



Long Term Care Coordinating Council
State Plan for Alzheimer's and Related Disorders Working Group

Access

11:00 – 12:30 pm
Thursday, April 11, 2013
RICCMHO
Small Conference Room
40 Sharpe Drive
Cranston, RI 02920

Agenda

1. Review of Subgroup work from past several months
 1. Transportation and mobility challenges
 2. Telemedicine
 3. How can we improve care and access for disproportionately affected communities?
 - a. Minority outreach
 4. Clinical Care coordination
 5. Discharge planning and coordination
 6. Non-residential care services
 7. Funding
 8. Cultural competency and service availability (geographically, linguistically)
Pathways to care: co-existing conditions, early onset Alzheimer's disease

2. Discussion of recommendations: The Outline pasted below served as the guide for the Subgroup's discussion.
3. Subgroup Planning
 - a. The month of May will be dedicated to drafting. Please be aware that drafts will be sent out to all participants of the Subgroup for feedback.
 - b. The first draft will be presented at the June 6, 2013 meeting at Child & Family at 8:30 am.
 - c. Other Needs or Concerns?
 - i. None were expressed.
4. Public Comment
 - a. There was no public comment.
5. Adjourn
 - a. The meeting was adjourned at 12:25 pm.

1) **Transportation:**

- a. RIPTA:
 - **More robust Trip Planning capabilities** needed to help individuals and caregivers
 - Initiate online capability and enhance in person/phone call
 - Real-time response to appointment cancellations and rescheduling: a carve out/back-up for riders who need to change plans at the last minute. How can RIPTA become more accommodating? (a la emergency / on call appointments).
 - Drop-offs by RIPTA to large medical campuses need “**curb to counter**” assistance
 - **Physical appearance** of the RIdE vans needs to differ from Flex vans
 - Buses need to have “**kneeling**” capability
 - Additional and consistent **driver training** needed for RIPTA employees
 - RIPTA is considering **non-cash payment** options for RIdE – *the subgroup recommends this*
 - “How to take the bus” **education** needed
 - AARP's book – improve dissemination to doctors offices and senior centers and adult day program

- Home visits – take with them to see clients (case management and home care agencies, EOHHS)
- Clarity is needed among residences and senior centers, *adult day centers* as to the **distance policy** for RIdE trips
- The RIdE application could be simplified (is it available in various languages?)
 - It is online
 - No doctor signature required
- **Early onset** individuals under age 60 are left out of this system – how can the state address this?
 - If eligible under ADA, no age requirement
- Mobility remains a challenge for those living outside urban centers
 - What smaller cities/towns [or volunteers] offer their own senior transportation (includes medical trips out of the geographic area)
 - A list is needed
 - *Taxi voucher program? (URI student program model, MD, Boston) or Donated car program run by paid and volunteer drivers...*
 - *Some sort of supplemental transportation network needed*
- Ride rebidding their broker program – need an update

b. Taking the Keys” Away:

- There is a need for **enhanced communication** between primary care providers and the families around safe driving
 - Challenge: physicians comfortable assessing cognitive ability but not necessarily ability to drive
 - Law enforcement makes contact with DMV; DMV requests letter from physician re. the person’s ability to drive
 - Is there data available to better track this?
 - AAA: senior driving tests and a class on safe driving for seniors
 - Recommendation:

- Identify opportunities for seniors to get a driving test done
 - Alz. Assoc. can make some recommendations here
 - Rec: connecting those who are concerned with resources for testing, safe driving, what to do, etc.
- *Add information on Memory Center's work on **driving ability analysis** to state plan – much material in subgroup minutes. Dr. Ott provided driving test company directory and research on recommended best practices for assessing driving ability.
 - *Any additional Subgroup recommendations here?*

2) The POINT as a resource for families:

- Options Counseling is robust, but may need supplemental assistance for **private pay options**.
 - Perception is that this population may not be finding the support and guidance they need.
- Resources to our **ADRC's** – need increased support here given expanded role they are being asked to play in communities; senior patrol, SHIP counseling, all options counseling.
 - Harness navigators funds under Medicaid expansion?
- Among ADRC case management agencies, is there any specialty in caregiving? Any specialty in dementia care and services?
 - What kind of training do those agencies receive on dementia?
 - Does a list of those agencies exist – if so, include in plan
- A “**Process Map**” is needed.

- Diagnosis made; now what? What do I/we need to think about and plan for?
 - Options for transportation, elder law attorneys, real estate attorneys (with specialty helping seniors sell their homes).
 - CA model for dementia-specific care management policy – *take a look at this.*
 - Advanced planning and end of life issues needs to be incorporated into this “map.”
- Both Subgroups were interested in seeing The POINT eventually have the ability to sort call-in data collection to determine community needs and geographical break-down with respect to calls re. dementia and caregiving.
 - What are the federal guidelines on reporting?
 - What are their software capabilities?
 - Is there an ability to drill down further than “long term care” call? Or “prescription drugs” or Medicare.
- Need to connect Regional POINT offices with Alzheimer’s Association so that they’re aware of changing docket of programs in their area.
- Is there a way to encourage options counseling to occur earlier in the disease progression? Any natural partnerships that can be forged to improve awareness of how important it is to plan early?
 - Adult days?
 - Primary Care?
 - Senior Centers?
 - Law Enforcement/Legal?
- *Does the Subgroup have a specific recommendation here?*

3) Telehealth

- Telehealth represents a promising technological advancement for the improvement of ongoing healthcare for people living with dementia.
- Platform may include video conferencing, phone, chat, clinical data/tools, audio conferencing and payment portal.
 - **Caregivers**, paid and unpaid, would benefit from ability to telepresent with their loved one or patient from home with consultation from nurses, physicians and specialists.
 - The healthcare system stands to benefit from efficiencies associated with telehealth model of care; access to hospitals, specialists, etc. Reduces transitions, transportation needs, cost; eases coordination and collaboration.
 - Medication reconciliation may be aided by telehealth portal
- Insurance companies are inconsistent with their coverage of telehealth
 - Currently covered for psychological visits and to a greater extent in rural areas; not yet for primary care and specialty care
- Medicare/Medicaid approaching from pilot perspective. Slow to infiltrate market.
- *Specific recommendations:*
 - RI insurance companies should cover telehealth for people with chronic illness
 - Medicaid policy here?

4) Funding

- Acuity based payment for providers with dementia population: adult day, nursing home, assisted living
- LTC with dementia – percentage
 - LOI charts
- State needs better and more consistent assessment for acuity
 - Diagnosis can be made, but the acuity level is measured differently across providers

