How CalAIM Supports Best Practices in Dementia Care

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Introductions

Presenting today
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Overview

- California’s Dementia Challenges
- Review of Dementia Care Best Practices – Six Notable Models
- How CalAIM Can Help
- Q&A
California’s Dementia Challenges

- **Prevalence of Dementia.** The number of Californians diagnosed with dementia is projected to reach **1.3 million in 2040**, a doubling since 2020.
  - It is 2X in Black adults and 1.5X in Latinx adults

- **Under-detection** 39.5% older adults with probable dementia go undiagnosed, and 19.2% are unaware of their diagnoses.

- **Dementia and Medi-Cal**
  - 1/4 of older Californians living with dementia are dually eligible
  - Dual eligibles are 3x as likely to have dementia than those with just Medicare -> estimated 150,000 to 300,000 of the roughly 1.5 million duals.
California’s Dementia Challenges

- **PLWD Health Care System Utilization Compared to People Without Dementia**
  - Longer hospital stays (5.1 days vs. 4.5 days)
  - Higher 30-day hospital readmission rate (23% vs 18%)
  - 28% increase in emergency room visits in the last decade
  - More likely to be institutionalized in nursing homes by the time they are 80 years old (75% vs 4%)

- **Costs of Dementia**
  - Average cost of care for someone with dementia is $43,444/year, 3x the cost for an older adult without dementia
  - **For the person and family**
    - Out-of-pocket spending by patients’ families: $87 billion in 2023
    - 48% of caregivers of older adults nationwide are caring for someone with dementia
      - 83% are not paid for that work.
  - **For Medicaid/ Medi-Cal**
    - The cost is $6,739 for a PLWD/year. It is $303 for someone without dementia, a 22X difference.
Best Practices in Dementia Care: *The Goals*

<table>
<thead>
<tr>
<th>Focus on personalized care</th>
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<tbody>
<tr>
<td>Contain costs</td>
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<tr>
<td>Delay or minimize institutionalization</td>
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Best Practices in Dementia Care: The Elements

1. Embrace Collaborative Care
   - Dyad of (Patient and Caregiver) + (Primary Care Clinician + Team)
   - Team, licensed and non-licensed, supports care plan implementation

2. Develop detailed care plans that include multicomponent interventions
   - Care plans: 1) personalized and updated 2) treatment and care management, 3) medication management, 4) caregiver support
   - Multi-component interventions: 1) safety interventions 2) physical activity and cognitive therapy interventions

3. Promote community living arrangements and support
   - Types of living:
     - 1) group living 2) small-scale homelike settings 3) dementia village
   - Delivery of meals e.g. medically tailored meals

4. Do more to support caregivers
   - Caregiver Assessment
   - Respite: include all settings (adult day programs, in-home care, institutional)
   - Education or psychosocial therapy
How Can CalAIM Help?

<table>
<thead>
<tr>
<th>ECM component</th>
<th>Dementia care best practice</th>
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<tbody>
<tr>
<td>Outreach and engagement</td>
<td>💫 Partner with dementia friendly initiatives to generate referrals</td>
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<tr>
<td>Comprehensive assessment and care management plan</td>
<td>👀 Defined care manager role</td>
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<tr>
<td></td>
<td>👀 Personalized and comprehensive care plan that is regularly updated according to the patient’s needs</td>
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<tr>
<td></td>
<td>👀 Care plan includes treatment and care management</td>
</tr>
<tr>
<td></td>
<td>⚠️ Care plan includes medication management</td>
</tr>
<tr>
<td>Enhanced coordination of care</td>
<td>👀 Defined care manager role</td>
</tr>
<tr>
<td>Health promotion</td>
<td>👀 Caregiver education includes dementia education including managing stressors, medication management, self-management and community resources.</td>
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<tr>
<td>Transitional care services</td>
<td>👀 Defined care manager role</td>
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<tr>
<td>Member and family supports</td>
<td>👀 Care plan includes caregiver support</td>
</tr>
<tr>
<td></td>
<td>⚠️ Caregiver support includes education on self-management</td>
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<tr>
<td>Coordination of and referral to community and social Support Services</td>
<td>👀 Defined care manager role</td>
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</tbody>
</table>

**Symbols:**
- 🌟 Opportunity
- ⚠️ Limitation
- 💫 Partner
- 👀 Defined role

**ECM** = Enhanced Care Management
## How Can CalAIM Help?

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<th>CS component</th>
<th>Dementia care best practice</th>
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<tr>
<td>Environmental accessibility adaptations (home modifications)</td>
<td>Multicomponent interventions: safety intervention</td>
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<tr>
<td>Respite services</td>
<td>Caregiver support: adult day programs</td>
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<tr>
<td>Personal care and homemaker services</td>
<td>Supports identified barriers to access to care such as functional requirements and hour limitations for in-home support services</td>
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<tr>
<td>Medically tailored meals or medically supportive food</td>
<td>Community dwelling intervention: home-delivered meals</td>
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<tr>
<td>Nursing facility transition or diversion to assisted living facility</td>
<td>Community Dwelling Intervention: small-scale home-like care models</td>
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- Overlap
- Opportunity

*CS = Community Supports*
How Can CalAIM Help?

Funds to train dementia care specialists
- PATH Funding

Extra help for dual eligible
- Assessment
- Data collection
- Integration of dementia care specialist into care

New opportunities in Medicare
- GUIDE and CalAIM: dementia-specific programs
Question & Answer