CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

RHODE ISLAND DEPARTMENT OF HEALTH

Welcome

Delivering Age-Friendly Care
Implementing the 4M Model and Supporting Care Partners of People with Dementia: A Path to Level 1 or Level 2 Recognition from the Institute for Healthcare Improvement

Mid Point Learning Collaborative

November 14th, 2024

Agenda

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Topic	Presenter	Duration
Welcome and Introductions	*Victoria O'Connor*	7:30 – 7:35 AM
Practice Case Studies	*Breakwater Primary Care- Dr. Yamada, Brown Medicine, PACE*	7:35 - 8:05 AM
Practice PDSAs	*University Internal Medicine, Breakwater Primary Care-Dr. Steinmetz, Family Care Center*	8:05 – 8:20 AM
The Point	*Aura Medina*	8:20 – 8:35 AM
CareLink	*Robyn Earley*	8:35 -8:50 AM
Discussion, Questions, Next Steps	*Suzanne Herzberg, Jayne Daylor, Christine Ferrone*	8:50 – 9:00 AM

Coming soon – Spring 2025

We call it "all teach, all learn."

ECHO participants engage in a virtual community with their peers where they share support, guidance and feedback. As a result, our collective understanding of how to disseminate and implement best practices across diverse disciplines continuously improves and expands.

During an ECHO session, participants present real (anonymized) cases to the specialists—and each other—for discussion and recommendations.
Participants learn from one another, as knowledge is tested and refined through a local lens.
This continuous loop of learning, mentoring and peer support is what makes ECHO unique, with a long-lasting impact far beyond that of an in-person training, webinar or e-learning course.
Our knowledge-sharing model brings together specialists from multiple focus areas for a robust, holistic approach.

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Practice Case Presentations

Care Transformation Collaborative of RI

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Breakwater Primary Care – Dr. Yamada

Refining Care Partner Education and Resource Provision

Practice Facilitator: Suzanne Herzberg

Care Transformation Collaborative of RI

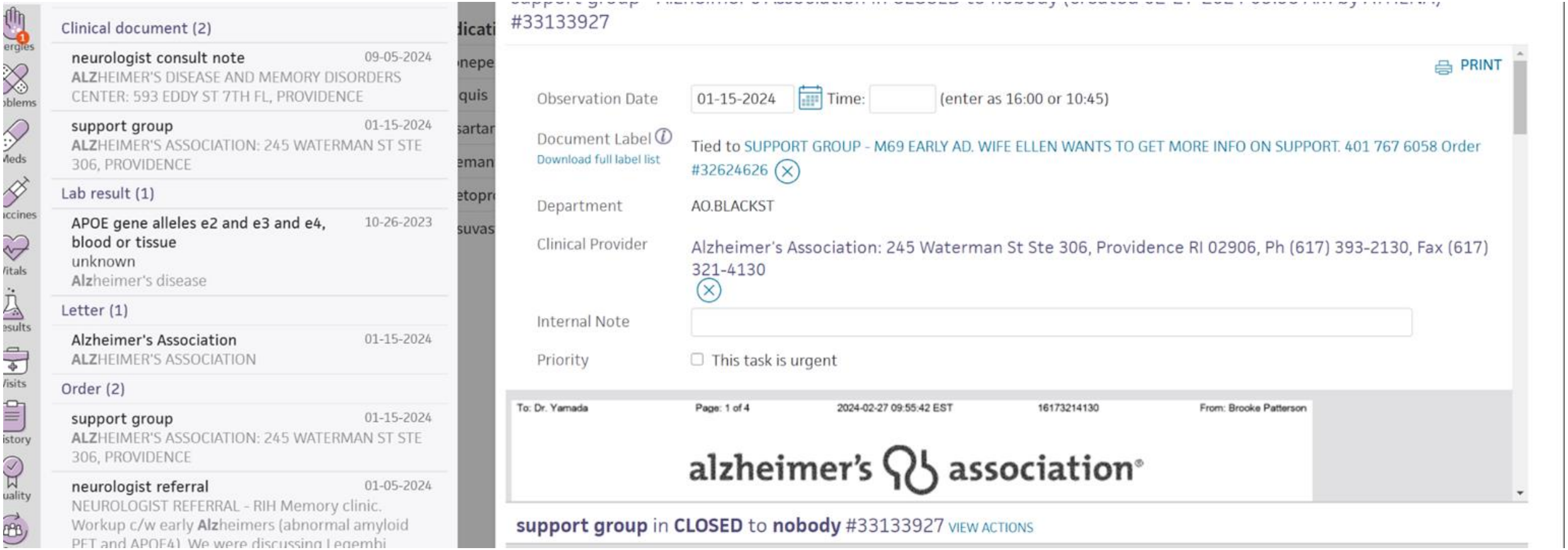
Particpant background:

Age	70M
Brief Medical History	70M college professor who experienced worsening of cognitive impairment after retiring (9/2023). MMSE=26/30. Metabolic w up neg. W up by neuro: 10/26/23 POS ApoE, P E3/E4 12/29/23 PET: FREQUENT NEURITIC PLAQUES
What Matters	1/15/24 Meeting with patient, caregiver (spouse): delay progression of the disease
Living arrangements	Home, independent
Dementia stage (early, mid, late)	Early

Care partner background

Age and relationship to participant	Spouse
How we identified the care partner	Specific demographic field in the EHR
How we assessed the care partner's needs assessed and any screenings/results.	Modified Caregiver Strain Index (built in the EHR)
What matters to the care partner?	Preserve function, delay progression
Care partner's current work situation	Retired
Living arrangements (do they live with participant? If not, how far away are they?	Yes
Areas of concern: medical, social, financial	Decision to refer patient for Leqembi infusion. Patient has a h/o PAFIB, was on apixaban. Referred for the Watchman procedure, now awaiting cardio clearance to DC DAPT.

Actions we have taken to connect care partners to resources and education:



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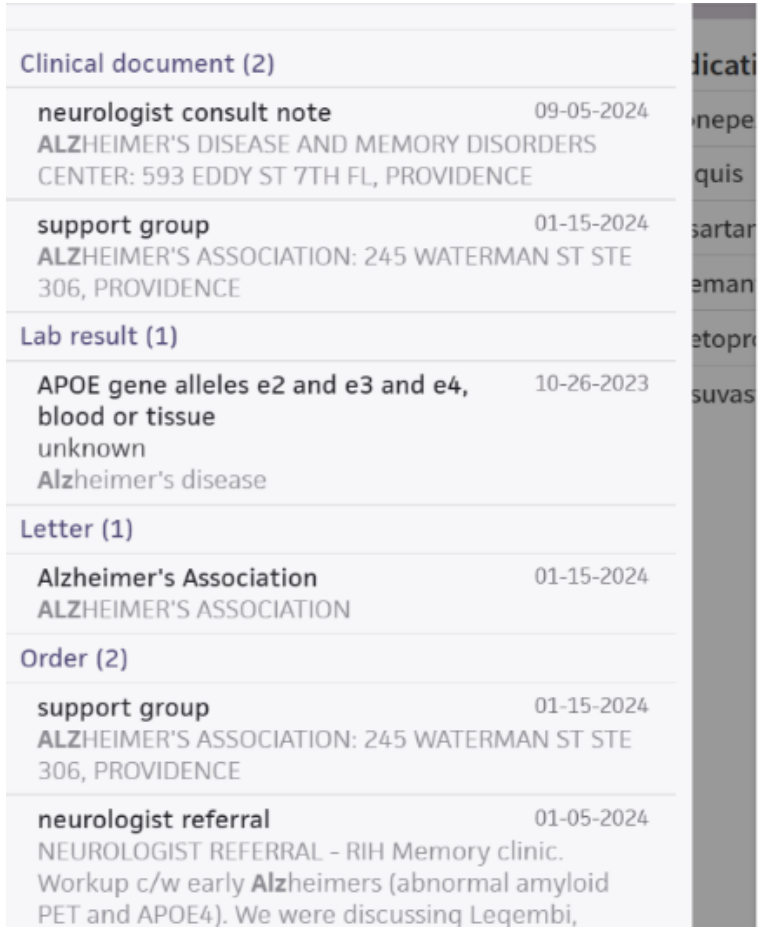
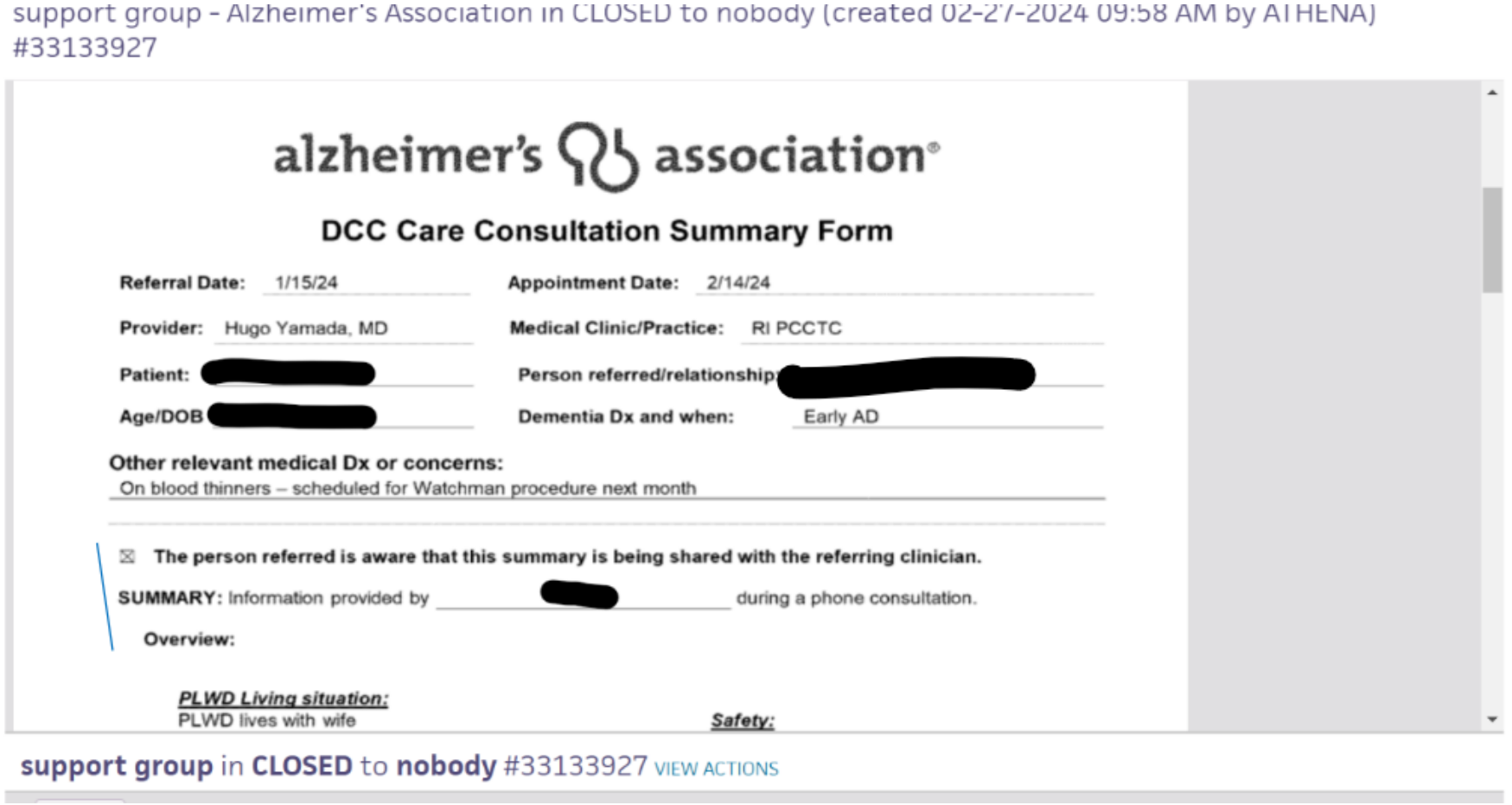




Outcomes:

Patient remains independent at home

Most recent MMSE: 28/30

Has followed with neuro, off cholinesterase inhibitor, glutamate receptor antagonist

Awaiting Leqembi infusion

EHR Workflow

Entering (clicking) “magic words” (cognitive impairment) triggers a clinical template

Structured fields, questionnaires, clinical macros, ICD10 codes, referrals populate in the clinical encounter template

EHR Workflow

Modified Caregiver Strain Index

Modified Caregiver Strain Index

Directions: Here is a list of things that other caregivers have found to be difficult. Please put a checkmark in the columns that apply to you. We have included some examples that are common caregiver experiences to help you think about each item. Your situation may be slightly different, but the item could still apply.

Answer key: Yes, On a Regular Basis=2 Yes, Sometimes =1 No=0
My sleep is disturbed (For example: the person I care for is in and out of bed or wanders around at night): 2
Caregiving is inconvenient (For example: helping takes so much time or it's a long drive over to help): 0
Caregiving is a physical strain (For example: lifting in or out of a chair; effort or concentration is required): 1
Caregiving is confining (For example: helping restricts free time or I cannot go visiting):0
There have been family adjustments (For example: helping has disrupted my routine; there is no privacy): 0
There have been changes in personal plans(For example: I had to turn down a job; I could not go on vacation): 2
There have been other demands on my time (For example: other family members need me): 0
There have been emotional adjustments (For example: severe arguments about caregiving): 0
Some behavior is upsetting (For example: incontinence; the person cared for has trouble remembering things; or the person I care for accuses people of taking things): 0
It is upsetting to find the person I care for has changed so much from his/her former self (For example: he/she is a different person than he/she used to be): 0
There have been work adjustments(For example: I have to take time off for caregiving duties): 0
Caregiving is a financial strain: 1
I feel completely overwhelmed (For example: I worry about the person I care for; I have concerns about how I will manage): 0
Total score:6

WHY: Informal supporters provide the majority of long-term care to chronically disabled older adults. Caregiving has been recognized as an activity with perceived benefits and burdens. Caregivers may be prone to depression, grief, fatigue, financial hardship, and changes in social relationships. They may also experience physical health problems (Thornton & Travis, 2003). Perceived caregiver strain has been associated with premature institutionalization for care recipients along with reports of unmet needs. Screening tools are useful to identify families who would benefit from a more comprehensive assessment of the caregiving experience.

EHR Workflow

16. Caregiver role strain - Behavior management strategies Caregiver stress Disease education Communication techniques Staying home alone Driving/transportation options Management of activities of daily living Housing options: skilled nursing/assisted living Care options: adult day health/in-home Legal & financial/long-term care planning Family dynamics ☐ General safety tips Medicare/Medicaid Transitioning to long-term care Geriatric care management End of life care/hospice
Z73.3: Stress, not elsewhere classified

- SUPPORT GROUP - Schedule Within: 8 weeks

17. Assessment of caregiver stress
Z71.89: Other specified counseling

18. Needs assistance with community resources - SDOH screening positive in the area(s) checked below. Will refer patient for a CHW consultation
Addressing family/interpartner violence:
Control of asthma:
Control of high blood pressure/cardiovascular disease:
Control of stress:
Control of sexually transmitted disease:Diabetes prevention and control:
Chronic pain self-management:
Chronic disease self-management:
Immunizations:
Improvement in safety, environmental health of housing:
Improvement in nutrition:
Improvement of physical fitness:
Injury prevention:
Prevention of fetal alcohol syndrome/neonatal abstinence syndrome:
Reduction in the misuse of alcohol and drugs:
Tobacco cessation:
Promotion of preventative screenings:
Other:
Z76.89: Persons encountering health services in other specified circumstances

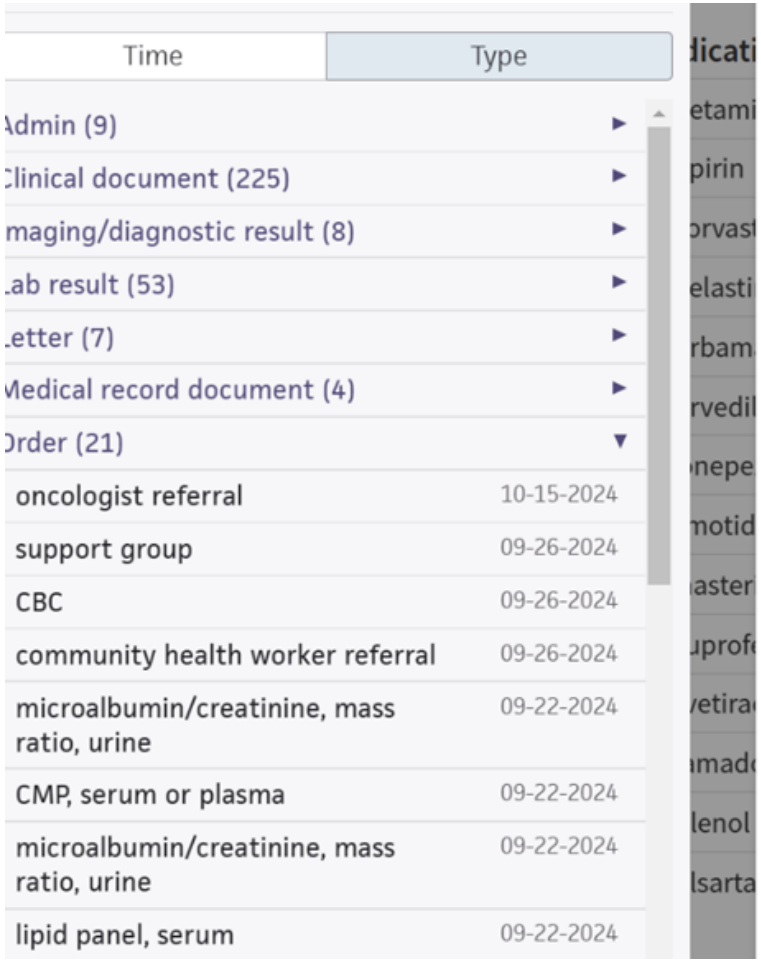
- COMMUNITY HEALTH WORKER REFERRAL - Schedule Within: 4 weeks Note to Provider: MOD DEMENTIA, HELP CAREGIVER W RESOURCES

Procedure code: T1016

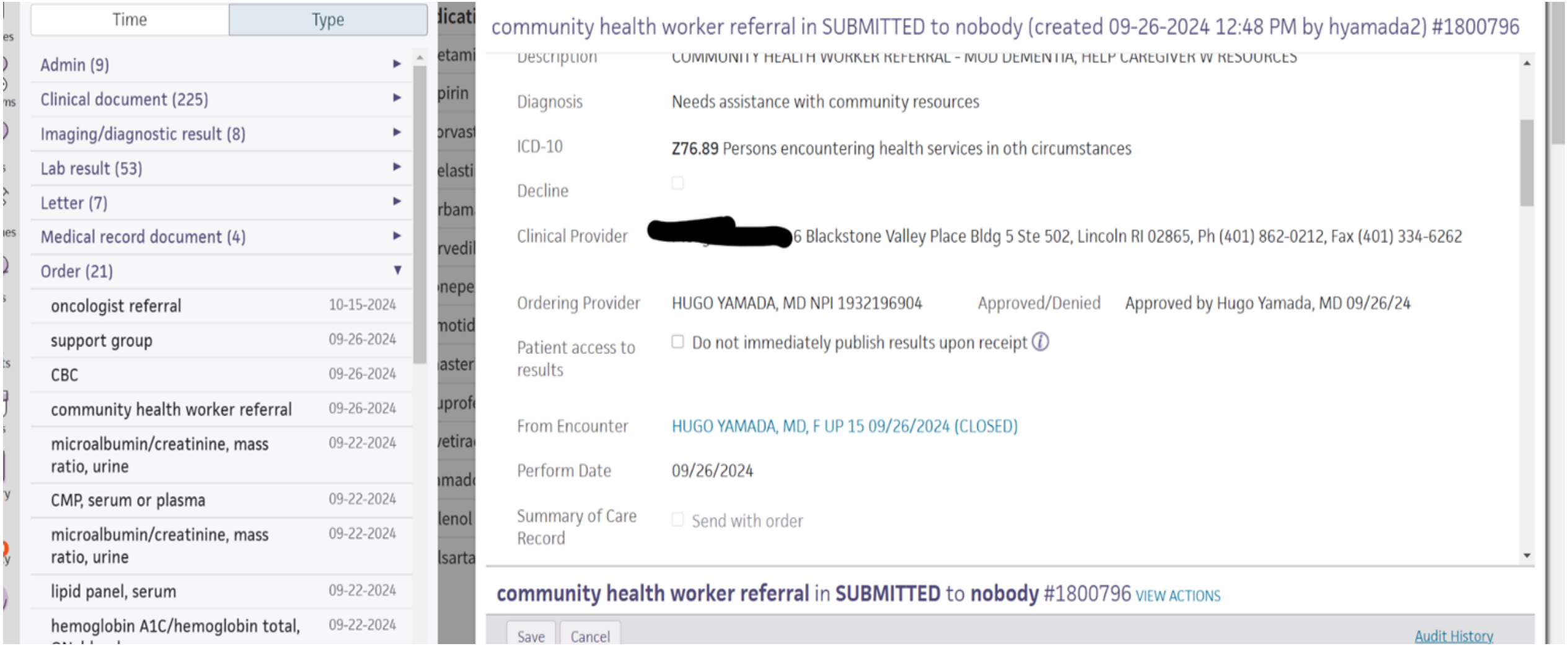
Discussion Notes

What Matters: as we discussed, managing your chronic conditions is important to maintain your quality of life but at the same time we also understand that

EHR Workflow



EHR Workflow



CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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ADVANCING INTEGRATED HEALTHCARE

Brown Medicine

Refining Care Partner Education and Resource Provision

Practice Facilitator: Christine Ferrone

Care Transformation Collaborative of RI

Patient background:

Age	94 year old female
Brief Medical History	Afib, Asthma, Hypothyroidism, Anemia, Asthma, depression, anxiety, weight loss, dementia
What Matters	Patient social engagement, stimulation, stability housing
Living arrangements	Strained-with daughter temporarily, was at ALF
Dementia stage (early, mid, late)	Mid, 6bFast
Other Measures:	Katz=2, Lawton and Brody=0, PHQ-9 for pt is 9, GAD is 12, Promise total score=32

Care partner background

Age and relationship to patient	Dtr, age 61
How we identified the care partner?	Brought to PCP appointment by Dtr
How we assessed the care partner's needs assessed and any screenings/results	Zarit Caregiver Burden, severe burden, high score
What matters to the care partner?	Being able to work, needing to find a place for her mom to go during the day, or long term.
Care partner's current work situation	LOA unpaid, used FMLA
Living arrangements (do they live with patient? If not, how far away are they?	Yes, live with PT temporarily 2nd floor apartment of a 2 family home in Cranston, RI
Areas of concern: medical, social, financial	Financial concerns, complicated picture, housing, PT owns property and has son with SUDs living there.

Caregiver Strain index used for ADC program

MODIFIED CAREGIVER STRAIN INDEX

(To be completed by caregiver)

Caregiver Name: _____

Date: _____

Directions: Here is a list of things that other caregivers have found to be difficult. We have included some examples that are common caregiver experiences to help you think about each item. Your situation may be slightly different, but the item could still apply.

	Yes, On a regular basis	Yes, Sometimes	No
1. My sleep is disturbed (For example: the person I care for is in and out of bed or wanders around at night)	☐	☐	☐
2. Caregiving is inconvenient (E.g.: helping takes so much time or it's a long drive over to help)	☐	☐	☐
3. Caregiving is a physical strain (E.g.: lifting in or out of a chair, effort or concentration is required)	☐	☐	☐
4. Caregiving is confining (E.g.: helping restricts free time or I cannot go visiting)	☐	☐	☐
5. There have been family adjustments (E.g.: helping has disrupted my routine; there is no privacy)	☐	☐	☐
6. There have been changes in personal plans (E.g.: I had to turn down a job; I could not go on vacation)	☐	☐	☐
7. There have been other demands on my time (For example: other family members need me)	☐	☐	☐
8. There have been emotional adjustments (E.g.: severe arguments about caregiving)	☐	☐	☐
9. Some behavior is upsetting (E.g.: incontinence; the person cared for has trouble remembering things; or the person I care for accuses people of taking things)	☐	☐	☐
10. It is upsetting to find the person I care for has changed so much from his/her former self (E.g.: he/she is a different person than he/she used to be)	☐	☐	☐
11. There have been work adjustments (E.g.: I have to take time off for caregiving duties)	☐	☐	☐
12. Caregiving is a financial strain	☐	☐	☐
13. I feel completely overwhelmed (E.g.: I worry about the person I care for; I have concerns about how I will manage)	☐	☐	☐

SCORE: ☐

Brown Medicine's ADC Program

April 2022

ZARIT CAREGIVER BURDEN EXAMPLE

	Never	Rarely	Sometimes	Frequently	Nearly Always
1) Do you feel stressed between caring for your relative and trying to meet other responsibilities for your family or work?	0	1	2	3	4
2) Do you feel embarrassed you're your relative's behavior?	0	1	2	3	4
3) Do you feel angry when you are around your relative?	0	1	2	3	4
4) Do you feel that your relative currently affects your relationship with other family members or friends in a negative way?	0	1	2	3	4
5) Are you afraid what the future holds for your relative?	0	1	2	3	4
6) Do you feel strained when you are around your relative?	0	1	2	3	4
7) Do you feel that you do not have as much privacy as you would like because of your relative?	0	1	2	3	4
8) Do you feel that your social life has suffered because you are caring for your relative?	0	1	2	3	4
9) Do you feel uncomfortable about having friends over because of your relative?	0	1	2	3	4
10) Do you feel that you have lost control of your life since your relative's illness?	0	1	2	3	4
11) Do you wish you could just leave the care of your relative to someone else?	0	1	2	3	4
12) Do you feel uncertain about what to do about your relative?	0	1	2	3	4
13) Do you feel that you should be doing more for your relative?	0	1	2	3	4
14) Do you feel you could do a better job in caring for your relative?	0	1	2	3	4
15) Overall, how burdened do you feel in caring for your relative?	0	1	2	3	4
16) Do you feel that your relative asks for more help than (s)he needs?	0	1	2	3	4
17) Do you feel that because of the time you spend with your relative that you do not have enough time for yourself?	0	1	2	3	4
18) Do you feel your relative is dependent upon you?	0	1	2	3	4
19) Do you feel your health has suffered because of your involvement with your relative?	0	1	2	3	4
19) [illegible] you feel your health has suffered because of your involvement with your relative?	0	1	2	3	4
20) Do you feel that your relative seems to expect you to take care of him/her as if you were the only one he/she could depend on? I am	0	1	2	3	4
21) Do you feel that you will be unable to take care of your relative much longer?	0	1	2	3	4
22) Do you feel that you do not have enough money to care for your relative in addition to the rest of your expenses?	0	1	2	3	4

Scoring Instructions: Add Items 1-12 **Total 1-12 (maximum score = 48)** 35
Add Items 13-21 **Total 13-21 (maximum score = 36)** 30
Score #22 (maximum score = 4) 4

Total Score (88) 69

Source: Zarit SH, Reever KE, Bach-Peterson J. Relatives of the impaired elderly: correlates of feelings of burden. The Gerontologist 1980; 20:649-655.

Actions we have taken to connect them to resources and education:

1. Met with DTR alone and completed caregiver burden index, sent email with following points summarized…
2. There is a lawyer who you've been working with to do the LTSS Medicaid application process but will need to still gather the supporting documents
3. Have applied for Cranston Day program and if they need a medical release form, please have them or you can send to me, and I will get MD to sign it.
4. Alzheimer's Association. Please go to www.MyAlzTreatment.com [myalztreatment.com] and also you can call to try to get a Dementia Care Coordinator @353-0317 who can help navigating some things and has caregiver support groups and information.
5. The Cost-Share program which she may qualify for (while she is waiting for Medicaid…not sure if they let you apply for 2 things, but you can ask) you should call the POINT at 211 and tell them you are looking for information about Cost-share at home. https://oha.ri.gov/resources/home-care/home-cost-share [oha.ri.gov]
6. Enrollment in GUIDE Program
7. Caregiver outreach weekly check in call or email

Outcomes:

Pt does go 5x per week to adult day center.

Discussed in interdisciplinary rounds meeting recommendation was for PACE referral.

Medicaid LTSS under review/unclear due to PT owning property

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ADVANCING INTEGRATED HEALTHCARE

PACE-RI

Refining Care Partner Education and Resource Provision

Practice Facilitator: Suzanne Herzberg

Care Transformation Collaborative of RI

Patient background:

Age	87 years old
Brief Medical History	Dementia with history of behavioral disturbances (FAST 6C), depression; congestive heart pacemaker; diabetes with neuropathy, CKD stage 3,; hx of fracture to left pubic and humerus.
What Matters	Staying in the community
Living arrangements	In a private home with daughter and son in law
Dementia stage (early, mid, late)	Mid/late

Care partner background

Age and relationship to patient	Mid 60s. Daughter
How we identified the care partner	Identified at intake as caregiver
How we assessed the care partner's needs assessed and any screenings/results.	Part of SW assessment. Zarit tool (Current score 1. Previously 6)
What matters to the care partner?	Keeping mom at home as long as possible.
Care partner's current work situation	Recently retired.
Living arrangements (do they live with patient? If not, how far away are they?	Currently living together. Last year, ppt had been in a memory care ALF but went to daughter's home for the weekend.
Areas of concern: medical, social, financial	Medical- progression of disease

Actions we have taken to connect them to resources and education:

-Participant comes to Day Center 5 days week

-Options for periodic respite stays (Just recently, daughter was able to get away for a week)

-Attends PACE Caregiver Support Group (was also part of Focus Group)

-Social Worker provided Alzheimer's Association information (website)

-Social Worker provided support group information from Hope Health re virtual support groups

Outcomes:

With PACE support to caregiver, she was able to bring her mother back to living with her full time. This is less stress on both mother and daughter. Mother has less anxiety when at the Day Center with a more consistent routine. Daughter's Zarit score had been a 6 (we suspect that she minimized stress). In September her score was a 1.

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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ADVANCING INTEGRATED HEALTHCARE

Participating Practices PDSAs

Care Transformation Collaborative of RI

University Internal Medicine

Applying for Level 2 Recognition

Provider Champion: Cheryl Davis, RN, NCM
Site Supervisor: Addie Fandetti
Practice Facilitator: Jayne Daylor

University Internal Medicine

Summary of PDSA: We are implementing our process for identifying, assisting and supporting caregivers of patients with dementia.

1.- Our providers will refer a patient and their caregiver to the NCM.

-The NCM will call a patient/caregiver from a created list with a diagnosis of cognitive impairment related to dementia

2. NCM will speak to caregiver, receive permission to have a Caregiver form with their information on file and scan it in patients' chart(and /or enter their name in patient demographics)

3. Patients caregiver will be asked what is important to them, resources in place, recent changes in patient and assess caregivers stress level

4. Resources will be provided. The Alzheimer's Association is faxed or emailed information about the caregiver on a referral form and they contact the care giver and send a report back to the NCM to inform our office what has been discussed.

5- NCM makes follow up call and assesses what has been done. NCM checks in periodically and follows up as needed.

Barriers/successes: We have had success with the calls and the caregivers are very grateful that they are being provided with help and being able to express their needs. There is need for more assistance with help at home benefits for patients and their caregivers

How are you identifying caregiver needs? NCM or Provider speaks to them assessing how they are doing caring for the patient

What strikes us as most interesting or valuable about this work? The amount of need there is for this is most valuable and that caregivers do not know about the resources is interesting

Breakwater Primary Care

ADVANCING INTEGRATED HEALTHCARE

Applying for Level 1 Recognition

Provider Champion: Gregory J. Steinmetz, MD

Site Supervisor: Jamie Handy

Practice Facilitator: Jayne Daylor

Identify care partners of patients with dementia and provide support, information, etc. PDA

Barriers/Success:

- Barriers: Initial collection of care partner information was inconsistent and not standardized within the Electronic Medical Record (EMR) system.
- Successes:
  - Developed a standardized method for documenting care partner information in two specific EMR fields: the warning tab and the Next of Kin tab.
  - This process was communicated to all staff during the monthly meeting on 10/7/24.
  - As of 10/11/24, successfully identified and documented five care partners.

Identifying Caregiver Needs:

- Plan Implementation:
  - Reviewed patient charts to assess current documentation practices.
  - Engaged in discussions with the Practice Manager and Physician to finalize the documentation approach.
  - Medical Assistants (MAs) tasked with updating information in the specified EMR fields.
- Next Steps:
  - Utilizing the Stress Thermometer tool to address the emotional and support needs of care partners.

Most Interesting/Valuable Aspect:

•The integration of care partner information into easily accessible and reportable EMR fields streamlines communication and ensures comprehensive support for patients with dementia. This proactive approach not only enhances the quality of care but also emphasizes the importance of caregiver well-being in the overall treatment plan.

Family Care Center

ADVANCING INTEGRATED HEALTHCARE

Applying for Level 2 Recognition

Provider Champion: Joanne Wilkinson, MD
Practice Facilitator: Christine Ferrone

Care New England

Summary of PDSA:

1. Explore available options for documenting care partner information in the EMR using structured data fields that will enable the practice could generate a care partner report for patients with dementia ICD codes.
2. Additionally, we are testing a process for providers to utilize community health workers to complete/submit referrals and be the liaison between patient/partners and the PCP and/or NCM.

Barriers/successes:

1. Our EMR system (EPIC) does not yet have the structured field in which to document care partner information. It is currently being documented in provider notes and sometimes in the "FYI" tab, which can be clinically helpful (but is not standardized) and not currently data-friendly for a report.
2. This process should work well once it's up and running, but we just started 2 weeks ago.

What strikes us as most interesting or valuable about this work?

Process of trying to move from clinically helpful to standardized and data-friendly can be a struggle; important to keep in mind what is most meaningful and helpful for patients and families.

Welcome our Subject Matter Expert!

Aura Medina is a mother, wife and caretaker. She has a 20-year long experience in the Long-Term Care Field. She has a comprehensive knowledge of Long-Term Services and support programs, Medicare, Medicaid and various State and Federal Social Service Programs. As the POINT Network Manager/ Aging and disability Resource Center Aura oversees a team that handles over 60,000 calls a year providing support and guidance to the aging and disabled adult population in the Rhode Island.

Aging & Disability Resource Center

RHODE ISLAND OFFICE OF HealthyAging

Point United Way of Rhode Island
Rhode Island's Free Aging and Disability Resource Center

The Point, Rhode Island's Aging & Disability Resource Center (ADRC)

The Point, Rhode Island's Aging and Disability Resource Center (ADRC) is a statewide resource that provides information and assistance to seniors, adults with disabilities, and their caregivers based on individual needs and preferences.

- Implemented at United Way in March of 2010
- The POINT is fully funded by RI Office of Healthy Aging
- Specialized information and referral services, person centered options counseling, application assistance for older adults, adults with disabilities, and caregivers
- Point team houses Community Resource Specialist and MyOptions Advisors provide assistance with enrollment into Long Term Services, Home & community care, Medicare and Medicaid, prescription drug programs, advantage health insurance plans, information for both public and private long-term care, housing options, and veteran benefits
- Over 50,000 contacts a year

Point United Way of Rhode Island
Rhode Island's Free Aging and Disability Resource Center

The Point Rack Card Outline

The Point offers valuable information and assistance for you and your loved ones about:

- Long Term Services
- Home and community-based care
- Access to public assistance programs such as Medicare, Medicaid, SNAP, Heating and Utility Assistance
- Resources for caregivers and their families
- Assistance with planning for Memory and Cognitive Care
- Information and answers to your COVID-19 questions
- Information regarding other valuable resources in the community

- The Point is a free and confidential service. Call us today to get the information and assistance you need - 401-462-4444.

Point United Way of Rhode Island
Rhode Island's Free Aging and Disability Resource Center

The Point Community Visits

- You can often find us out in the community as well at community visits, office hours, outreach and with our 211 Partners

- Through different methods we conduct several outreach events to educate, empower, support, and assist those community members that are not able to come to us or are not aware of all the help that they could get

Point United Way of Rhode Island
Rhode Island's Free Aging and Disability Resource Center

Senior Disability Services

- **POINT Call Center –** Rhode Island Aging & Disability Resource Center, a statewide call center
- **Person Centered Options Counseling (PCOC)** – working with the Office of Health and Human Services and Office of Healthy Aging to help individuals and caregivers make informed decisions regarding their long term and home care services
- **Medicare & Medicaid Enrollment Program (MME)** – Unbiased Options Counseling for Medicare & Medicaid Beneficiaries, known as “duals”
- **Benefits Enrollment Center (BEC)** – Enrollment Program for Medicare Beneficiaries in Medicaid, Supplemental Nutrition Assistance Program (SNAP), Medicare Savings Program (MSP), Extra Help, Low Income Home Energy Assistance Program (LIHEAP), and more
- **Medicare Information Assistance and Awareness (MIAA): SHIP/SMP/MIPPA –** Unbiased information and education provided to Medicare beneficiaries about all of their options. Educates and empower beneficiaries to protect, detect and report healthcare fraud and abuse. Enrollment assistance in Medicare assistance programs.

Point United Way of Rhode Island
Rhode Island’s Free Aging and Disability Resource Center

Senior Disability Services (Cont.)

- **After Hours Crisis Line** – 4:00 p.m. to 8:00 a.m. Monday to Friday and 24 hours on the weekends and holidays intake services for Office of Healthy Aging Protective Services Unit
- **Lifespan Respite Grant** – Managing the Family Caregivers Alliance to support caregiver across Rhode Island, in partnership with Diocese of Providence, RI College/URI/New England Tech/Salve Regina school of Nursing and Healthcentric Advisors
- **HSRI Navigator Program** – Unbiased information and enrollment services for health coverage offered through the RI Marketplace
- **SNAP Outreach (SNAPOR) –** Conduct educational outreaches to promote the SNAP Program. Application assistance is also provided
- **Medicaid Enrollment & Renewal –** Assist with Medicaid renewal and application
- **Medicaid Outreach** – New grant from CVS to develop direct contact with pharmacies for Medicaid applications and renewals

Home Care – Cost Share Program

- Older adults who do not qualify for Medicaid LTSS may be eligible for in-home supports, adult day health programming and/or Assisted Living Services, including the @Home Cost Share, a program administered by the Office of Healthy Aging (OHA), a division of the Rhode Island Department of Human Services (DHS).
- Rhode Island residents over the age of 65 & 18-64 with Dementia/Alzheimer related conditions
- There are eligibility income limits, but no assets limits
- A person must be unable to leave the home without considerable assistance and must require help with daily living activities
- Can be approved for up to 20 hours per week with a co-pay between $4.50 to 7.50 an hour or $15.00 a day for adult day program
- FY 2023 Gross Income Limits: $36,450 max for a single person and $49,300 max for a couple

SHIP Services

- The State Health Insurance Assistance Program (SHIP) is a federally funded, state-based program.
- SHIP provides free unbiased counseling and assistance (via in-person or telephone) to Medicare beneficiaries navigating the world of Medicare.
- There are currently fifty-four (54) SHIP grantees to include all fifty (50) states, Puerto Rico, Guam, DC and the US Virgin Islands.
- SHIPS are either located in a State Unit on Aging or in the State Departments of Insurance.
- The Office of Healthy Aging (RI's State Unit on Aging) oversees SHIP for the State of Rhode Island.

SHIP
State Health Insurance Assistance Program

Point United Way of Rhode Island
Rhode Island's Free Aging and Disability Resource Center

We are all Caregivers

- Our team have personal connections to what we do
  - Parents with Alzheimer's, Cancer, hospice care….
- We ADVOCATE for ALL!
  - Person Centered Options Counseling

- Client stories:
  - Home visit for Medicare understanding and set up
  - Respite for Caregivers
  - Emergency help for family that lost everything in a fire
  - Help with 90 year old mom who wants to stay at home

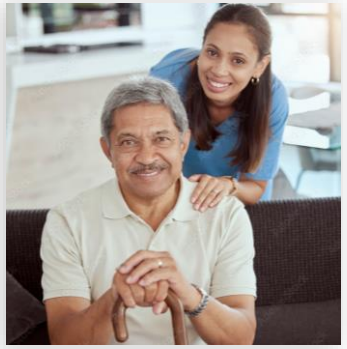
To Access Services

- POINT phone number is **(401) 462-4444**
- **Contact center** is open Monday through Friday 8:30 a.m. – 5:00 p.m., after hours appointments can be schedule upon request and availability
- **Multilingual staff**: English, Spanish and Portuguese with access to nearly **200 languages** and dialects
- **24/7 intake/triage** through the 2-1-1 call center
- **Walk-in services** 8:30 a.m. – 4:30 p.m.
- MyOptions – Web intake https://myoptions.ri.gov/
- UWRI Website -- https://www.unitedwayri.org/get-help/point/

The POINT is funded by the Administration for Community Living and the Centers for Medicare and Medicaid Services, in partnership with the Rhode Island Office of Healthy Aging.
This institution is an equal opportunity provider.

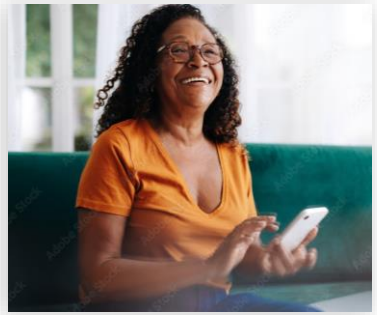
RHODE ISLAND OFFICE OF HealthyAging

Point United Way of Rhode Island
Rhode Island's Free Aging and Disability Resource Center



Thank You.

United Way of Rhode Island
50 Valley St., Providence, RI 02909
(401) 444-0600
info@unitedwayri.org
https://www.unitedwayri.org/get-help/point/



Support Our Work:

Point United Way of Rhode Island
Rhode Island's Free Aging and Disability Resource Center

Questions?

Point United Way of Rhode Island
Rhode Island's Free Aging and Disability Resource Center

Welcome our Subject Matter Expert!

Robyn Earley is a Speech-Language Pathologist and health care administrator who received her BA in Speech-Language Pathology from the University of Florida and her MA in Communication Sciences and Disorders from San Diego State University. She has over 20 years of experience as a healthcare leader in a variety of settings including long-term acute care, subacute rehab, outpatient, home health, hospice, long-term care and senior housing. Robyn served as the founder and head of a large Speech-Language Pathology and Audiology team at a Harvard Medical School-affiliated healthcare continuum. Robyn also developed and successfully pitched the adoption of an employee wellness plan to her healthcare organization as part of an executive training program. Most recently, Robyn worked in business development and as a clinical specialist for an established mobile healthcare company. During her tenure specializing in swallowing disorders, Robyn found many patients with high levels of stress and anxiety had physical problems such as trouble swallowing. After recommending deep breathing exercises, Robyn found that patients had considerable relief and had an improved physical response. This led her to study the impact of mindfulness on older adults. In 2019 Robyn completed the Mindfulness Based Stress Reduction course. Shortly thereafter, Robyn founded Oria Mindful a program that improves access to mindfulness meditation for older adults. Currently, Robyn serves as the Chief Clinical Officer for CareLink a growing non-profit healthcare network providing post-acute and community-based care for older adults and adults with disabilities. Robyn is a recent graduate of the Leadership Rhode Island's Tau II class. In her spare time, Robyn serves on the board of the Rhode Island Speech Hearing Language Associate, is a competitive sailboat racer serving as the Commodore of Twenty Hundred Club and is an outdoor enthusiast.

Age-Friendly EBP Support

Robyn Earley MA, CCC-SLP, CDP

Chief Clinical Officer, CareLink RI

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November 5, 2024

Welcome

Evidence-Based Dementia Therapy Programs

Care EcoSystem Model

Functional Mobility Assessment

Questions

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Evidence-Based Dementia Therapy Programs

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Skills2Care® (S2C)

- Evidence-based intervention
- Addresses behaviors that negatively impact the individual living with dementia and their caregivers
- Treatment provided by specially trained Occupational Therapists
  - teach caregivers how to manage the day-to-day challenges of dementia
  - through education, skill-building, and environmental strategies

- Program content includes:
  - Understanding dementia
  - Reducing challenging behaviors
  - Promoting function
  - Communicating effectively
  - Making the home safer
  - Caregiver self-care

Skills2Care Outcomes

- Improvements noted in:
  - Caregiver confidence in managing challenges associated with ADRD
  - Caregiver understanding of disease process
  - Caregiver knowledge of community resources
  - Caregiver depressive symptoms
  - Overall well-being
  - Perceived change in their life
  - Emotional and behavioral functioning

Skills2Care Data

316 participants enrolled in this program

Outcome Measure	Data
Perceived Change Scale (PCS)	89% of participants demonstrated improved caregiver self-efficacy after intervention
Revised Memory and Behavior Checklist (RMBC)	• Significant reduction in "reaction score" which represents how upset/bothered they were by the problems *This data indicates improved caregiver coping strategies and behavioral management techniques as a result of this intervention

Cognitive Stimulation Therapy® (CST)

- Evidence-based intervention
- Group format; 2x/week x 7 weeks
- Facilitated by specially trained Speech-Language Pathologists and Occupational Therapists
- Addresses memory, thinking skills and quality of life using standardized, themed sessions
- Designed for individuals with mild to moderate Alzheimer's Disease and Related Dementias (ADRD)
- Sessions include a range of activities to stimulate thinking, memory, and social connections
  - discussing current news stories
  - listening to music or singing
  - language-based activities
  - practical activities such as baking
  - critical thinking activities
  - group games
  - light exercise

CST Outcomes

- Renewed interest in activities outside the home
- Improved orientation
- Improved carryover of new information
- Increased social connections
- Improved mood and quality of life
- Improved functional communication

CST Data

186 Participants enrolled in the program

*Data reveals that participants benefited from the intervention, experiencing improved quality of life, cognitive abilities, and emotional functioning. Some participants continued to decline in various areas due to the nature of the neurodegenerative disease process.

	DEMQOL	DEMQOL (30 days post)	DEMQOL – PROXY	DEMQOL – PROXY (30 days post)
Improved	38	12	13	3
Decline	19	8	15	4
No change	4	1	2	0

Referrals to Center for Brain Health and Cognition

Evidence-Based Program

- Specialized assessment of cognitive-communication and cognitive functional related to ADLs and IADLS
- Addressing behavioral manifestations
- Providing specific tools for Caregivers to support remaining in the community

Individuals Served

- Older adults with a change in cognition, individuals with Primary Progressive Aphasia and individuals with Intellectual and Developmental Disabilities

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Referrals

Email healthservices@carelinkri.org

Fax to 401- 432- 6687

For more information contact Kelsey Akinsinde:

401-490-7610 ext. 116

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Care EcoSystem Model

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2024 ACL ADPI Grant

- The new 3-year ACL ADPI will focus on enhancing and sustaining RI's dementia-capable Home and Community-Based Service (HCBS) system by delivering person/ caregiver dyad-centered care navigation implementing the Care Ecosystem Model utilizing Community Health Workers (CHW)

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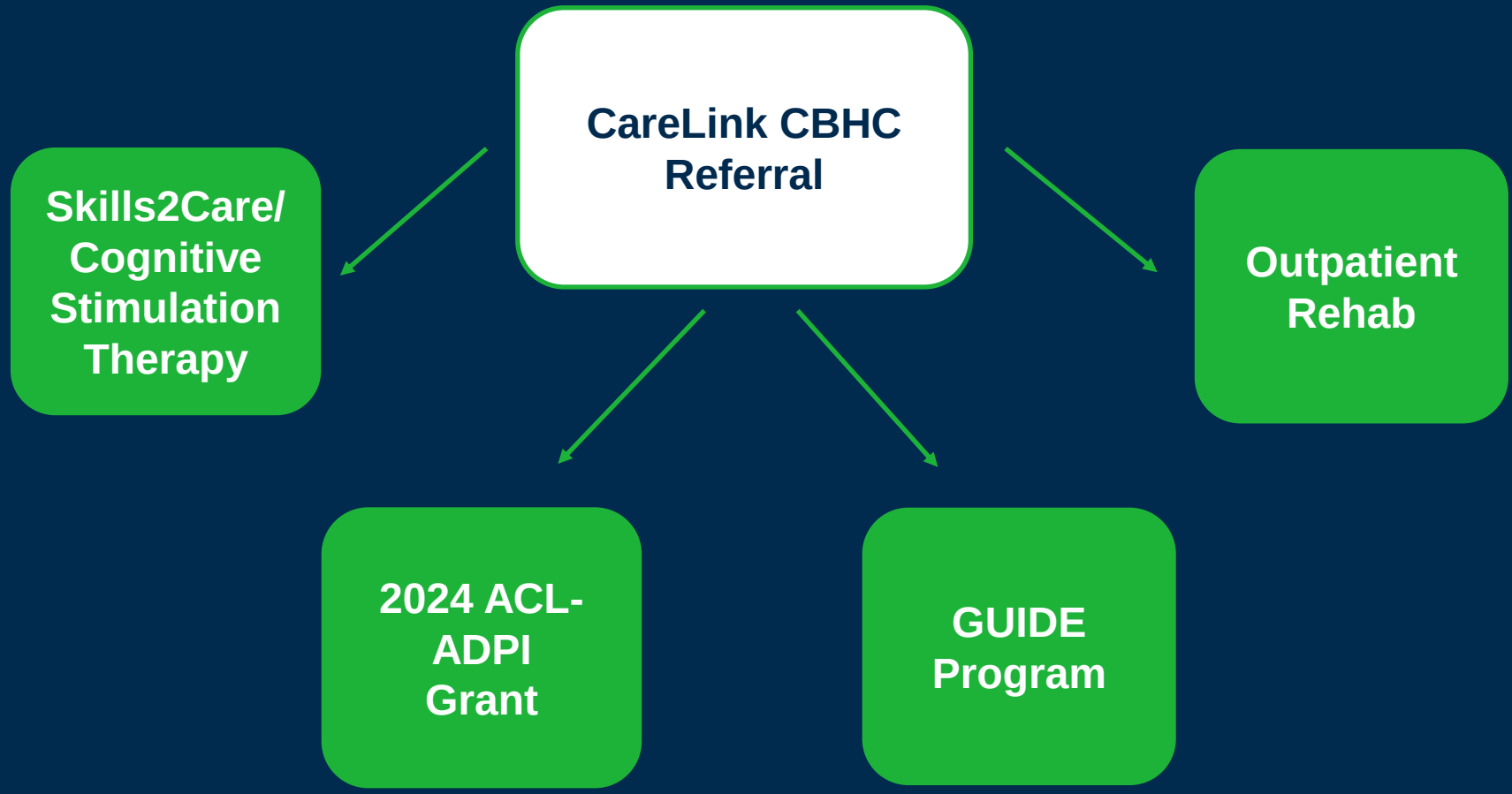
Care Ecosystem

Designed to help address unmet needs for persons with Dementia and their caregivers

This model includes:

- Care team navigators (CTNs)
- Clinicians with dementia expertise (nurse, pharmacist, SLP, OT)
- Care protocols
- Curated information and resources

Referral Process



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Functional Mobility Assessments

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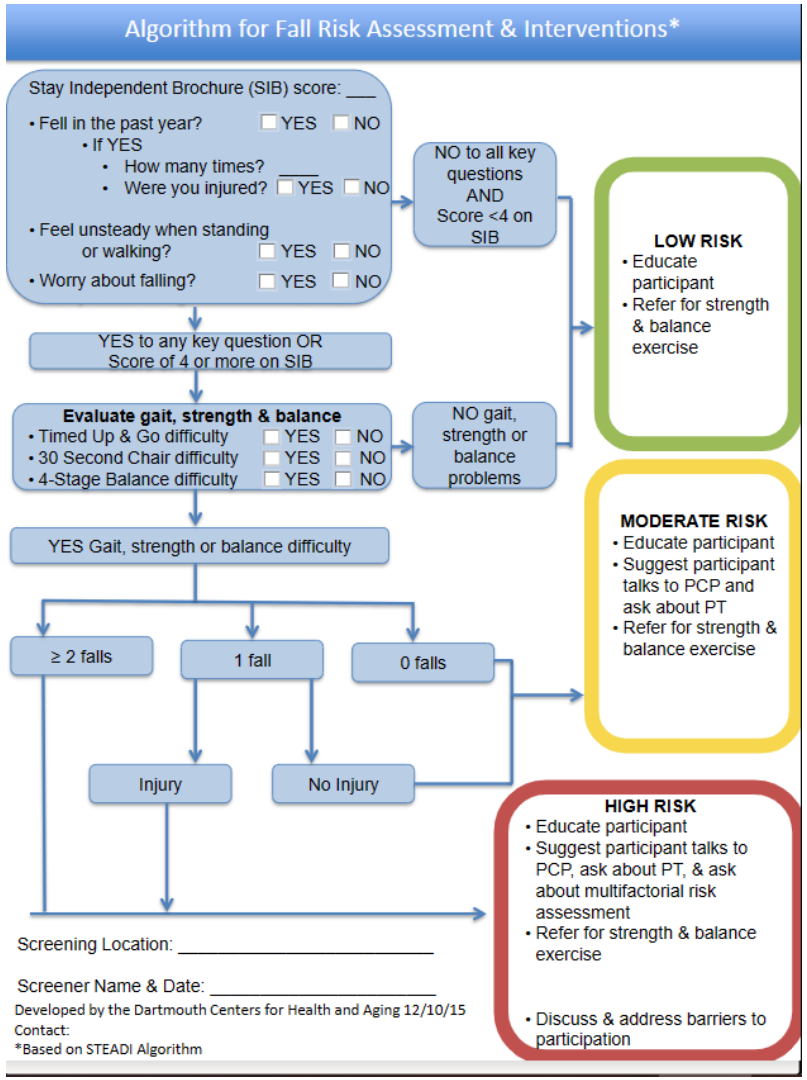

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STEADI Protocol

- Stay Independent Brochure (SIB):
  - Answering yes on any key questions or a score greater than 4 on the SIB questionnaire
  - https://www.ncoa.org/tools/falls-free-checkup/
- Timed Up and GO (TUG)-recommended: mobility, balance, walking ability and fall risk
  - https://www.cdc.gov/steadi/media/pdfs/steadi-assessment-tug-508.pdf
  - Video link: Timed Up and Go video training
- 30 Second Chair Stand (Optional)-functional lower extremity strength
  - https://www.cdc.gov/steadi/media/pdfs/STEADI-Assessment-30Sec-508.pdf
  - Video link: 30 Sec Chair stand video training
- 4-Stage Balance Test (Optional)-static balance
  - https://www.cdc.gov/steadi/media/pdfs/STEADI-Assessment-4Stage-508.pdf
  - Video link: 4 stage balance test video training

Functional Mobility Assessment

Tinetti or the Performance-Oriented Mobility Assessment

Measure of balance, gait and fall risk

On-line scoring tool:

https://neurotoolkit.com/tinetti/

Video link: TInetti (POMA) training video

CareLink

- Center for Brain Health and Cognition
- Physical, Occupational Therapy and Speech-Language Pathology-specialized outpatient services
- Wellness Programs-Focus on Fall Prevention and Social Isolation and Loneliness-both in congregate care and in community/senior centers

Referrals: healthservices@carelinkri.org

For more information:

Robyn Earley
rearley@carelinkri.org
617-694-7799

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Discussion, Questions, & Next Steps

Wrap up Learning Collaborative:

- February 20th, 2025, 7:30 AM - 9:00 AM

Post Assessment Due:

- February 13th, 2025

Level One: View Milestone

- Final PDSA, presentation template due February 13th, 2025

Level Two: View Milestone

- Case study template and final presentation template due February 13th, 2025

THANK YOU

Debra Hurwitz, MBA, BSN, RN
dhurwitz@ctc-ri.org