ty, Director, Milken Institute Alliance to Improve Dementia Care and Director, Center for the Future of Aging, Milken Institute
- George Vradenburg, Chairman, UsAgainstAlzheimer's
- Kai Walker, Director, Head of Inclusion Transformation, Retirement & Personal Wealth Solutions, Bank of America