The Council of State Governments

NATIONAL LONG-TERM CARE WORKFORCE NETWORK

Topic: Dementia Care Workforce

May 24, 2023

Agenda

- Introduction and Project Recap
- Presentations on the Dementia Care Workforce
  - Diane Ty, Senior Director, Center for the Future of Aging, Milken Institute
  - Andrew Ross, Director of State Affairs, Alzheimer's Association and Alzheimer’s Impact Movement
- Discussion
- Next Meeting and Adjourn

Long-Term Care Policy Guide

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CSG The Council of State Governments

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- National Long-Term Care Workforce Network
- National Online Resource Center
- State Technical Assistance Services

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Building a Dementia-Capable Workforce

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Alzheimer’s vs. Dementia

- **Dementia** is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life. Alzheimer's is the most common cause of dementia.
- **Alzheimer’s** is a progressive disease and accounts for 60-80% of dementia cases. In its early stages, memory loss is mild, but with late-stage Alzheimer's, individuals lose the ability to carry on a conversation and respond to their environment.

More than 6 million Americans are living with Alzheimer's.

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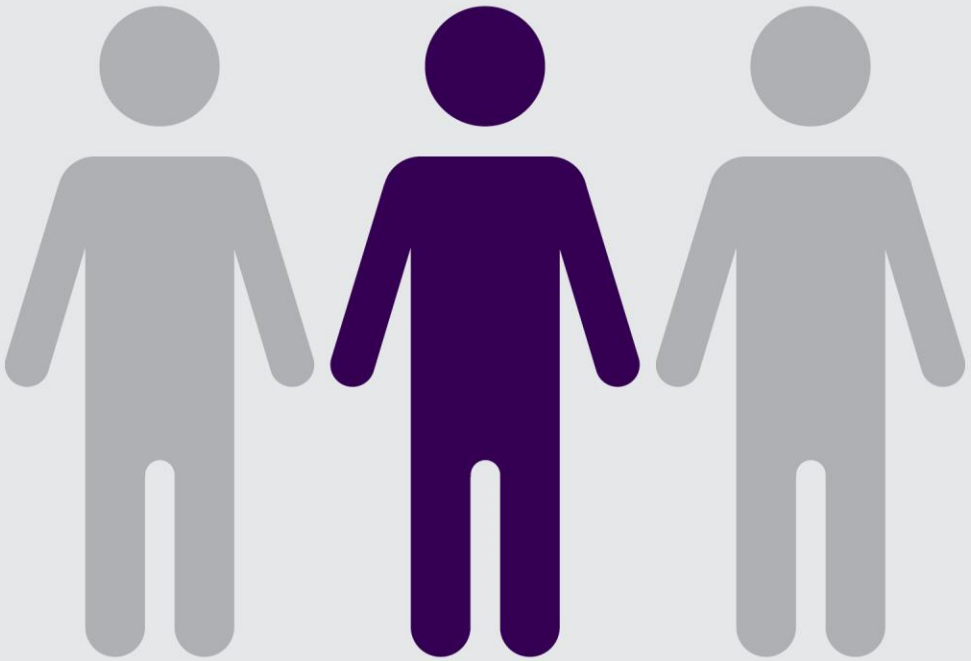

1 in 3 seniors dies with **Alzheimer's** or another dementia.

55% of primary care physicians say there are not enough dementia care specialists in their communities to meet patient demand.

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Lack of Dementia Care Specialists

- **20 states** have been termed "**dementia neurology deserts**," meaning they are projected to have fewer than 10 neurologists per 10,000 people with dementia in 2025.
  - *States include: AL, AR, DE, HI, IA, ID, KS, KY, ME, MS, MT, ND, NM, NV, OK, SC, SD, VT, WV, WY*

- **12 states** will need to increase the number of practicing geriatricians at least five-fold to care for those projected to have Alzheimer's dementia in 2050.
  - *States include: AL, IA, ID, KS, KY, LA, MS, MT, OK, TN, WV, WY*

Dementia in Long Term Care

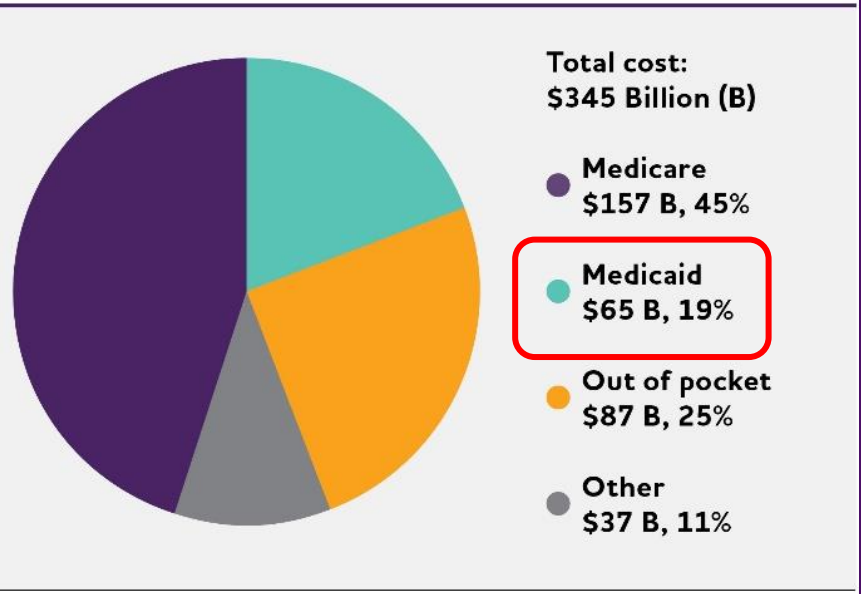
49%	**Nursing home residents have a form of dementia**
36%	Home health recipients live with dementia
34%	Residents in residential care facilities have some form of dementia

At age **80**, approximately **75%** of people with Alzheimer's live in a nursing home compared with only **4%** of the general population at age 80.

Alzheimer's is One of the Costliest Conditions to the U.S. Economy and particularly challenging for states.

Figure 13

Distribution of Aggregate Costs of Care by Payment Source for Americans Age 65 and Older with Alzheimer's or Other Dementias, 2023*



*Data are in 2023 dollars.

Created from data from the Lewin Model.[A12] "Other" payment sources include private insurance, health maintenance organizations, other managed care organizations and uncompensated care.

The sum of individual dollar amounts does not equal the total cost due to rounding.

Average annual *Medicaid* payments among dually eligible Medicare beneficiaries 65+:

WITHOUT dementia: $303/year

WITH dementia: $6,739/year

22x more costly

Table 20

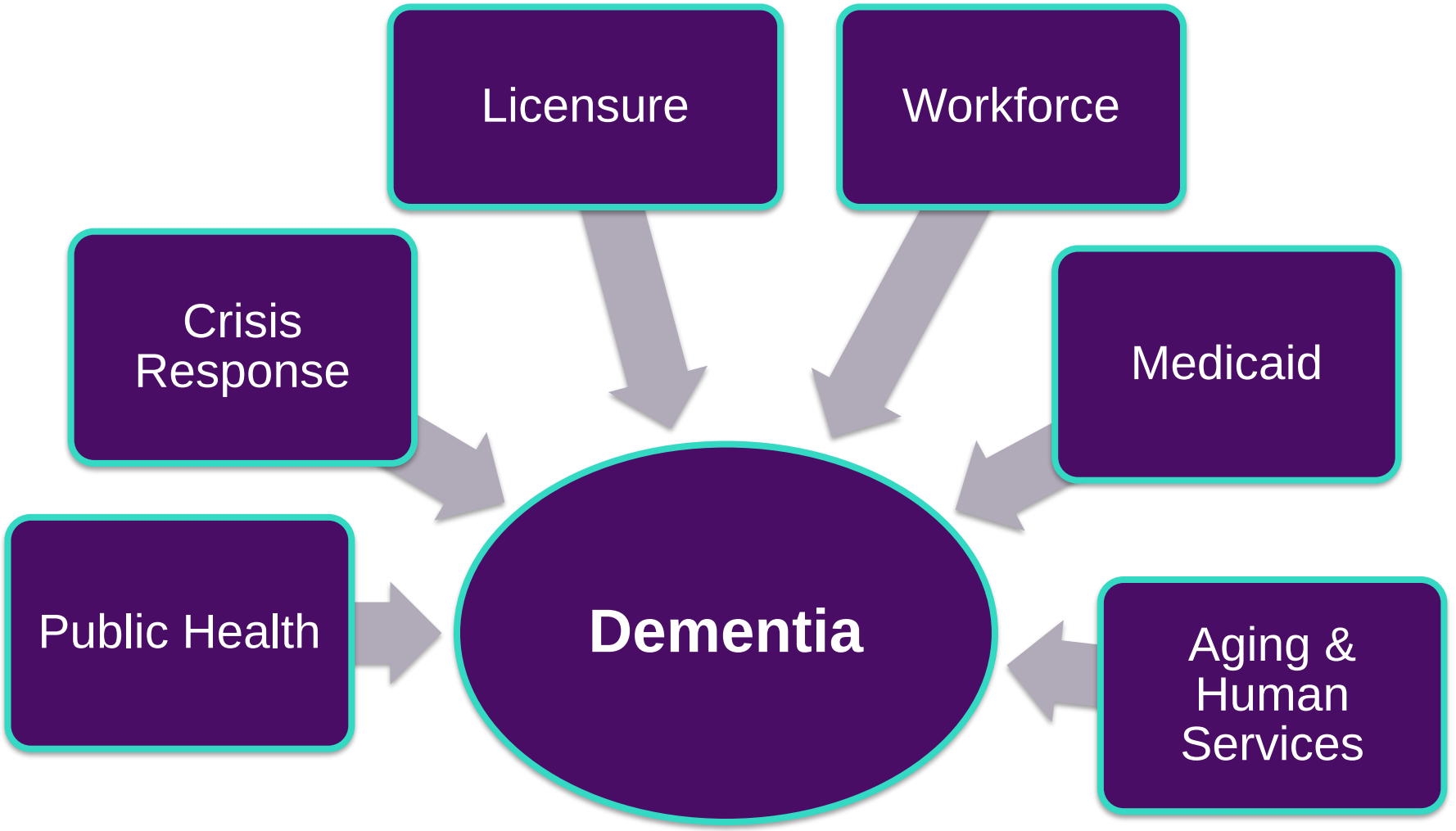
Total Medicaid Payments for Americans Age 65 and Older Living with Alzheimer's or Other Dementias by State*

State	2020 (in millions of dollars)	2025 (in millions of dollars)	Percentage Increase	State	2020 (in millions of dollars)	2025 (in millions of dollars)	Percentage Increase
Alabama	$925	$1,127	21.8	Montana	$166	$203	22.2
Alaska	76	110	44.6	Nebraska	372	411	10.3
Arizona	414	545	31.7	Nevada	203	277	36.5
Arkansas	396	454	14.6	New Hampshire	254	335	31.9
California	4,197	5,235	24.7	New Jersey	2,186	2,614	19.6
Colorado	635	789	24.1	New Mexico	227	279	22.9
Connecticut	1,022	1,187	16.1	New York	5,453	6,306	15.6
Delaware	253	313	23.6	North Carolina	1,332	1,628	22.2
District of Columbia	126	135	6.8	North Dakota	190	215	13.2
Florida	2,689	3,453	28.4	Ohio	2,534	2,940	16.0
Georgia	1,265	1,594	26.0	Oklahoma	516	611	18.3
Hawaii	240	285	18.7	Oregon	253	317	25.4
Idaho	149	196	31.2	Pennsylvania	3,658	4,029	10.2
Illinois	1,787	2,199	23.1	Rhode Island	470	565	20.1
Indiana	1,054	1,233	17.1	South Carolina	652	818	25.4
Iowa	676	792	17.2	South Dakota	182	212	16.6
Kansas	473	543	14.6	Tennessee	1,109	1,377	24.2
Kentucky	803	949	18.2	Texas	3,202	3,949	23.3
Louisiana	765	934	22.1	Utah	185	235	27.0
Maine	212	274	29.5	Vermont	116	146	26.4
Maryland	1,231	1,535	24.7	Virginia	1,000	1,266	26.6
Massachusetts	1,753	2,031	15.9	Washington	547	689	26.0
Michigan	1,487	1,738	16.9	West Virginia	445	521	17.1
Minnesota	905	1,087	20.1	Wisconsin	777	924	18.9
Mississippi	606	729	20.4	Wyoming	86	111	28.8
Missouri	973	1,137	16.8				

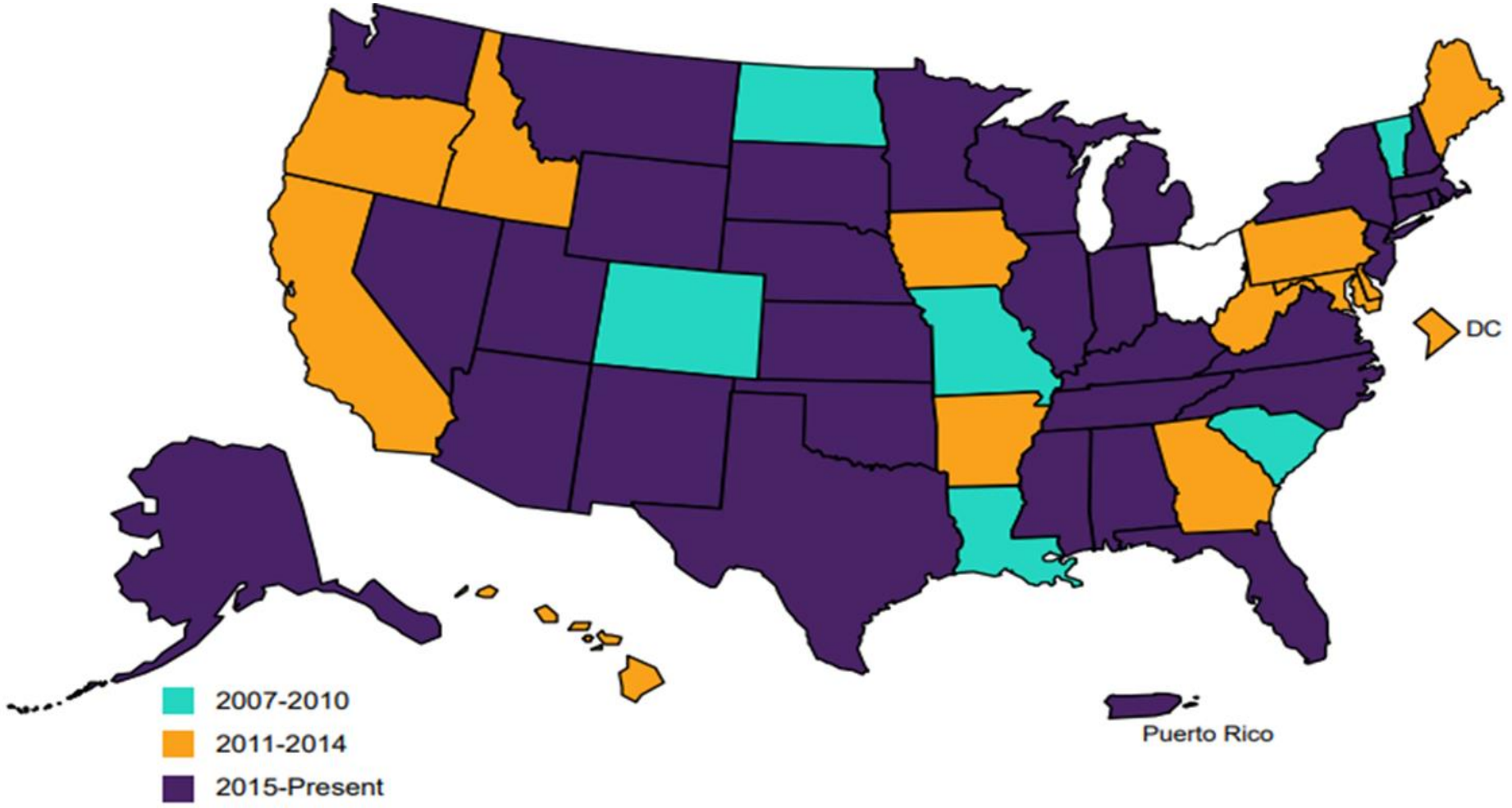
*All cost figures are reported in 2020 dollars. State totals may not add to the U.S. total due to rounding.

Created from data from the Lewin Model.[A12]

Dementia Requires a Statewide Response



State Alzheimer's/Dementia Plans



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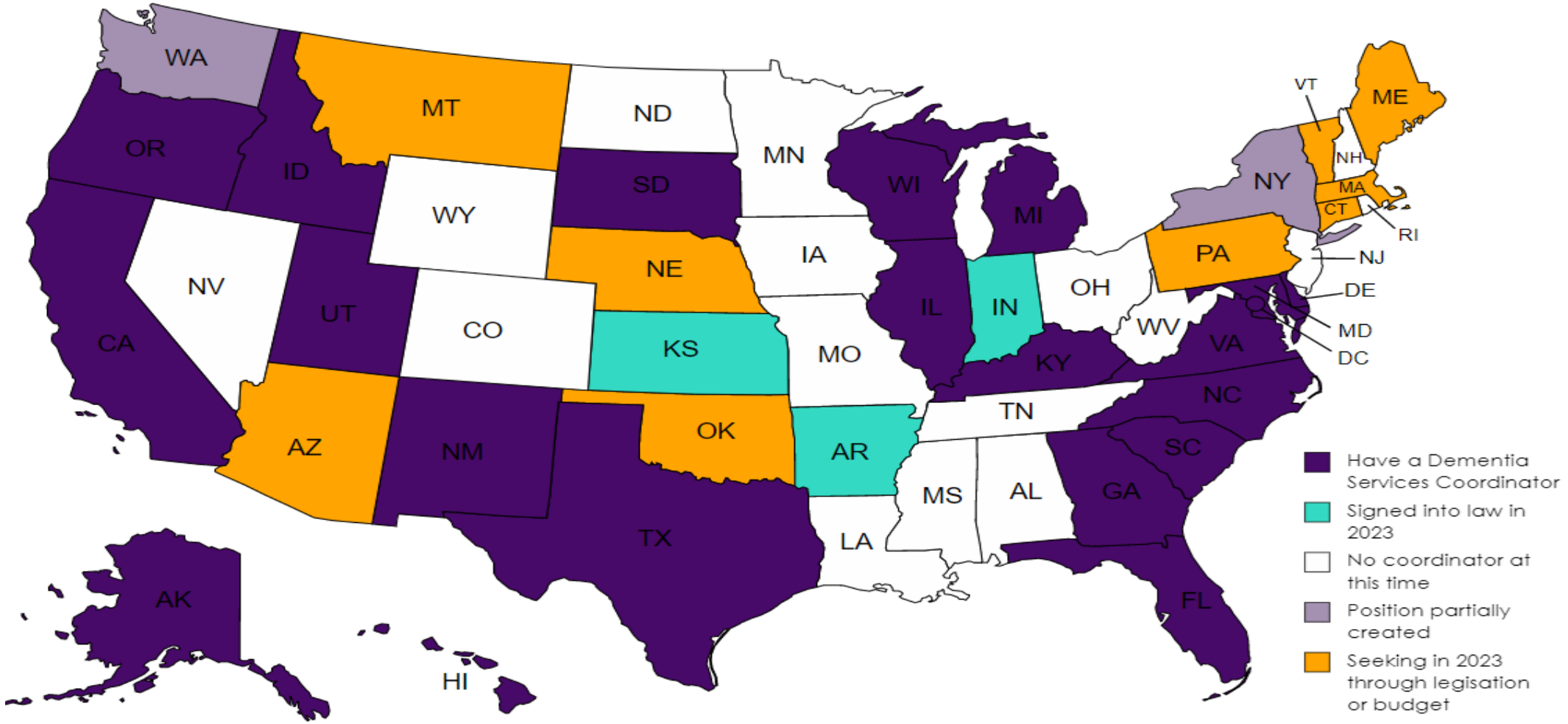
Why are State Alzheimer's Plans Important?

- ➔ Ongoing effort to make dementia a state priority
- ➔ State government buy-in and ownership
- ➔ Survives changes in gubernatorial administration, agency, and legislative leadership
- ➔ Creates a statewide infrastructure of support
- ➔ Formalized stakeholder group

State Dementia Services Coordinators



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Dementia Services Coordinator Positions

An individual within the state government whose job is to ensure coordination of Alzheimer's programs and policies across state agencies.

- Implement/update the State Alzheimer's Disease Plan
- Coordinate Alzheimer's and dementia work groups and task forces
- Establish and maintain relationships with all relevant state agencies and community organizations to prevent duplication of services
- Evaluate existing Alzheimer's and dementia programs and services and identify gaps
- Increase awareness of and facilitate access to quality, coordinated care

Problem: Dementia Workforce Shortages

Insufficient numbers of dementia care specialists (geriatricians and neurologists) and direct care workers threaten access to care.

- **What can states do?**
  - Create career pathways for direct care workers that are licensed, certified, registered or state approved with a focus on dementia.
  - Secure financial incentives, including loan forgiveness programs and grant programs, to recruit dementia care specialists and direct care workers with dementia-specific training.
  - Include dementia in any legislation, executive order, or state agency directive that creates or directs a workforce commission, council, taskforce, workgroup or study.

Growing the Dementia-Care Workforce

- ★ **COLORADO** SB 158 (2021) adds geriatrics to the list of eligible specialties for physician assistants and advance practice nurses to participate in the Colorado Health Service Corps program which provides loan repayment to health care professionals working in underserved communities for two or more years.
- ★ **GEORGIA** (2020) The state's HOPE career grant program, which provides free tuition to programs where there are workforce shortages, was updated to include the Certified Nursing Assistant Program to better support the growing needs of the dementia care workforce.

Growing the Dementia-Care Workforce

- ★ **MICHIGAN** Executive Order 2021-15 was signed and created the Nursing Home Workforce Stabilization Council to identify strategies to improve recruitment and retention, develop career pathways and ensure quality care in long-term care.
- ★ **WASHINGTON** SB 5693 (2022) appropriated $3.18 million to develop and execute apprenticeship career pathway programs for nursing assistants and home care aides to advance into nursing. Funds also support long-term care workforce apprenticeship grants; virtual certified nursing assistant (CNA) trainings; and stakeholder surveys to address retention and career pathways in long-term care.

Problem: Clinicians report difficulty diagnosing

Alzheimer's is significantly under-diagnosed limiting access to treatment and care planning

- **What can states do?**
  - Require training on the diagnosis, treatment, and care of patients with cognitive impairments for the renewal of a physician's license.
  - Issue evidence-based clinical assessment and diagnostic practice guidelines to licensed health care professionals within their scope of practice.
  - Establish or update public health campaigns for providers on the early warning signs of dementia, the Medicare care planning code, and the benefits of early detection & diagnosis.
  - Cover the billing code for diagnosis and care planning under Medicaid.

Establishing Dementia Training Standards for Clinicians

- ★ **DELAWARE** SB 283 (2022) requires physicians and nurses who treat adults in a health care setting to complete one hour of continuing education in each reporting period on the topic of diagnosis, treatment, and care of people w/dementia.

- ★ **ILLINOIS** SB 677 (2021) requires all health care professionals serving adults age 26 and older complete one hour of dementia education for license registration and renewal.

Problem: Care workers lack dementia knowledge

Individuals with Alzheimer's have needs that make care delivery challenging and more demanding yet direct care workers often do not have sufficient dementia training.

- **What can states do?**
  - Require a minimum of six to eight hours of evidence-based dementia training for all care providers who are involved in the delivery of care or have regular contact with people with Alzheimer's disease or other dementias.
  - Designate a state agency to formally monitor dementia training programs, evaluate their effectiveness, and ensure compliance with state dementia training requirements.

Strengthening Dementia Training Standards for Direct Care Workers

- ★ **ARKANSAS** HB 1518 (2023) requires assisted living facilities that serve people living with dementia to establish training for staff on delivering person-centered dementia care. Staff who work closely with residents living with dementia are required to receive four hours of initial training and all staff are required to receive two hours of continuing education annually.
- ★ **GEORGIA** HB 987 (2020) strengthens memory care programs across the state by establishing dementia training standards for staff and a licensing structure for memory care centers. All staff will be required to receive four hours of dementia training within their first 30 days of employment. Direct care staff in the memory center must receive at least 16 hours of specialized dementia training within their first 30 days of employment and eight hours of dementia training each year thereafter.

Strengthening Dementia Training Standards for Direct Care Workers

- ★ **KENTUCKY** SB 61 (2021) requires home health and personal care workers complete six hours of initial dementia training and three hours of annual continuing education on dementia. SB 11 (2022) establishes comprehensive dementia training standards for staff in the Dementia Care Unit of an assisted living facility – 8-16 hours of initial dementia training (depending on roles) and 8 hours of annual continuing education.
- ★ **MARYLAND** SB 204 (2021) establishes a memory care regulatory framework to include dementia training requirements for memory care staff. HB 141 (2021) requires three hours of initial dementia training and two hours of annual continuing education around dementia for all home care workers.
- ★ **NEW HAMPSHIRE** HB 4 (2019) establishes six hours of required initial training and four hours of continuing dementia training each year for the direct care workforce and other long-term care staff. The training program must incorporate competency and portability components to strengthen direct care worker training and to support staff retention.

Other Efforts and Selected States

- Dementia-Specific Respite Programs
  - *AR, CT, ME, NH, SC, WI, WV*
- Medicaid Structured Family Caregiving
  - *MO*
- Assessment and Care Planning Code in Medicaid
  - *HI, IA, MA, MI, ND, NV, UT*

Key Takeaways

Alzheimer's impacts everyone.

States need a comprehensive, coordinated strategy.

Workforce shortages threaten access to care.

Inadequate training can lead to low quality care.

Keep the Conversation Going!

- **Reach out** to the Alzheimer's Association policy staff in your state to discuss opportunities, or contact Andrew Ross (National): ajross@alz-aim.org

- **Visit** alzimpact.org/state to learn more about current policy efforts in your state.

24/7 Helpline

800.272.3900

alz.org

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CENTER FOR THE FUTURE OF AGING

Alliance to Improve Dementia Care

CSG National Long-Term Care Workforce Network

May 24, 2023

Milken Institute

By the Numbers

7

We operate out of seven offices in Santa Monica, Washington DC, New York, South Florida, London, Abu Dhabi, and Singapore.

1991

The year our chairman, Mike Milken, founded the Milken Institute.

7

Seven centers lead our programmatic work across a range of issues that advance prosperity across the globe.

MI Health Pillar

Center for the Future of Aging

Elevates awareness, advances solutions, and catalyzes action to promote healthy longevity and financial wellness

Center for Public Health

Promotes sustainable solutions that lead to better health for individuals and communities

FasterCures

Accelerates biomedical research and treatment for patients, improving the system for all

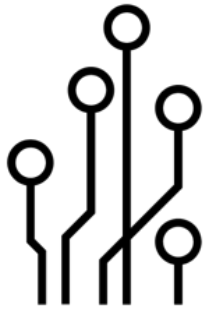
Feeding Change

Catalyzes a more nutritious, sustainable, resilient and equitable food system

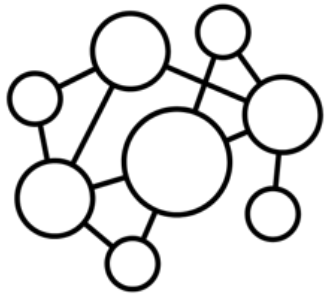
Center for the Future of Aging: What We Do

Elevate awareness of how an aging population impacts ***all* societal structures** and the urgent need for public, private, and nonprofit institutions to adapt

Convene experts from various disciplines and sectors to develop consensus-based policies and solutions that **address the realities and realize the opportunities** of longer lifespans



Leverage our neutral platform to break down silos and forge connections for **faster adoption of evidence, best practices, and innovations**



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Alliance to Improve Dementia Care

Cross-Sector Collaborative

> 100 leading organizations across eight key stakeholder groups

Areas of Focus/Working Groups

- Health and Economic Equity
- Workforce and System Capacity Building
- Comprehensive Dementia Care Models

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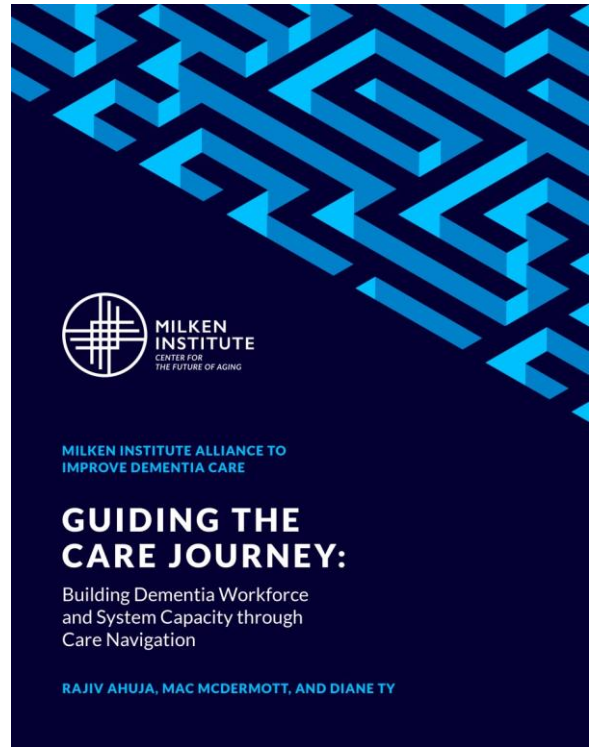
Alliance Publications to Date

Read the full reports at https://milkeninstitute.org/alliance



Released March 21

Read here

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Building Workforce Capacity

A Population-Health Approach to Dementia Care

Patient Needs	Workforce	Care Plan for Patients

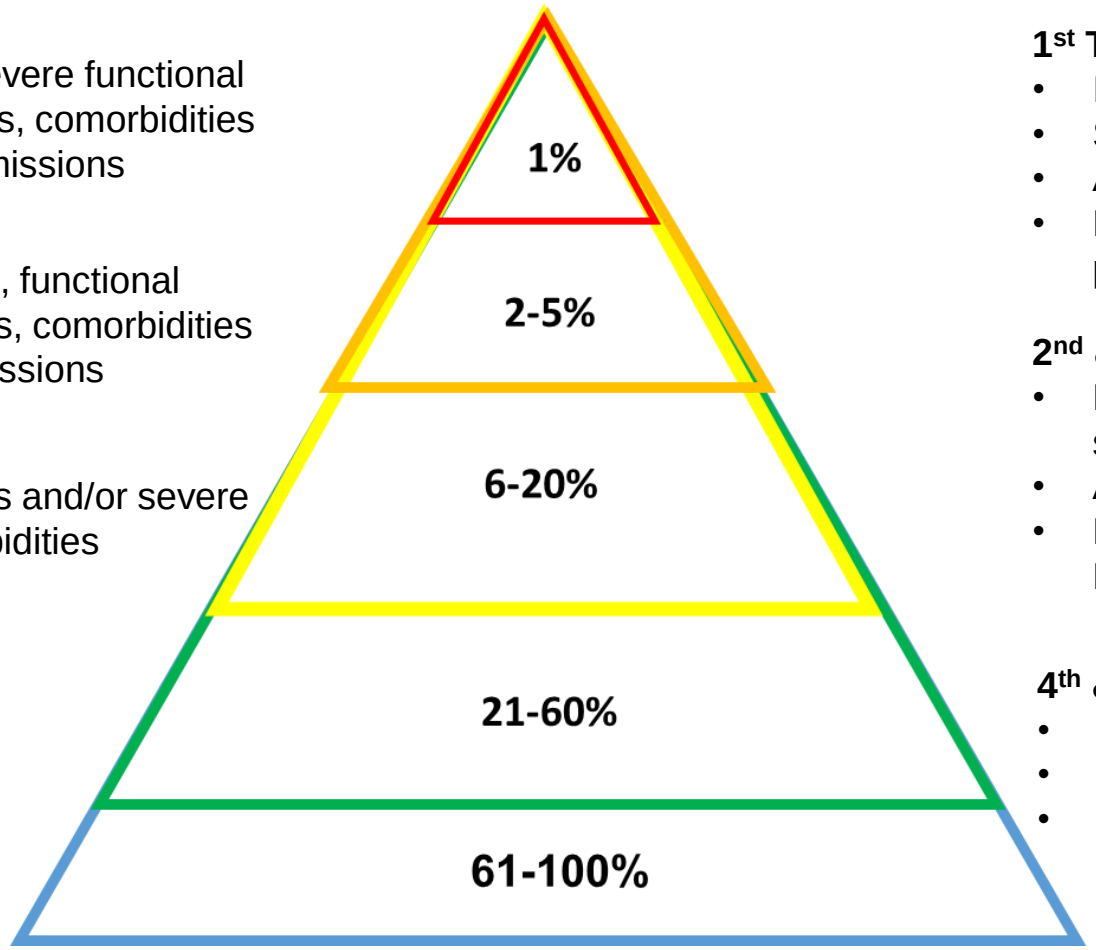
1st Tier
- Many behavioral problems, severe functional impairment, minimal resources, comorbidities
- Frequent ED and hospital admissions

2nd Tier
- Frequent behavioral problems, functional impairment, minimal resources, comorbidities
- Multiple ED and hospital admissions

3rd Tier
- May have behavioral problems and/or severe functional impairment, comorbidities

4th Tier
- Mild dementia
- Getting routine health care

5th Tier
- Mild dementia
- Getting no health care



1st Tier
- Intensive individualized care
- Small-panel primary care
- Advance Care Planning
- Palliative Care, Psychiatry, Dementia Care program

2nd & 3rd Tier
- Dementia Care program & increased social services (e.g. daycare programs)
- Advance Care Planning
- Neurology, Psychiatry, +/-Care Navigators

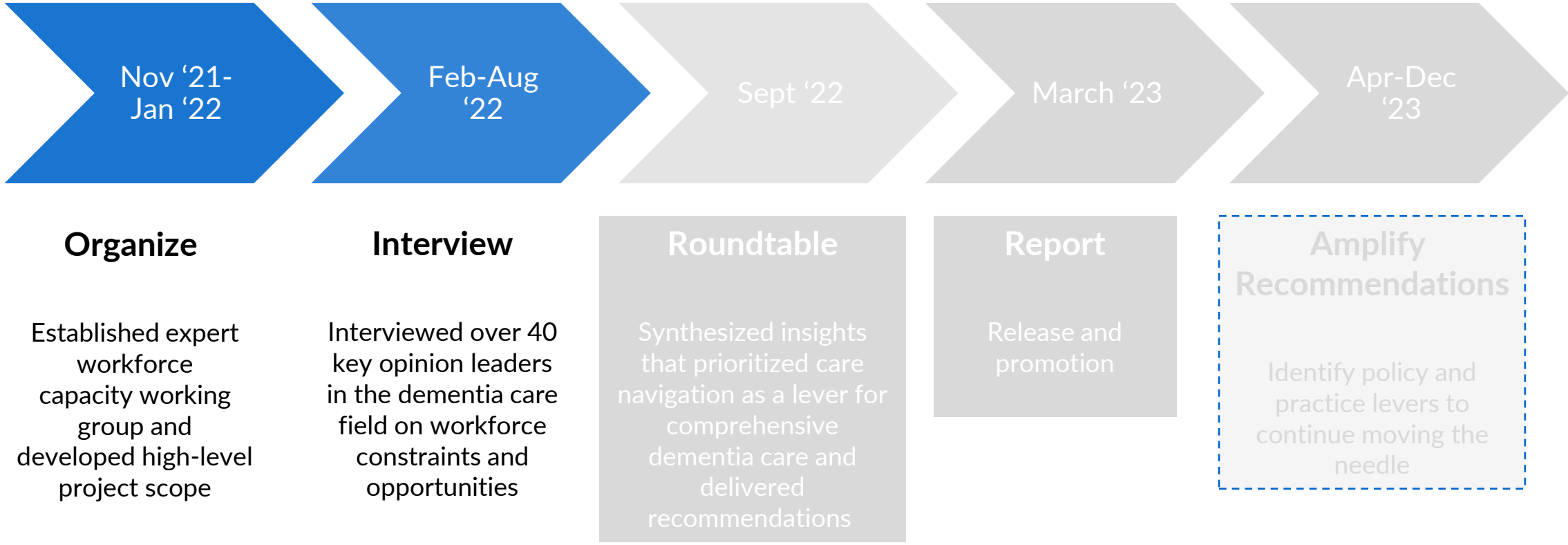
4th & 5th Tier
- Information & referral
- Care Navigators
- Caregiver education & monitoring

Total # & Yearly Minimum Utilization By Risk Tier

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/.

Building Workforce Capacity: Our Process

Landing on Care Navigation for Comprehensive Dementia Care



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Key Opinion Leader Interviews

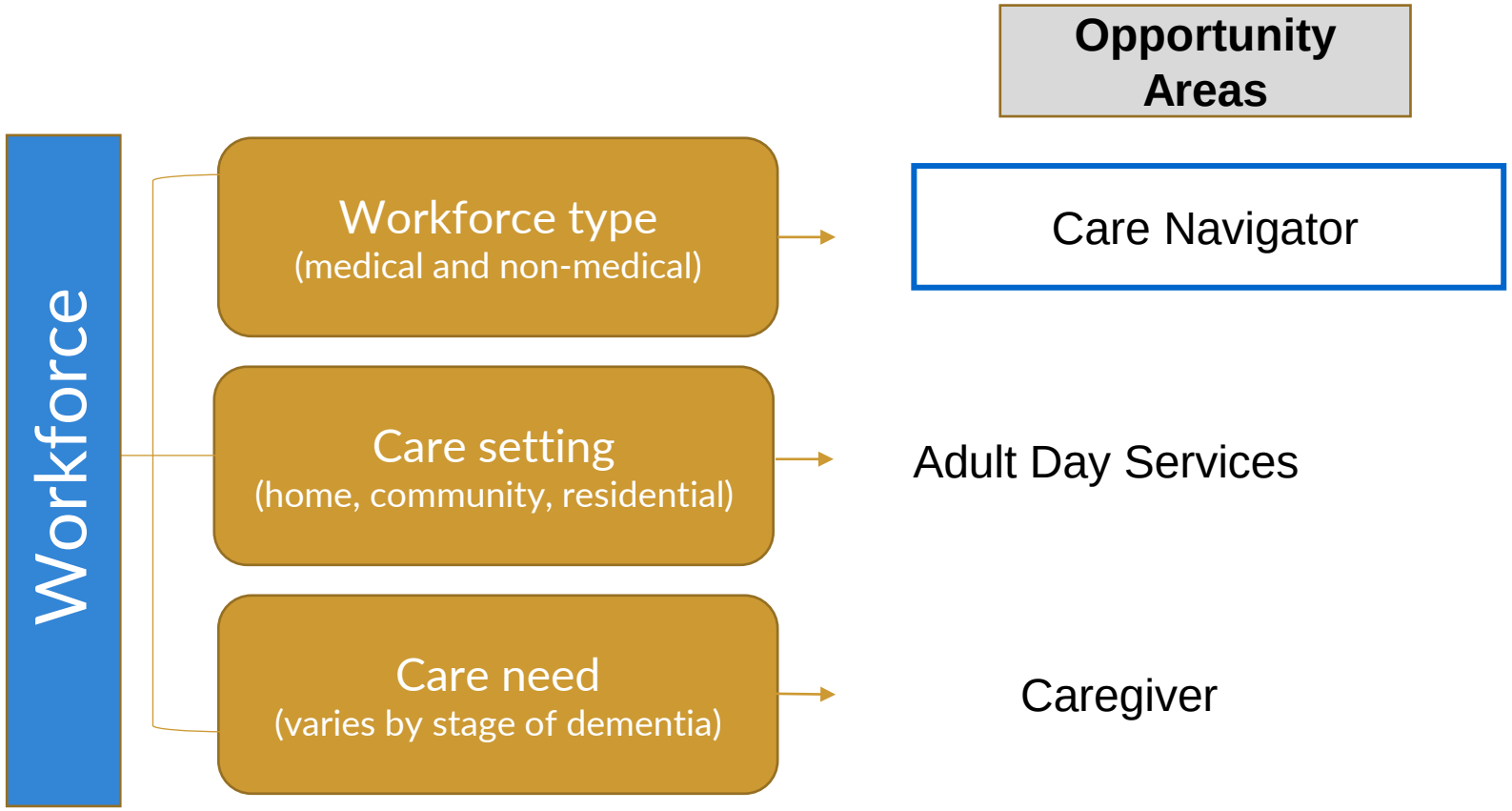
✓ = completed/scheduled
X = to be scheduled

Workforce Type	Association	Practitioner
Advance Practice Nurse		✓
Family Caregiver	✓	✓ ✓
Certified Nursing Assistant (CNA)	X	
Community Health Worker (CHW)		✓
Dementia Care Specialist		✓
Direct Care Worker	✓	✓
Geriatrician		✓
Geriatric Psychiatrist		✓
Licensed Practical Nurse (LPN)		✓
Neurologist		
Nurse Practitioner (NP)	✓	✓
Pharmacist		
Physician Assistants (PA)	✓	
Primary Care Physician (MD or DO)		✓
Registered Nurse (RN)		✓
Senior Housing		✓
Social Worker	✓	✓

Care Setting	Association	Practitioner
Adult Day Center	✓	✓ ✓
Assisted Living		✓
Community-Based Organization	✓ ✓	✓
Continuing Care Retirement Community		
Emergency Departments		✓
Federally Qualified Health Center		✓
Health System - urban		✓
Health System - rural		✓
Hospice Care		✓
Hospital		
Imaging and Radiology Centers		
Nursing Home	✓	
Palliative Care	✓	
Rehabilitation Centers		
Urgent Care		

Other	Exemplary Models	
GWEP Programs	✓ ✓	✓ ✓
Comprehensive Dementia Care Models	✓ ✓ ✓	✓ ✓ X

Opportunity Areas



Building Workforce Capacity: Our Process

Landing on Care Navigation for Comprehensive Dementia Care

Nov '21-Jan '22

Feb-Aug '22

Sept '22

March '23

Apr-Dec '23

Organize

Established expert workforce capacity working group and developed high-level project scope

Interview

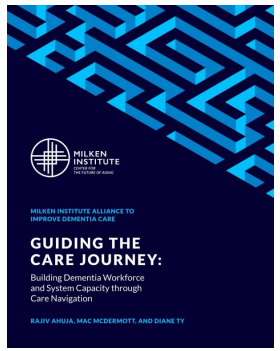
Interviewed over 40 key opinion leaders in the dementia care field on workforce constraints and opportunities

Roundtable

Synthesized insights that prioritized care navigation as a lever for comprehensive dementia care and delivered recommendations

Report

Release and promotion



Amplify Recommendations

Share broadly the recommendations and evolve as needed

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Value Proposition of Dementia-Care Navigation

- Improves Quality of Life
- Supports Caregivers
- Promotes Person-Centered Care
- Coordinates Medical and Social Care
- Reduces Health-Care Utilization

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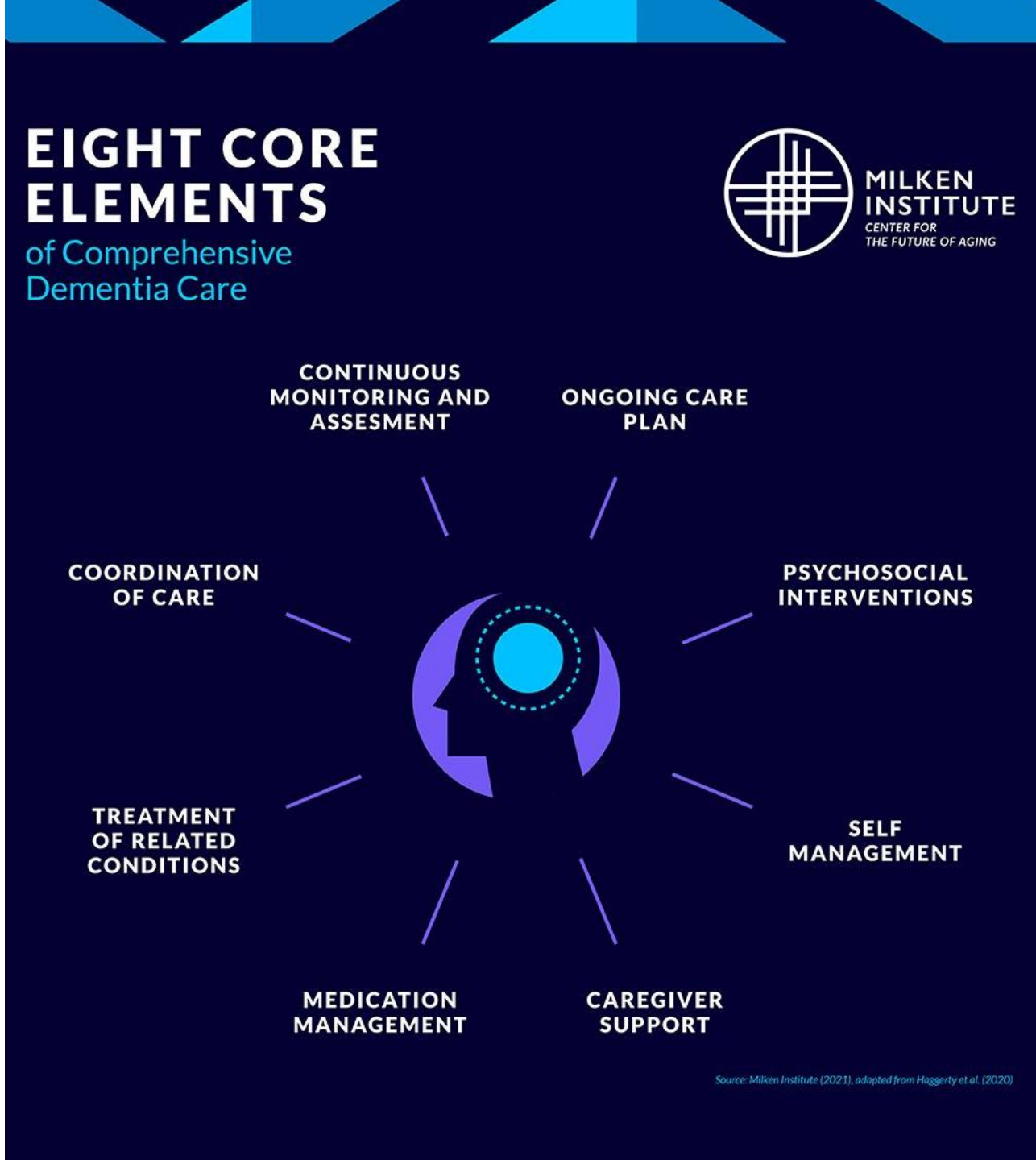
Care Navigation in Dementia

As a mechanism to help deliver comprehensive dementia care's eight core elements, the Alliance developed the following definition of care navigation:

"Individualized assistance offered to patients, families, and caregivers to overcome health-care system barriers and facilitate timely access to quality health and psychosocial care through all phases of the dementia-care journey, which encompasses early detection and diagnosis, care planning and delivery, end-of-life wishes and care, and all the transition points and moments of crisis in between."

Adapted from the Oncology Nursing Society, National Association of Social Workers, and Alzheimer's Association



Care Navigation Roles and Services Across Settings of Care

	Telephonic or Online Setting	Home- or Community-Based Setting	Clinical Setting
Frequent Name(s)	• Care team navigator • Care consultant	• Dementia-care specialist • Coordinator • Community health worker or *promotora*[28]	• Patient care coordinator • Dementia-care specialist • Dementia-care assistant • Care coordinator assistant • Journey coordinator[29]

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Care Navigation Roles and Services Across Settings of Care

	Telephonic or Online Setting	Home- or Community-Based Setting	Clinical Setting
Responsibilities and Services Provided	• Screening questions regarding behavior, function, and care needs • Scheduling assistance • Care triage • Disease education • Coordination among interprofessional dementia-care team members • Guidance on public benefits (e.g., Medicaid eligibility) and community-based services (e.g., adult day services, home-delivered meals, elder law attorneys, etc.) • Care team point of contact for individuals with dementia and their caregivers • Patient-caregiver dyad support and education • Behavioral interventions	• Dementia-friendly community training • Memory screening • Disease education • Informational counseling • Guidance on and referrals to public benefits (e.g., Medicaid eligibility), community-based services (e.g., adult day services, home-delivered meals, elder law attorneys, etc.), and research opportunities • Recommendations for remote care devices (i.e., to monitor wandering or falls) • Facilitating transportation • Patient-caregiver dyad support and education • Ongoing assistance with care planning	• Scheduling assistance • 24/7 telephonic support • Initial and ongoing assessments • Disease education • Medication management • Care for comorbid conditions • Behavioral interventions • Advanced care planning • Crisis resolution • Facilitating transitions of care • Patient-caregiver dyad support and education • Referrals to community-based services (e.g., adult day services, home-delivered meals, elder law attorneys, etc.) • Facilitating transportation • Ongoing assistance with care planning

At a Glance: Report Overview

Theme 1: *Develop a Framework to Embed and Scale Care Navigation on Dementia-Care Teams*

Recommendation 1. Define and adapt the core services of dementia-care navigators

Recommendation 2. Identify and promote best practices to recruit, train, and retain dementia-care navigators

Recommendation 3. Leverage online and technology-based solutions to support dementia-care navigation tasks

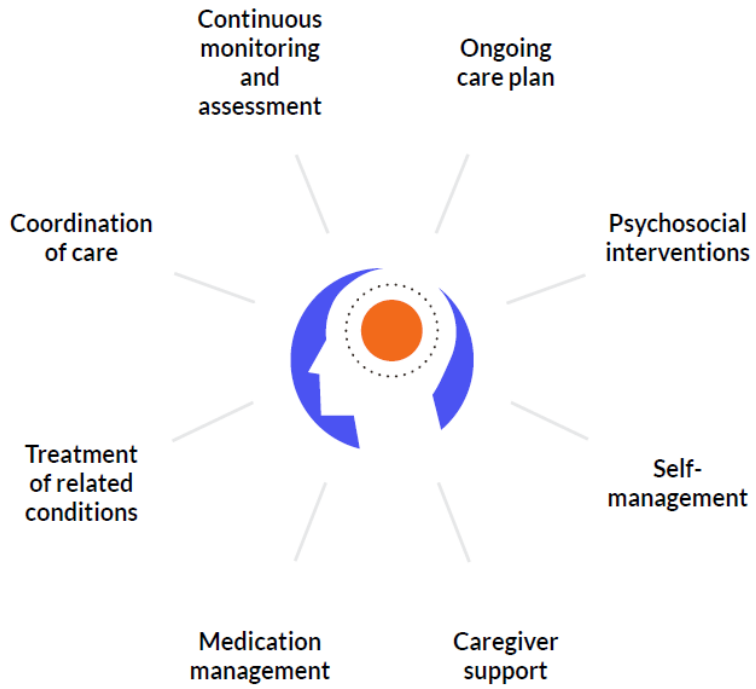
Theme 2: *Expand Payment Mechanisms in Medicare to Incentivize the Adoption of Care Navigators*

Recommendation 4. Implement alternative payment models for comprehensive dementia care that deliver care-navigation services

Recommendation 5. Expand and clarify CMS guidance on using traditional fee-for-service Medicare payment mechanisms for dementia-care navigation services

Recommendation 6. Embed care navigation services within Medicare Advantage plans

1. Define and Adapt the Core Services of Dementia-Care Navigators



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.

- Care navigation services help deliver the core elements of **comprehensive dementia care**
- Care navigation can occur in a **variety of settings**, including telephonic or online, home- or community-based, and clinical models
- A **variety of licensures** can serve as care navigators, such as nurse practitioners, physician associates, social workers, and paraprofessionals
- Dementia-care teams should **tailor the core roles and responsibilities** of care navigation to the individual with dementia's level of need

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2. Identify and Promote Best Practices to Recruit, Train, and Retain Dementia-Care Navigators

"… So what can a care navigator do to alleviate the stressors [of caregiving]? A qualified dementia specialist will know your local resources for funds, classes, placement, support groups, and certified elder law attorneys. They'll be able to coordinate your comorbidities, your prescriptions, your tests, and so forth."

Sharon Hall, Family Care Partner, Young Onset Dementia Advocate and Co-Founder, Innovative Care Partners with Real Experience (iCARE), on her experience with care navigation services from Emory University's IMCC for her husband, who lives with frontotemporal dementia

- Focus **recruitment efforts** on the growing numbers of nurse practitioners, physician associates, and social workers
- Adopt a **training curriculum** for care navigators who deliver comprehensive dementia care
- Disseminate toolkits that **integrate online resources with personalized mentorship**
- **Leverage existing certifications** to include paraprofessional dementia-care navigators
- **Explore expanding the role** of existing cancer and diabetes care navigators by training them to deliver dementia-specific navigation services

3. Leverage Online and Technology-Based Solutions to Support Dementia-Care Navigation Tasks

- Technology-based solutions can help care navigators manage daily tasks, communicate with health-care providers, and share patient information with an interprofessional care team
- Artificial intelligence (AI) and machine learning (ML) can automate repetitive and time-consuming navigation tasks and identify gaps in care.
- These technologies are not meant to replace the importance of compassionate and high-touch dementia care, but rather reduce administrative tasks, increase access to real-time information, and help members of dementia-care teams operate more efficiently

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4. Implement Alternative Payment Models for Comprehensive Dementia Care that Deliver Care Navigation Services

- **S. 1125 / H.R. 2517 - Comprehensive Care for Alzheimer's Act**
  - Care navigation services, as the Alliance defines them, are encompassed in the following components:
    - **Self-management tools:** "Tools to enhance the skills of the unpaid caregiver [...] to manage the Alzheimer's disease or related dementia of the eligible individual and to navigate the health-care system," including disease management training, problem-solving strategies, and care navigation support
    - **Care coordination:** "Necessary assistance or referrals to social and community-based organizations, collaboration with primary care providers and the interdisciplinary team of the eligible individual, and support for care transitions and continuity of care"
  - Leveraging the definitions of self-management and care coordination to include the breadth of services identified by the Alliance would support the care navigation role on interdisciplinary teams

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5. Expand and Clarify CMS Guidance on Fee-for-Service Medicare Payment Mechanisms for Dementia-Care Navigation

Case Study: Payment in the Care Ecosystem Dementia-Care

- Chronic Care Management (CCM) and Principal Care Management (PCM) Current Procedural Terminology (CPT) billing codes reimburse PCPs and specialists who establish, manage, and revise a Medicare beneficiary's care plan and coordinate care activities
  - Associated challenges currently restrict widespread utilization:
    - Lack of clarity regarding licensed clinical social workers' eligibility to serve as "clinical staff"
    - Codes require 24/7 access to the eligible billing provider on the clinical team
    - Medicare also requires 20 percent cost-sharing with the use of these codes
  - Broadening guidelines on who can bill using these codes, and for what services, will increase the use of the codes and improve workforce capacity to deliver care navigation

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6. Embed Care Navigation Services within Medicare Advantage Plans

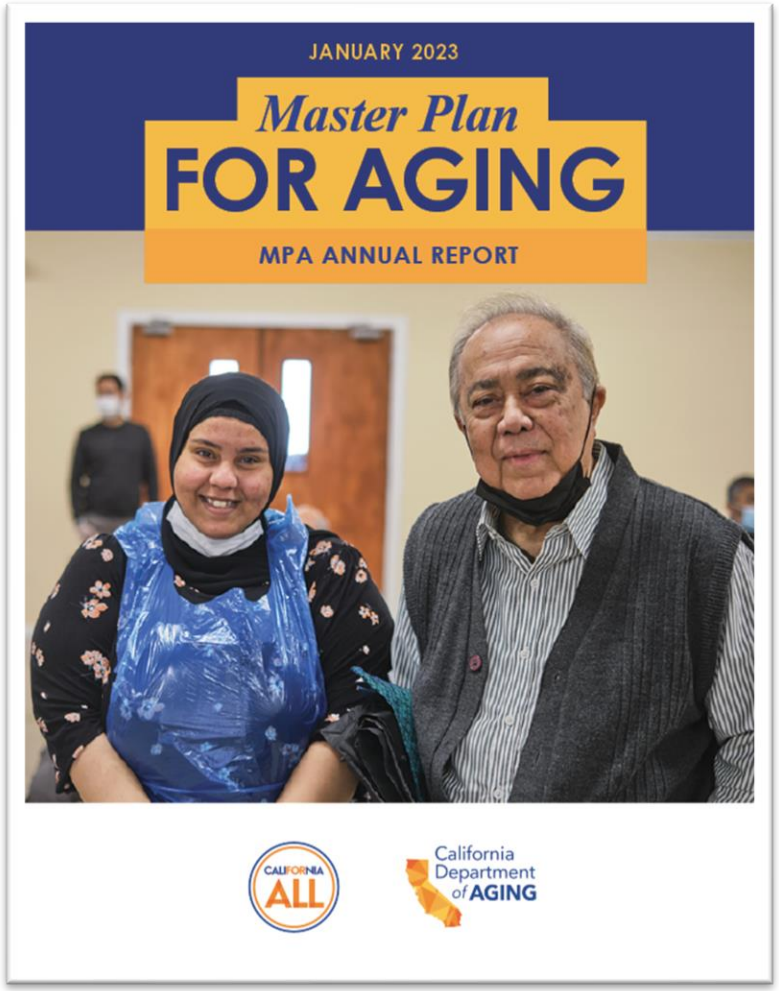
- Medicare Advantage seeks to improve the health outcomes of its members at lower costs, aligning with care navigation's goal of delivering services that reduce acute care episodes resulting in high-cost emergency department visits or hospital readmissions
  - Several levers within Medicare Advantage have potential to deliver care navigation services
    - **Supplemental Benefits:** Medicare Advantage can offer special supplemental benefits for the chronically ill (SSBCI) that are not primarily health-related, including benefits like food delivery, nonmedical transportation, pest control, companion care, and rent subsidies; CMS later expanded the definition of "primarily health-related" supplemental benefits, allowing nonmedical services that help prevent or address cognitive and functional decline, such as caregiver respite and in-home supports
    - **Special Needs Plans (SNPs):** Implement interprofessional teams that tailor benefits, provider choices, and drug formularies to meet members' specific needs and include care coordination services to some degree; in 2022, 42 percent of SNPs offered SSBCI
  - The Alliance recommends Medicare Advantage plans increase access to care navigation services via supplemental benefits and SNPs

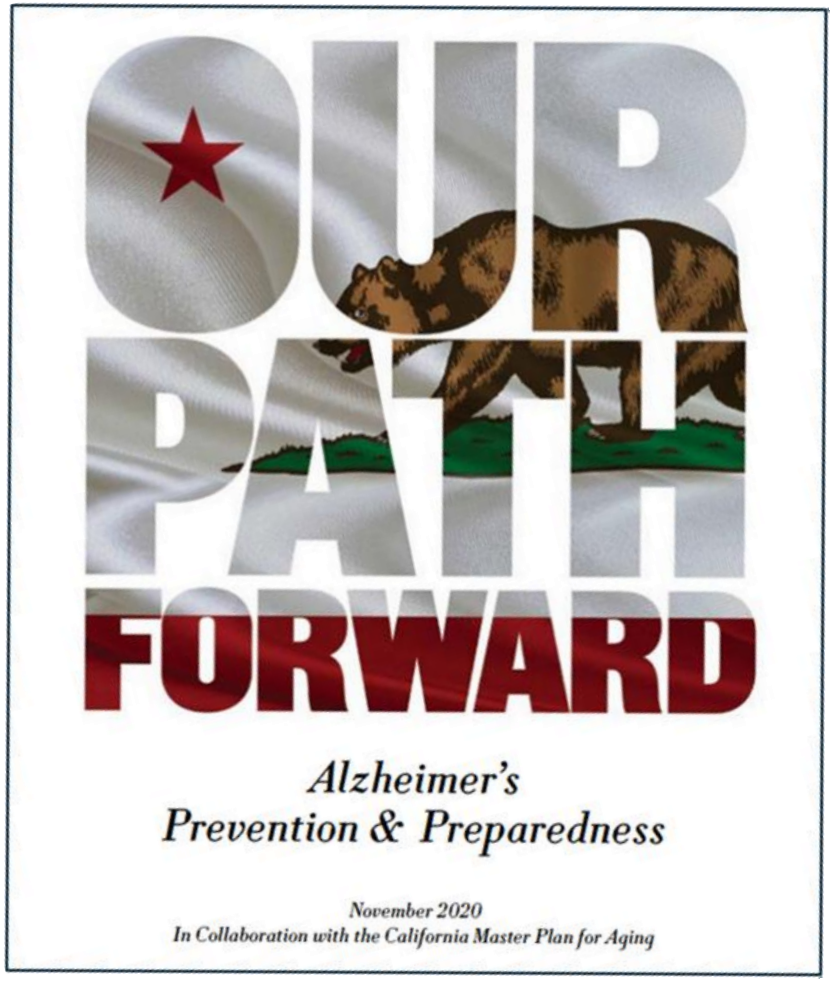
State and National Highlights

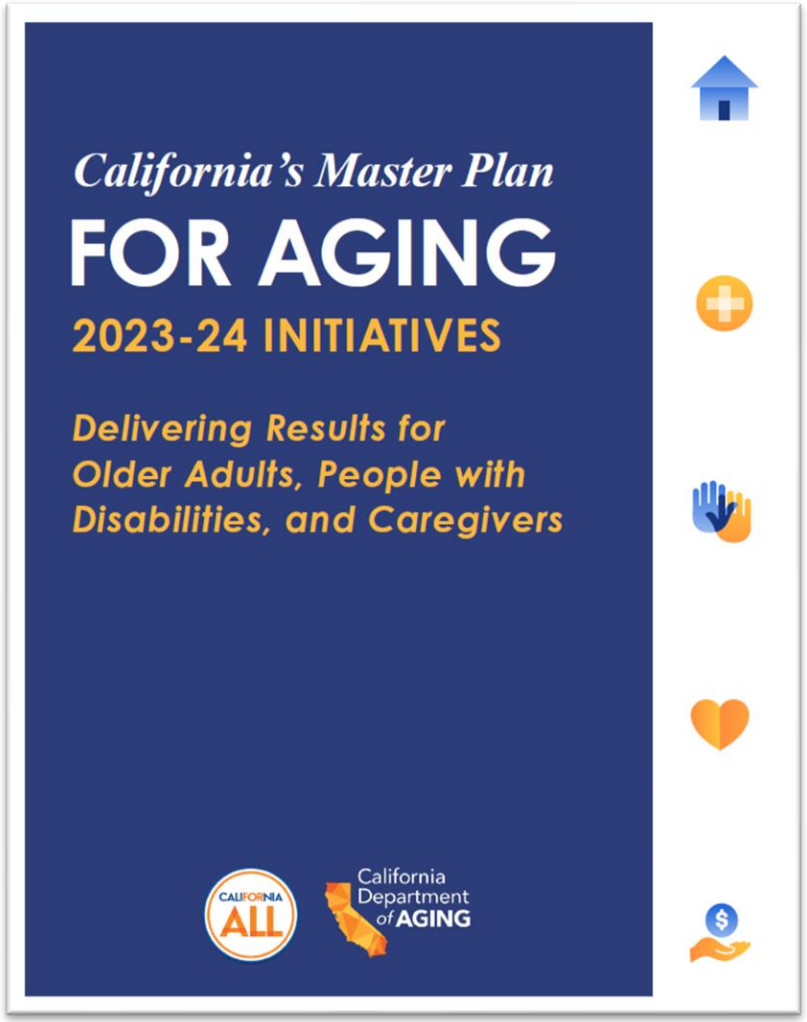
Spotlight: California's 10-year Blueprint

"We can't talk about aging without focusing on Alzheimer's."

- Governor Gavin Newsom

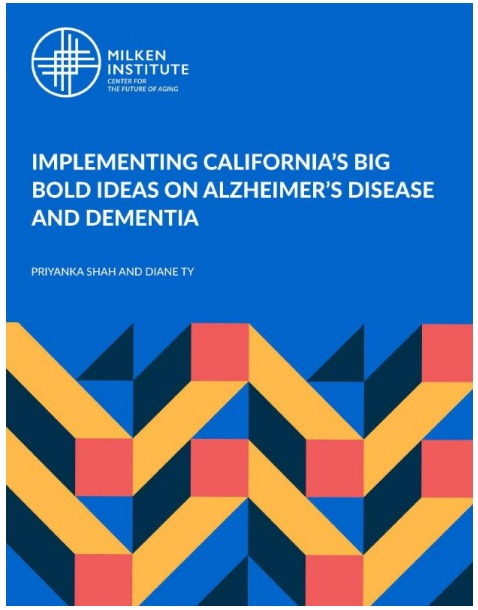






Scaling Comprehensive Dementia Care in California

Identify a collaborative project that will help scale comprehensive dementia care in California as part of the State's goal to "model a statewide standard of care for the nation."



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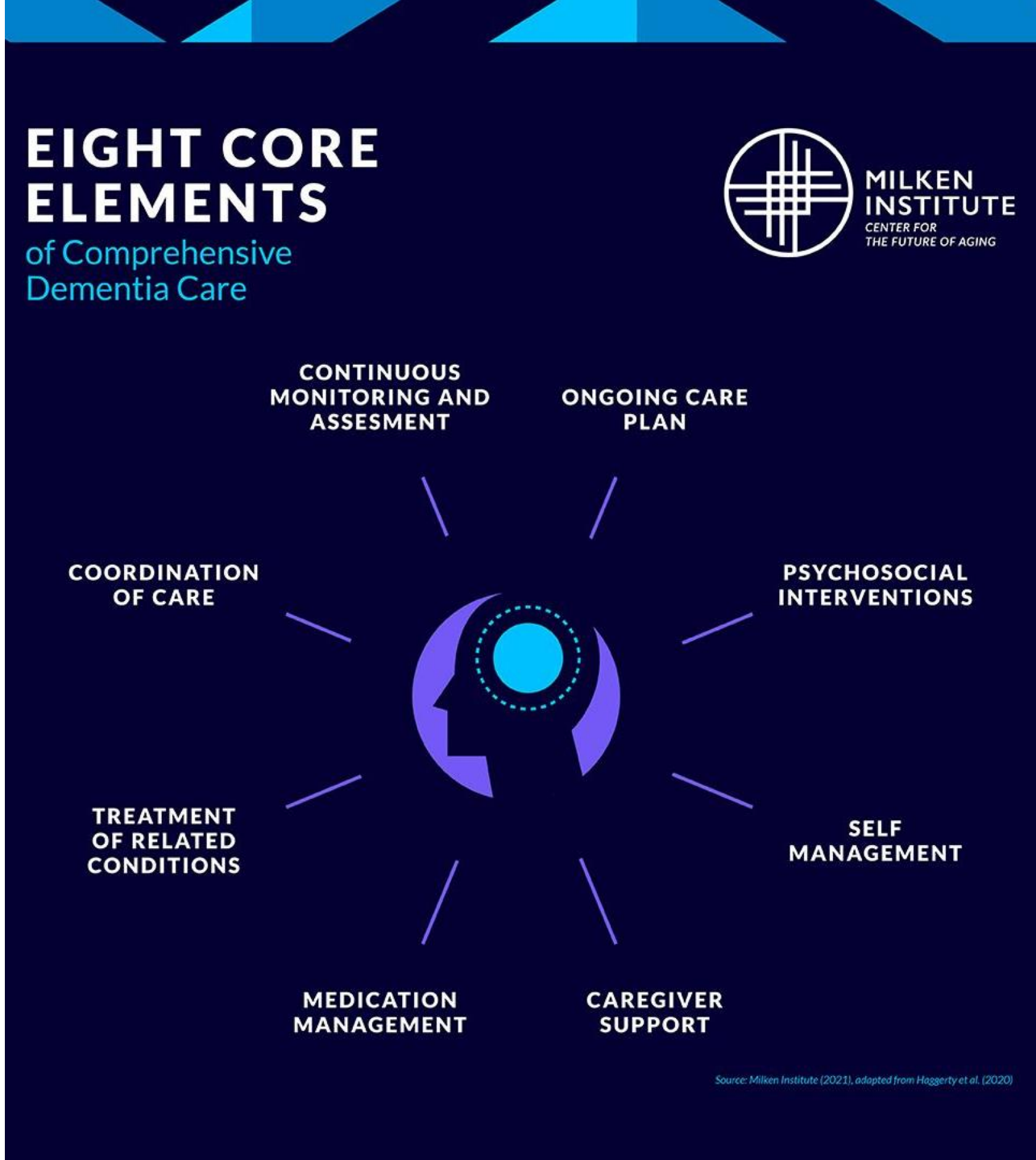

Highlight

DEMENTIA Care Aware

Empowering primary care providers to improve dementia screening, detection, and care

- Offers trained Medi-Cal providers the **opportunity to bill for a Cognitive Health Assessment** (CHA) of older adults aged 65+ with Medi-Cal only.
- March 2022-March 2024, partners will disseminate **training**, and **support to primary care providers** to implement the Cognitive Health Assessment
- **90-minute on-demand online training** offers Continuing Medical Education (CME)/Continuing Education Units (CEU)/Maintaining Certification (MOC) on Cognitive Health Assessments (CHA)*
  - Take the patient history
  - Use tools to assess for cognitive and functional decline
  - Establish and document a patient's support person and/or health care agent
- **Monthly webinars and on-line trainings**; Podcasts about dementia-related news and other topic; Support via DCA@ALZ.org and the "warm line"; Practice implementation support services

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**Any team member, including a caregiver, can perform these elements for the provider to review at the same or a later visit*

Highlight: Cal-COMPASS

California Community Program for Alzheimer's Services and Support Pilot Program

- **Cal-COMPASS** - $5M for Alzheimer's day center and day health center pilot in seven sites, including an evaluation contractor – aimed at creating a modernized Alzheimer's community care model

- Community-based, dementia-specific models designed to develop best practices to prevent or delay the institutionalization of persons living with Alzheimer's and other dementias, support caregivers, and advance health equity.
  - Alzheimer's Family Center (Orange County)
  - Choice in Aging (Contra Costa County)
  - City of Sacramento, Triple R Adult Day Centers (Sacramento County)
  - Collabria Care (Napa County)
  - Hearts and Minds Activity Center (Santa Clara County)
  - Innovative Health Care Services, Peg Taylor Center for Adult Day Health Care (Butte County)
  - OPICA Alzheimer's Day Program and Counseling Center (Los Angeles County)

Highlight: California GROWS

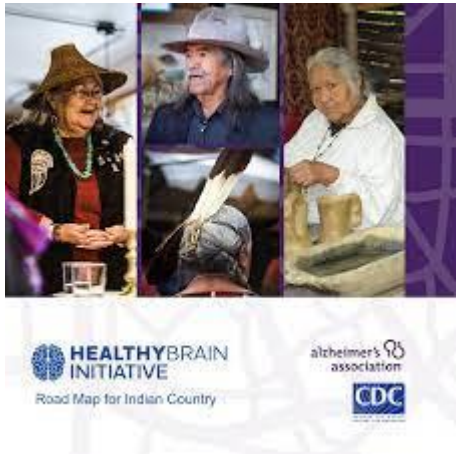
California Department of Aging's Direct Care Workforce Initiative

- CalGrows, CDA's Direct Care Workforce Training and Stipends Program, will incentivize, support, and fund career pathways for the Home and Community-Based Services (HCBS) workforce (non-IHSS).
- $55M Innovation Fund Grants
  - Multilingual family caregiver dementia care training program
  - Responsive workforce to support family caregivers in dementia care
  - Dementia and End-of-Life Care, multiethnic, multilingual certification program for direct care workforce
  - Training for Promotores

Highlight: Healthy Brain Initiative

State and Local public health partnerships to address dementia

HEALTHYBRAIN INITIATIVE



2018-2023

2023-2027
Coming soon!

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Alliance Steering Committee

Q&A

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Q&A/Discussion

Next Steps

- Next Network Meeting: Late June
- Focus: AMDA, The Society for Post-Acute and Long-Term Care Medicine
- Coming Soon: National Online Resource Center: https://longtermcare.csg.org
- Send Us: Relevant Bills, Reports, Resources, Articles, Initiatives
- Request State Technical Assistance Services
- Reach Out With Your Thoughts (sslone@csg.org)

Thank You!