

The Lewin Group
Delivering Dementia Capable Care within Health Plans: Why and How?
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Caroline Loeser: Thank you. My name is Caroline Loeser. I am with The Lewin Group. Welcome to the webinar, Delivering Dementia Capable Care within Health Plans: Why and How? Today's session will include a 60-minute presenter-led discussion followed up with 30 minutes for a discussion among the presenters and participants. This session will be recorded and a video replay and a copy of today's slides will be available at www.resourcesforintegratedcare.com.

The audio portion of the presentation will automatically stream through your computer. Phone lines for this presentation are also available. To access the number click the black phone widget at the bottom of your screen.

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On the next slide you will see the disclosure statements of the planners and faculty for this webinar.

Here we have laid out the various continuing education requirements for both social workers and nurses. You can obtain continuing education credits through NASW if you complete the pretest at the beginning of the webinar and complete the post-test. Additional guidance about obtaining credits and accessing the links to the pretest and post-test can be found within the Continuing Education Credit Guide in the Resource List on the left-hand side of your screen or at the Resources for Integrated Care website.

This webinar is supported through the Medicare-Medicaid Coordination Office at the Center for Medicare and Medicaid Services. MMCO is helping beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high quality healthcare that includes the full range of covered services in both programs. To learn more about current efforts and resources please visit our website or follow us on Twitter for more details. Our Twitter handle is [@integrate_care](https://twitter.com/integrate_care).

At this time I would like to introduce our moderator. Carol Regan is a Senior Advisor to Community Catalyst Center for Consumer Engagement and Health Innovations and has over 30 years of experience with national and state-based public policy and advocacy organizations. Carol?

Carol Regan: Thanks, Caroline. Welcome everyone. I am thrilled to be continuing to work with The Lewin Group and MMCO on these really important webinars. Part of our work at

Community Catalyst is committed to helping vulnerable adults and improve the care for older adults in this country. This is part of our commitment to doing that.

I am going to introduce our speakers and then we are going to do some short polls, talk about the agenda and I will turn it over to folks. I am going to introduce everyone now and they will go to the next person after they speak.

We have an incredible lineup of faculty here. Dr. Christopher Callahan is a Professor of Medicine at Indiana University School of Medicine and he is the Chief Research and Development Officer at Ezkenazi Health in Indianapolis, Indiana. He serves on the Faculty of the Indiana University School of Medicine for 30 years. His clinical practice in Indianapolis focuses on the care of older adults with depression and dementia. He is also a scientist at the Regenstrief Institute and is the Founding Director of the Indiana University Center for Aging Research, now in its 22nd year of operation.

Dr. Callahan conducts observational and interventional research to improve the care of older adults with dementia and depression in primary care settings. This work includes clinical trials, exploring new models of care, seeking to improve the care of vulnerable elders. These models increasingly focus on the integration of family and community and medical services. We are delighted to have him join us today.

The next speaker will be Dr. Debra Cherry who is a Clinical Psychologist. She completed her PhD in Clinical Psychology at the University of Southern California and went on to complete a post-doc fellowship in Geriatric Psychology at UCLA's Neuropsychiatric Institute where she serves on the faculty. Debra is the Executive Vice President of Alzheimer's Los Angeles, a community-based, non-profit dedicated to supporting people living with dementia and their caregivers.

Throughout her career Dr. Cherry's work has focused on improving access to dementia care for underserved, ethnic communities. She has published numerous articles on this work including practice guidelines for primary care providers. She serves on several advisory bodies including an Advisory Council on Alzheimer's Research Care and Services in the State of California's ADRC Advisory Council. She is the past recipient of the Rosalyn Carter Leadership in Caregiving Award, granted to recognize individuals for leadership and innovation in caregiving.

Next we will have Megan Dankmyer who has a Master's of Science in Gerontology from the University of Laverne and has worked for managed care organizations for 20 years in a variety of roles. In the early part of her career she worked directly with members conducting in-home assessments with older adults and their caregivers. Over the last ten years Megan has worked in a management role at health plans that serve Medicare, dual-eligible and Medicaid members.

She also has a background in long-term services support and in linking members to services that allow them to live in the setting of their choosing as long as possible. She joined Molina Healthcare in California in April of 2014 and she currently serves as the Associate Vice President of Case Management.

Our final speaker will be Katie Scott who is the Senior Director of Dementia and Caregiver Support Services at Baker Ripley. She holds a Master's of Public Health Degree and Health Promotion and Behavioral Sciences from the University Of Texas School Of Public Health and she has worked in dementia care for over 10 years. She served as the Project Director for the Houston Alliance to Address Dementia, Texas Takes on Dementia and Dementia Connections and three administrations of community living-funded projects focused on improving the region's capability to serve people with dementia.

Katie also serves as the Director for the Baker Ripley Dementia Day Center which is the first dementia-specific adult day center in Houston and is a Director for their case management and caregiver support work.

So you can see we have an incredible group of faculty. Next slide.

I just want to review quickly the learning objectives for this webinar to recognize how cognitive impairment and dementia impact older adults and caregivers, identifying opportunities to reduce the high healthcare and societal costs of dementia, to recognize key features of dementia-capable systems and what that means and what quality dementia care coordination is, and then identify key approaches for health plan collaboration with patients, family caregivers and community organizations. Next slide.

This is the agenda for today. We are going to do some poll questions and then you will hear all of the speakers address their particular areas around capable, an overview that Dr. Callahan will provide some strategies and tools to improve dementia care in the financial alignment initiatives in California and how Texas is implementing its dementia program. At the end we will have a good amount of time for a question and answer session. Next slide.

So what is really important for us is to know who is on the phone and who is joining us for the webinar. If you can quickly answer, "What setting do you work?" If you work in more than one what is your primary setting in where you work; health plan, ambulatory care? You can see the list here, community-based organizations. So just one more second. Great. Okay. Let's see what we have learned about who is on the webinar.

Terrific, great. We can see that almost 70% are from health plans, a few from ambulatory care, long-term care setting and great, 10% from community-based organizations. Wonderful. Alright, our next poll, "Which of the following best describes your professional area?" Again, if you work in a number of fields or areas what is your primary professional area? Great. One more second. Terrific. Okay, let's see who we have on. Okay, almost half are with health plans and managed care coordinator. Other people work in health plan management, administration and then about 8% are clinical providers. Wonderful. Thank you. Next slide.

Alright, now it is my pleasure to turn it over to Dr. Christopher Callahan. Chris?

Christopher Callahan: Thank you and good afternoon, everyone. I just want to express my thanks to all of you who are on the phone for your work in this area and interest in this area because it is such an area of high need. I am going to give kind of a mile-high overview that is

designed to provide the rationale for the new models of care and the implementation of those new models that you are going to hear later in the presentation. Can we go to the first slide?

I think most of us are aware that millions of people will develop Alzheimer's disease but one of the things we would like to point out is that most of these numbers you see on the slide here represent people who are already alive and have already survived to the age of 65. So this is a population that we are not estimating or projecting will grow. We are going to see a lot more Americans with Alzheimer's disease and that is one of the reasons why we have some urgency about improving our care. The next slide.

One of the disappointing things I am sure many of you have heard over the past 10 years or so is that there are no known medications to prevent, cure or slow the progression of Alzheimer's disease and other dementias. Sadly there has been over 100 drugs tried which have failed in clinical trials. Sometimes this makes us feel a bit pessimistic about what can be done but I think what you are going to learn today is that there is so much more we have to offer persons living with dementia and to their families. Next slide.

When we talk about people living with dementia we are talking about people who might be living with this disease for over a decade. In this slide I have put the light-blue arrow by the group who at baseline already had moderate to severe dementia. You can see that almost half of those people living with dementia are still alive at five years. When we think about earlier and earlier recognition and diagnosis of these conditions then we start to see that these people are our neighbors and family members and they will be living with us and in our community for a decade or more and it provides a little of the rationale for why we need to redesign not only our healthcare system but also our communities. Next slide.

Dementia is among the costliest conditions in the U.S. We have provided a lot of information on this slide. I would like to just bring your eye to the second bullet; that over 1 out of 4 patients with dementia receive both Medicare and Medicaid benefits. We often think of those dual-eligible, older adults with dementia as residing in nursing homes and many of them do but really over the past few years we have increasingly seen that again many more of those persons living with dementia are receiving community-based services that are provided in their own home.

We also have to remember that many people with dementia also have other chronic conditions and ailments that are more common with older adults and it is typically those comorbid conditions that are responsible for a large percentage of the healthcare costs. Next slide.

One of the sad issues around the cost of dementia is that it is increasingly pushing some families into poverty. If we look at just the Medicare expenditures for dementia compared to other chronic conditions like congestive heart failure or chronic obstructive pulmonary disease those Medicare expenditures are similar but we see dramatic differences in the out-of-pocket costs. These include things like co-insurance and deductibles but they also include just day-to-day issues such as hiring people to assist with dressing or personal hygiene and then other more day-to-day issues like absorbent pads or other supplies that one might have to keep in the home.

What has been particularly striking is that these out-of-pocket medical expenses are pushing some families into poverty and because so many of the caregivers are women, spouses and daughters one of the things we see is that these expenditures on the person living with dementia reduce the intergenerational wealth transfer. So in other words these are savings that aren't available to the daughter or the grand-daughter or the great-granddaughter. Next slide.

We know that medical care for dementia falls short. Too few people have their cognitive impairment recognized. Even when it is recognized it is not often evaluated according to current guidelines. Even with people are evaluated their provider often doesn't tell them about the diagnosis or educate their family about the diagnosis. We see too often these patients are prescribed medications that may not be in their best interest. Next slide.

One of the things that we also see that makes medical care for these patients so difficult is they have frequent transitions. Again, many of us had the idea that as the dementia progresses patients inevitably move to a nursing home and they live out their days in that nursing home but that is not at all what happens with persons living with dementia. They move between their home and the hospital and subacute rehabilitation. They go back to the home and back to the hospital. This ping ponging across sites of care puts a great deal of strain on the patient and the family and their providers. Next slide.

Another sort of mile-high recognition that has been true for 100 years and we suspect it is going to be true for the next 100 years is that families provide the majority of care. We are recognizing more and more that the persons living with dementia are often adapting their own lives and their own homes to be able to provide their own care for many years. But when we look at persons that now require a caregiver these are typically going to be women and they are going to be the family members. Those families are going to provide billions of hours and billions of dollars in unpaid care. Next slide.

When you put all of these first issues together the large number of persons living with dementia in our communities who are largely cared for by their families then we can see we need systems of dementia care that better reflect those realities. Most of this is going to be provided through support for caregivers. We can do more to improve the quality of medical care but we need to do much more to coordinate the care across the different sites of care and particularly with the community-based organizations. Next slide.

When we look at these new models of care if you focus your attention on the left side of this diagram with the colored boxes you will see that these programs typically try to do one of three things; to improve the quality of the caregiver support, to improve the quality of the medical care or improve the coordination with community resources. What we are going to hear about today are the programs that try to do all three. The reason that they do all three is depicted in the middle part of this diagram.

We believe if we can decrease caregiver stress and we can decrease the troublesome neuropsychiatric symptoms of the patients then we might be able to decrease the rate of cognitive decline and in particular functional decline. That might lead to a decrease in

hospitalization and nursing home use. That might lead to a decrease in healthcare costs but also an improvement in the patient's quality of life. Next slide.

Now we are going to make a somewhat artificial distinction in these next three slides between medical components of the integrated care models and social components. What I have listed on these slides are what are often viewed as the medical component, the things that are done in a medical setting by medical providers. That is to identify people at risk. It may be through case finding or early screening but certainly to diagnose the patient early, to evaluate them for treatable causes or reversible causes. It is so important to discuss this diagnosis and prognosis. This is what we have found in recent years that providers often fall short.

When we have made the diagnosis we of course need to continue to care for the comorbid conditions like congestive heart failure or diabetes and we need to help in the treatment of behavioral symptoms. Some of the models that focus more on these medical components are listed in the box on this slide. Next slide.

In these next two slides we are going to look at things that are perhaps considered more social components but I want to reiterate that quality care includes all of these things. That is to engage the community support agencies. We are relying on these agencies to provide individualized and culturally competent services and they are often in and part of the communities that they serve. We need an individualized care plan that focuses on that particular patient and families' needs with the goal of maximizing independence. We need to discuss advanced care planning and facilitate the kind of physical and social and cognitive activity that we think helps people remain independent for as long as possible. Now some of the models that have focused more on these components of integrated care are shown in the box in this slide. We can move to the next slide.

A few more of these social components and now you are all getting a sense I would think of the complexity of these models and why we need a more systematic approach. We also need to do things like provide guidance to the patient and their family about financial fraud and some of the other risks such as driving and patients getting lost. We see these problems all of the time in clinic. I am sure many of you have seen them in the news. They are terribly tragic and they are completely preventable.

Some of the things that might help are home modifications that can support independence and increase the patient's comfort. These might be very simple things like grab bars or elevated toilet seats and they might be more complicated interventions for the family that wants to go in this direction including technology such as videos and other monitoring devices in the home. It is also important to provide culturally sensitive emotional support to the caregivers but also track the wellbeing and the outcomes of the caregivers. If we have concluded that our best way to take care of an older adult with dementia is through their caregiver. Then we have to take care of the caregiver so they can provide that role. Next slide.

There are evidence-based models for dementia care. Several of these models have been tested in clinical trials and I think you can think of them as proof-of-concept models. The models have shown to improve patient and caregiver symptoms. These models may also delay nursing home use. We are hopeful they can reduce total healthcare utilization and cost but so far there is only

limited evidence that they can decrease costs. Part of that is because these models are, in a way, developed in a greenhouse setting, in a controlled environment and we are just now learning how to take them out of the greenhouse and put them into the real world.

That is what the other speakers are going to talk about this morning. If we know these medical and social components and we know these different players we want to organize into a system of care what does it take to put that into the real world and actually getting it working at scale across an entire community? We also think that we have really underutilized research on home redesign and the incorporation of new technologies and this is an area of active research. Next slide.

I am going to end my comments with what I hope will be a very hopeful note. That is the suggestion that perhaps one-third of dementia cases may be preventable. Now many of these areas of prevention, and I won't go through them on the slide, require us to start changing behavior and our treatment of illnesses and the design of our communities early. These are things that people do over a lifetime, certainly by middle age and into old age in order to decrease the number of dementia cases we will see in the future. That doesn't mean though that we won't be facing what we already depicted on the first slide and that is that we will be caring for millions of older adults with dementia.

I am going to turn the presentation over now to Dr. Cherry.

Debra Cherry: Thank you, Dr. Callahan.

Operator: That line may have dropped. I will grab it as soon as she dials in.

Caroline Loeser: Alright, we will give it another minute. Megan are you with us?

Megan Dankmyer: I am.

Caroline Loeser: Alright. Let's give Debra another minute or 30 seconds to join. Thanks, everyone, for hanging tight.

Christopher Callahan: One of the things that I might add while we are waiting for Dr. Cherry is that a number of these models that have been available for other chronic conditions for many years we refer to as collaborative care models whether it is for diabetes or congestive heart failure. Many of them find themselves in the same situation where we now need to work them into the flow and the design of the health system itself but also the community-based organizations that are waiting and available to help provide services for these patients.

Those community-based organizations are also trying to scale up from their end or to move into the future from their end so that they can more effectively communicate with the healthcare providers. That interface is another area of active research because we think a lot of the services that are being provided at a relatively high cost --

Debra Cherry: Hello, this is Dr. Cherry. I am sorry to have been disconnected. Can I start now?

Christopher Callahan: Go right ahead.

Debra Cherry: Okay. As Dr. Callahan mentioned because people living with dementia have many needs for home and community-based services the Financial Alignment Initiative which blends funding and oversight for medical care with long-term services and supports has the potential to be particularly beneficial to this population. So we will be talking to you today about Dementia Cal Mediconnect, California's effort in the Financial Alignment Initiative and sharing with you some strategies and tools we have used successfully in California. Next slide, please.

Funding for this project was provided by the Administration on Community Living Alzheimer's Program and a grant to the state of California. Alzheimer's Los Angeles managed the project along with two associated Alzheimer's organizations and the three organizations worked with ten health plans in our state's dual pilot. Those health plans are listed on that slide. Next slide, please.

Our indicators for dementia-capable care reflect some of those mentioned by Dr. Callahan. After reviewing the literature and existing clinical guidelines we selected indicators such as better detection and documentation of people living with dementia in the plan, better identification, assessment, support and engagement of family/friend caregivers and better partnerships with community-based organizations. Note I will discuss each of these indicators a little bit more thoroughly and share with you some of the tools we shared with health plans to address these issues. Next slide, please.

Our project had four key activities starting with advocacy. Those of you who are champions within health plans or community-based organizations need to make the case within your own systems about why focus on dementia care. Dr. Callahan provided a lot of that detail. We have also on our website some of the advocacy messaging we used which you can download and use yourselves. We also had to make the case of training the workforce, especially Care Managers, to deliver better dementia care.

Our second activity was health plan technical assistance including helping the health plans think about how to identify people living with dementia. How do you run your administrative data to find them? How do you improve your health risk assessments and put in better care processes or identification and care for the population?

The third activity was Care Manager training. Care Managers are the lynchpin determining what kinds of services these patients would get. We provided 550 health plan Care Managers with eight hours of dementia training and an additional 150 of those Care Managers became Dementia Care Specialists. All of the curriculum are available on our website and we will be giving you that website URL later.

Finally the third activity was helping the health plans either develop their own support services for people with dementia and caregivers or teaching them how to proactively refer to local community-based organizations so that we could provide services like disease education, caregiver skills training or care plans. Next slide, please.

Doing a little bit of a deeper dive into the indicators, the first being better detection of people with dementia. We worked with health plans to improve their health risk assessments. These are screens that many of you know that are administered to all members to assess their health and functional status and we wanted to make certain that each of the health plans we work with had a dementia screen embedded in the health risk assessment; at least one question on cognitive impairment. The questions we suggested are also available on our website.

We wanted each of the health plans to adopt a validated screening tool. We emphasized the AD8 which is an eight item tool that can be administered by telephone; most of the work is done by telephone in California. That could be administered to a family caregiver as easily as to a person with dementia. However, there are other tools and we provide links to them on these slides as well as on our website.

We also wanted the plans to document this cognitive assessment in the medical record and to establish follow-up protocols if the screen was positive. Next slide, please.

Our second indicator was about caregiver identification, support, assessment and engagement. Not all people living with Alzheimer's disease have a family or friend caregiver and not all people living with Alzheimer's disease want to engage caregivers in their care but as these conditions advance people living with moderate dementia develop difficulties in care including problems following medical directions or arriving for appointments. Identifying a caregiver can create a partner for the health plan in working with that individual. Who that caregiver is may not always be clear, especially among the dual and immigrant families. The person who comes with the patient may not be the caregiver but rather may be an English-speaking young person in the family while the person providing hands-on care may be at home or at work.

So we have been providing our health plans with a caregiver assessment tool as well as with validated assessment tools; a number of them appear on this slide, so that they can identify the caregiver, keep their emergency contact information current and then assess the caregiver's stress and whether they need support in certain areas. Next slide, please.

In addition to identification, assessment and support of the caregiver you want to consider identifying the caregiver for their input in the care planning. Care planning ideally should have the patient's input in it. Patient's goals can be really different than healthcare systems goals and patient may see attending a grandchild's wedding as a goal rather than aggressively treating their diabetes. Depending on the circumstances, it's also advisable to engage the family caregiver and care planning because they can alert you to care issues and also can help make sure that medical procedures are done correctly and dates are kept.

Once you have identified patient and the family caregiver part of the care plan should include providing for, or arranging for supports. Community-based organizations can provide these supports, and can do them at often at a lower, or at a plain language literacy level. Next slide please.

This is a list of some of the supports that home and community-based organizations can provide. I'd like to highlight something that we provided in California, which were plain language tip

sheets on the management of challenging behavioral symptoms and common caregiving issues. Those tip sheets cover 15 topics in four languages and are available on our website.

We also encourage health plans to develop a proactive referral forum. If you simply give community-based information, like a resource guide, to the family caring for a person with dementia they will not use it unless there's an emergency and then they may not be able to find it. It is much more effective to ask the family member or the patient if they're early enough in the disease, "Would you like me to have this organization..." could be an Alzheimer's organization, could be an area agency on aging or another community based organization in your community." "Would you like someone from that organization to call you and offer you some support?" Hopefully they will say yes and then you can make a confidential referral; the sample form again available on our website and can be modified for your local area. Next slide please.

Evaluation of our project was done by the Institute of Health and Aging at UC San Francisco. While it looked at a variety of components of our program, the part of the evaluation I would like to highlight to you is the examination of how well the top 10 participating health plans integrated recommended system changes that were viewed as indicators like the adoption of a validated screen. Next slide please.

Ten of the health plans, 10 out of 10, now include at least one question on cognitive issues in their health risk assessments. This is largely a requirement that came to them through our state Medicaid entity. Six of the health plans adopted a validated screening tool and integrated the results of that screening tool into either their E-medical records or their E-care management records. One health plan uses a proactive letter in addition to sharing care plans with the primary care provider to encourage that provider to do a fuller diagnostic workup when the cognitive screen is positive. Obviously doing more than sharing just a care plan would be more productive. Next slide please.

Looking at caregiver identification, eight of the health plans currently document a caregiver in their health medical records, 10 report engaging the caregivers in care planning. However, we know that that in practice is very limited because very few interdisciplinary care teams are actually in place. Three of the health plans have adopted validated screen that measures caregivers stress and integrated them into their e-medical record systems and all 10 plans are making referrals to community-based organizations and speaking just for Alzheimer's Los Angeles, my own organization, we received nearly 900 referrals from health care plans last year and these numbers have grown year after year. Next slide please.

Funding for this, thank you to our funders, especially the Administration on Community Living and our project team and at this point I'd like to turn it over to my partner, Megan Dankmyer at Molina Healthcare. Thank you.

Megan Dankmyer: Oh, great. Thank you Dr. Cherry. So I will go ahead and start. If you can go to the next slide. Great, I will go ahead and start with just giving some background on Molina. So Molina Healthcare has the dual plan in seven of it states. I represent the California health plan and so in California, as Dr. Cherry mentioned, the, MMP plan is the Cal MediConnect plan and in Molina Healthcare of California we currently have almost 600,000 members and of those

members approximately 10,000 are Cal MediConnect members. The MMP plan started back in California in 2014 and that's when staff here at Molina really began meeting with Dr. Cherry and her team to discuss California's approach to dementia capable care and also how we would be compliant with the three-way contract that requires that the plan specially designate care coordination staff and dementia care management. Next slide.

So at Molina we really focused on four different areas as our approach to dementia capable care. We first focused on the care manager training, then the member cognitive screening, caregivers' screenings and then also referrals to community resources and I will dive into these four areas. Next slide.

So the first piece you know that is obviously as important as having this additional training for our case management team. So Alzheimer's Los Angeles offered that training in two different tiers that Dr. Cherry went over. So the tier one is the eight hour training and the tier two training as 12 additional hours. This training was all done by Alzheimer's Los Angeles and was an addition to the training that Molina provides its case management team. All the training that our staff went through they had really positive feedback on really how practical and valuable the information provided and the training is to them and their role. We trained, not just our case managers here at Molina, but we trained other members of the healthcare services team like our transitions of care coaches. That's so important for them as well. Next slide.

This slide goes into more detail about the tier one training. At Molina we had about 48 staff go through this training and it really focused on the fundamentals of cognitive impairment, Alzheimer's and related dementia, really practical dementia care management tips and discussion around mandated reporting, medication management and managing behavioral symptoms which is so important. They trained on the AD-8 that Dr. Cherry mentioned and also the importance of caring for the caregiver and making those referrals to community resources and making sure the members and caregivers are linked to the support. Next slide.

The tier two training is the additional, the folks that they have to attend the tier one training. We had about 30 staff that then went on and also went the tier two training so then they're considered dementia care specialists. It is 20 total hours provided through Alzheimer's last Los Angeles and it really goes into the topics from the tier one training but in a lot more depth. Then once they go through that training, Alzheimer's Los Angeles also provided monthly huddles for the dementia care specialists and that was a great opportunity for them to continue to touch on the skills that they learned in the training. They are able to talk through different case studies and ask for input and really have access to the expertise that the Alzheimer's Los Angeles staff offers. Next slide.

Once they went through the care management training we really wanted to make sure that they had access to the tools that were discussed in the training. I am not sure if there's a delay but if you could go to the next slide, the member cognitive. Okay.

Molina's [HRA] does identify member's memory concerns and asks about any changes in their memory. Then we did add the validated tool, the AD-8, to our clinical software so that our staff could screen members for dementia and the staff are trained to utilize that screening based on the responses in the HRA or other concerns identified. Then Molina did create a letter to notify the

PCP of the score of the AD-8. That letter was created in collaboration with Alzheimer's Los Angeles and so it includes recommendations for the PCP, the need for a complete dementia diagnostic evaluation and other tips for them. Molina decided that this really was best practice and these tools and so we incorporated these tools and the process for all of our members and not just our Cal MediConnect members. Next slide.

The next area of focus is on caregivers screenings. So obviously there's such a huge component to the care for our members and so the HRA and other assessments identify caregivers of individuals with dementia and Molina added the AMA caregiver self-report questionnaire so that the case managers can assess the stress levels of family caregivers and they are trained to utilize that tool when they are interacting with caregivers. Then they then can link the caregivers to appropriate resources like the Alzheimer's Los Angeles or other types of long-term services and support. Our team then engages the caregiver in the care planning process. They include them in the individualized care plan and the care plan really focuses on the member and the caregiver's concerns, like Dr. Cherry mentioned. Really, that is where we want to start is addressing those concerns and that is really the focus of the care plan. Next slide.

Since we have had such a great relationship over the years with Alzheimer's Los Angeles it has really made it easier to test out different pilots. So one of the pilots we started was in January of this year and it is with Shield Healthcare, one of our medical solutions and supply partners. They agreed to begin asking some additional Molina specific questions to our Molina members during their existing intake process. The goal is to identify members who may be in need of case management and/or referrals to Alzheimer's Los Angeles. So staff from the Alzheimer's team did go out to Shield's Healthcare and provided some training on their programs and their resources and then the Shield team began adding some question. They ask about ADLs, if the member has any difficulty with those tasks or if they're speaking with the caregiver they ask the caregiver if they're having any difficulty helping with those tasks. They also ask about medications, trouble remembering medications, and any history of emergency room or hospital visits or falls. Next slide.

The questions that were selected were based on the research of predictors of nursing home placement and then Shield Healthcare sends us those responses on a weekly basis and we go through the responses and we either send referrals onto the Alzheimer's Los Angeles team if the member or caregiver agreed and also refer internally to Molina's case management to help with the linkage to other community resources. Next slide.

Molina has been so appreciative of our partnership with Alzheimer's Los Angeles. It's really been great as a leadership team to have direct access to their expertise, to talk through workflows and resources, and it has been great to have their partnership to train our case management staff and also our providers. I just wanted to share a quick success story of our partnership and collaboration. We have an MMP member that's 82 years old and she was assigned to one of our dementia care specialists last year. The member lived with one of her sons in a single story home and both the member and her family had had some concerns about her memory yet there had not been a diagnosis. So our dementia care specialists here at Molina worked with the member in her family and help to coordinate an evaluation by a neurologist and the neurologist did diagnose the member with dementia and they started her on a treatment regime.

The case manager was able to work with in California, we call it in-home supportive services where it is a personal care attendant and she was able to request a reevaluation of the number of hours a member was authorized to receive per month and we were able to increase those amount of hours based on this new diagnosis and also due to her need for protective supervision. The member's daughter did agree to be referred to Alzheimer Los Angeles and so we used the direct connects referral form and referred the member and her daughter over to their program. Through their program they were able to receive a safe return bracelet and the daughter participated in some caregiver workshops in her local area which the daughter said were so helpful and she plans to continue to participate. You know they have also been able to discuss the importance of end-of-life care planning. It has really been a great example about how we can work together to really ensure that the needs of both the member and her family, that they have the support and the education they need.

Now I will pass it off to Katie.

Katie Scott: Thank you so much Megan. In Texas we also recognize the need to create integrated systems of care and we have been working on these efforts through our Texas Takes on Dementia projects. Specifically this project is creating opportunities for health plans participating in the Texas duals demonstration to provide support to individuals with dementia and connects them directly to community organizations that serve this population. Next slide.

Baker Ripley is involved because we are a community-based organization that has existed [inaudible] for over 100 years and we are really focused on ensuring Houstonians get access to the resources that they need to thrive in the community. In our programming we offer senior services that impact various aspects of health and wellness, engagement in the community as well as connections to resources.

For over 30 years we have recognized the impact dementia has on our community and we have recognized that we needed to respond. Accordingly we opened Houston's first dementia-specific adult day center in 1987 and more recently we have started more community-based programs serving this population which include our dementia case management program and our caregiver support services. However, we recognize that we can't do it alone and we need to collaborate with health systems to better address this population. So this is where the Texas Takes on Dementia project was born and gives us the opportunity to test this collaboration. Next slide.

We know that we have a large population of individuals affected by dementia in Texas. Specifically in the dual eligible population, we estimate about 112,000 Texans over the age of 65 have Alzheimer's disease. But interesting to note, in 2017 only 12% of the Texas Medicare Medicaid plan members had a formal diagnosis of Alzheimer's, dementia or stroke listed in their medical record. Going back to Dr. Callahan's presentation we know that that has to be an underestimation of really how many people are affected by dementia within this service population. Next slide please.

So the Texas Takes on Dementia project is being led by Texas Health and Human Services and we are really focusing on the connection between the three managed care organizations that

serve in the Medicare Medicaid plans in both Harris County and Tarrant County. So those plans are Molina, United and Amerigroup. We are working on connecting them with community-based organizations that serve individuals with dementia. So this is Baker Ripley, United Way of Tarrant County. We also use the Alzheimer's Association with their education expertise as our training partners in this project. Next slide.

The project is overseen at the state level but has leadership at each county level as we know that the geographic regions are different. They have different populations, different resources. We also have evaluation partners and advisors from different backgrounds and across both the state and the nation. Next slide please.

We had developed our project based on what we know to be best practices. First, we looked at successful initiatives. First, the California initiative working directly with the health plans. California has been instrumental in the development of Texas Takes on Dementia. They have shared many of their tools, resources and lessons learned. Accordingly, they received funding from the Alzheimer's disease Supportive Services Program and Texas followed suit and applied for that funding through the Administration on Community Living to support this work.

We also built upon learning from two other dementia community system focus projects which include the Houston Alliance to Address Dementia in Harris County and the model for Alzheimer's and dementia services in Tarrant County. That also led to the reason why we chose to limit to the geographic region. One we led because of the large population, but also we know that there are existing community agency expertise because the prior work has been done.

Another difference in our project development from California is that we were able to secure the Medicare Medicaid plan support before the project because in Texas there is a long history of health plan roles in the long-term care supports and services. Finally we had to leverage the MMPs development and dedication to quality of care, not contract requirement for process change. In the three-way contract between CMS, the state of Texas and the plans we do not have language related to dementia care so we depend on the interest of the MMPs and their quality of care and services provided to their members. Next slide.

So the Texas Takes on Dementia project is very similar and operations to the California based projects. Our project team conducts assessments of each plan. We identified areas where each plan could improve their dementia related practices. We then provided each plan with training and tools to help them become more dementia capable. Then plan staff were to identify individuals with dementia and their caregivers and connect them to dementia-specific services via a warm handoff referral. Next slide.

The direct services that we were measuring specifically related to Texas Takes on Dementia were either evidence based or evidence-informed services both specific to the county in which the plan was serving. Though some of the services differ dependent upon county we did offer services for both the individual with dementia as well as the caregiver. Two programs that we offered across both the counties were the Stress Busting for Caregivers evidence-based class as well as our caregiver education program. Next slide.

So where are we to date with the Texas Takes on Dementia project. Training began in August of 2018 and today we have conducted 10 trainings with 164 service coordinators and case managers. Since December 2018 the plans have provided 56 warm handoff referrals to community organizations. The warm hand off referral is essential because it removes the burden from the beneficiary and requires the plan staff to connect directly with our community services organization. Just like in California the service coordinators and case managers gain consent from the beneficiaries and send case information directly to the community organizations. In the case of Texas Takes on Dementia, this referral process is made electronically through a HIPAA compliant and secure email system. So we can get very specific information about the case and then we can follow up directly with the case manager as needed.

Of those 56 referrals, 35 individuals with dementia and their caregivers have enrolled in one of the community services that we have offered through the project. Next slide.

We are using a variety of tools to measure the change in both dementia capacity and knowledge as well as any integration of dementia care practices; very similar to what you have seen in California. We are using a lot of the tools listed on this slide at both project onset and we are also using them to do follow up assessments. Next slide.

One of the things I wanted to point out is what we learned during the baseline assessment. We identified key elements needed to improve the dementia capacity of the plans. In general, we found that the plan service coordinators needed to know about community resources and how to connect to them and how to work with them. They wanted this coordination. We also recognize that the members needed additional caregiver education and support, again, coordination across health care and community services as well as advocacy while navigating all care systems.

What we discovered supported the concepts presented by Dr. Callahan earlier. Integrated care systems need to engage community support agencies and are based on individualized care plans and emphasize caregiver's health and support. Next slide.

Just like California, Texas Takes on Dementia is using similar indicators of systems change. As you can see all three MMPs adopted key processes to improve their dementia capability and one of our plans actually adopted everything in terms of what we consider indicators for systems change. So what I would like to do now is share with you some case studies on some of the success stories that we have had.

The first one, a Molina case manager identified a beneficiary with cognitive impairment who lived with her daughter. Despite the Molina case manager's efforts to provide additional services the beneficiary refused assistance from anyone but her daughter. The case manager recognized that the daughter showed signs of caregiver stress and burnout and referred her to the Baker Ripley caregiver support services.

Baker Ripley provided the daughter with one-on-one consultation and information on the Stress Busting for Caregivers course. The daughter was very thankful for the resources and actually now recommends the caregiver stress course to anyone that has a parent diagnosed with

dementia. She said that it helped her tremendously with techniques to manage her own stress. The next slide.

The next case study came from Amerigroup. Amerigroup case manager had visited the home in order to assess the beneficiary for services but the beneficiary did not allow her to come in. That case manager was able to interview him outside of the home and discovered that he had some significant memory impairment and was in need of more case management and therefore connected him with Baker Ripley. The Baker Ripley dementia specific case manager developed a relationship with the beneficiary's friend to gain access into the home and was able to complete the comprehensive assessment.

The assessment revealed a significant and chronic state of hoarding and self-neglect including consumption of unsafe foods, lack of utilities, numerous trip hazards, medication mismanagement and significant dementia. In combination with the Amerigroup case manager, the Baker Ripley case manager contacted Adult Protective Services to help address some of the emergent needs. Our dementia case manager at Baker Ripley was able to arrange and escort the beneficiary to the primary care physician as well as a neurologist to get a proper diagnosis. When that proper diagnosis was obtained the Amerigroup nurse case manager was able to obtain a waiver allowing the individual to qualify for assisted living.

The impairment that this individual had was so severe that the individual lacked capacity to manage his finances or his care. So in combination with Adult Protective Services and Amerigroup, our Baker Ripley case manager looked for family to take on this role as caregiver. Unfortunately they were unable to identify anyone so they did start seeking guardianship. However, though they are seeking guardianship, that's not the end of this story. All of the case managers in this story remain involved to ensure the continuity of service, particularly completion of the application for the guardianship program, proper management of that and to check on the client's wellbeing.

So thank you all so much for listening to what we have done in Texas and I will pass it on over to Carol and Caroline for questions.

Caroline Loeser: Great, thank you. Wonderful. A big thank you to our faculty, Dr. Callahan, Dr. Cherry, Megan and Katie for your presentation. This has been incredibly informative. Thanks so much for joining us today.

So with that, we have a few minutes for questions from the audience. So if you have any questions for our speakers please submit them using the Q&A feature on the lower left of the presentation. Type your comment at the bottom of the Q&A box and press "submit" to send it.

We got a quite a few number of questions throughout the presentation. Dr. Callahan, I will start with a question that came up during your presentation but I do think that other speakers could speak to this as well so feel free to chime in. Dr. Callahan, the question is, "How does culture play into caregiving?" And this individual gave an example that some cultures value community and others might value individuality. Any suggestions there?

Christopher Callahan: Probably the most obvious answer is that culture does play into caregiving. It is one of the things we under recognize and several of the speakers brought this up in terms of tailoring, whether someone embraces the caregiving role and whether someone embraces the care recipient role. Then even down to a very personal level of how people want to receive care or are willing to receive care.

I do think in my own practice the only way we have been able to get to these issues is by asking care recipients and the caregivers. It frequently goes wrong if you make assumptions about someone's cultural approach without letting them actually tell you how they would like to participate.

Debra Cherry: This is Dr. Cherry. If I may add to what Dr. Callahan said. We find that working with different cultures often means learning from them about how the disease is viewed and how the caregiving activity is viewed. Sometimes we use the word "caregiver" and people look at us with a great deal of confusion because they don't see that as a role. They think, well this is just what family does. Then some other cultures put different people into the caregiving role. Among most Americans it is a spouse or an adult daughter. Yet in some cultures there's a division and people take on different roles if caregiving. There may be a daughter-in-law, or the oldest son may be the caregiver. So as Dr. Callahan said I think it's really important to bring this issue up and speak to the family about it and also look at literacy level in English if you're going to be giving a lot of information to that family about medical care or other care.

Caroline Loeser: Great. Thank you both for providing your insights there. Dr. Cherry, we have a question that came in from an individual from Sun Health health plan and this came up during your portion of the presentation. The question is, "Which member of the care team is responsible for completing the phone assessment?"

Debra Cherry: So in California there are two levels of phone assessment we have mentioned. Health risk assessments have been often outsourced by the health plans to organizations that have been tasked with providing these screens of health status and functional status across all plan members. This is a challenging activity. So those folks are often not necessarily licensed professionals. For the cognitive screen, the AD-8 that we have been teaching in California, it is primarily the care managers who are administering that screen and they are nurses mostly or social workers. Though there are other professional groups that are also doing the screen. It is a fairly simple screen to administer.

Caroline Loeser: Thanks Dr. Cherry. The next question, Megan, this came up during your presentation. So there is a comment that speech language pathologists have been very helpful in dementia treatment. When do you include speech in the patient's plan?

Megan Dankmyer: That's a great point. Definitely would be something that would be included in the care plan if that was an issue identified through the member or the caregiver and something they could work with the PCP to get the authorization for. That's definitely a great point to add.

Caroline Loeser: Great, thanks. We have about a lot more questions coming in, so thanks everyone for your participation in the Q&A. Katie; we have a question here for you. This is just generally what resources are available for family caregivers in order to reduce the stress associated with caring for loved ones with dementia? I don't know if you want to share from your perspective.

Katie Scott: There are a variety of resources out there, everything from one-on-one type work to group work. What we offer through our project in Texas Takes on Dementia is we have our Benjamin Rose Institute one-on-one Care Consultation Program which offers one-on-one coaching with the individual, with the caregiver and teaches them how to manage the behavioral symptoms, manage care as well as how to action plan for their role.

We also offer classes such as the Stress Busting class, which is an evidence-based nine week program that teaches very specific stress management techniques. There are other products out there such as Powerful Tools for Caregivers which is also another class that helps individuals manage their caregiving role. We also offer through Texas Takes on Dementia in Tarrant County REACH, which is another evidence-based program that combines both one-on-one and group sessions to help people manage their stress.

So there are a variety of programs out there and I would really encourage anyone to look up some of the evidence-based resources. They are very simple in some ways to implement. There is a lot of great work being done out there for the caregiver.

Caroline Loeser: Great. Thank you. We have another question and I think I will open this up to all of our speakers. So the question is about stigma. "In what ways does stigma about dementia affect patient care? As Alzheimer's and other dementias are diagnosed earlier do you see the issue of stigma growing or changing?"

Debra Cherry: I'm happy to start. This is Dr. Cherry. We have seen the issue of stigma changing as the disease is diagnosed earlier. People are often stunned to see people with dementia who are articulate and able to speak up about their own desires and plan for their own futures. This has challenged the views of many professionals as they think about dementia in a very elderly person in a wheelchair, sitting near a television set in a long-term care facility.

So the early stage people are often acting as advocates for themselves and changing the way people look at the disease. I'd say that in our region of southern California this happens more in well-educated and primarily Caucasian communities though that is changing as awareness of dementia is increasing. More people are being diagnosed earlier and speaking up from other ethnic groups as well to challenge and challenging the stigma against the disease.

Christopher Callahan: I think one of the difficulties that we face with stigma is really from all directions because sometimes the providers think that they can't do much. So that's a stigma in a way just in terms of being pessimistic about what can be offered to the patient or the family. Sometimes the patient themselves will try to avoid the diagnosis for fear that they will lose access to their car or their checkbook or even their home. Even family members sometimes will collude in avoiding the diagnosis because perhaps if your spouse can no longer drive and you

don't know how to drive and it's going to be socially isolating if neither of you can drive, people will try to avoid the label. Then of course there's concerns about insurance including long-term care insurance.

But I think what Dr. Cherry said is really true. Over the past few years as we make it clearer that we do have things to offer and that we are aware that people can successfully live independently at home for long periods of time and even continue to manage their own affairs, I think that is an important first step in reducing the stigma because we need to celebrate a little bit more that things can be done.

Katie Scott: This is Katie. My experience with stigma really stems around our dementia specific case management program. Though the example I provided the individual did need to go into a more supportive living environment that is not always the case. What we have seen with stigma sometimes even stems from the service providers ourselves who are supposed to be age, or aging service providers. You will see the stigma when individuals get diagnosed. Are they being treated with the respect and with the knowledge of their own capacity that they can still make decisions? And I would agree with both Deborah and Dr. Callahan in the fact that the issue of stigma people are just so afraid. They still don't know even how to react sometimes around individual and where those lines are.

I think that's one of our biggest challenges.

Caroline Loeser: Great. Thank you Katie, Dr. Callahan and Dr. Cherry for providing your perspective on stigma. So another question that came in, and Katie this came in during your presentation, "If you have any tips for navigating HIPAA requirements for caregivers."

Katie Scott: So I am not quite sure what they're asking for but I will do my best. So if it is for the referral system we do work with each plan individually to make sure that how we get information back and forth between their system and our system does meet all of the HIPAA requirements so we get enough information to be able to do the initial call.

In terms of HIPAA issues for the actual caregiver we work with them to get consent. We try to identify does this person have any sort of legal status with that individual? If so, can we work with them to look at advanced care planning so that we have those pieces in place so that they can get access as they need to be a better caregiver? I hope one of those two answers answered the questions.

Caroline Loeser: Thanks Katie. Dr. Callahan, maybe you can answer this question. The question is, "How can you get primary care providers to refer patients to community-based organizations?"

Christopher Callahan: Well there are a couple of barriers to this. We have already alluded to a few which are recognizing the need for the community-based organizations input. But there's also a difficulty with understanding from the primary care providers perspective what's available. Then there's a lot of discouragement on the primary care docs perspective on getting information

back from the community-based organizations. Then of course the community-based organizations are frustrated with the low rate of referral.

I think these have to begin with more relationship building of those organizations with the primary care physician and unfortunately, but also fortunately, a lot of that communication barrier is going to be met by the family. Sometimes a person cannot open up the services without a referral from a primary care physician but most people on this call have experienced great frustration with the limited capacity of fax machines to facilitate communication. I think this has got to first happen with relationship building and then we need a lot better technology for these communications.

Remember each doc is going to have many conditions for which they will be referring patients to say Area Agencies on Aging or other providers in the community and they're as frustrated as the CBO on how to make it happen more smoothly.

Katie Scott: This is Katie. I would like to just add a two things that we've noticed when we did this. One is that community-based organizations need to make it easy. Sometimes we get a little bit complicated and how we want referrals and how we want information. The easier you can make it for the primary care team the better.

The other thing that we heard across this project and then my other work with the Houston Alliance to Address Dementia is that people want one resource for everything. Can we just know if we send it to this one email address it will be taken care of? That is something that we implemented. For example, we have dementia@bakerripley.org. It is a one stop shop. You don't have to remember it needs to go to this group for this, this group for this. The triage is then on the community-based organization side, which we believe is helped with our referrals.

Debra Cherry: This is Debra Cherry. I would like to add my 2 cents as well. When we started doing the work with the Cal MediConnect health plans we were hardly ever getting any referrals. Over the last three years, as I mentioned, we are now up to 900 referrals and we did this by providing the health plans with the tool that allowed them mostly through their care managers rather than primary care doctors to say to the family, "Would you like to be contacted by an organization that could provide you with some more assistance around the issue of dementia?" This [Alz direct connect form] which is on our website and they will provide a link later. That confidential e-referral has been promoted by the care managers throughout their systems and has resulted in growing numbers of referrals. At some point there may be too many for us to manage.

So I think it's possible and I think you can take the tool off of our website and adapt it for your local community.

Megan Dankmyer: This is Megan. I will just add at Molina we have educated our PCPs and physician groups on the resources and education available through Alzheimer's Los Angeles so they can make referrals. But, definitely agree with the group. I think sometimes it's overwhelming all the different types of resources for the different types of conditions. So it is much easier for them to make that referral, the case management and then the case manager can assess the need and make that appropriate linkage.

Caroline Loeser: Great. Thanks everyone providing your responses. Let's see. We have quite a few more questions that came in. We probably have time for one or two more. A couple of questions that came in about dementia day centers. Katie, one attendee asks if you could share more about your dementia day center.

Katie Scott: Certainly. We started our dementia day center in 1987. It was the first in Houston and so we are still actually only one of two centers in the greater Houston area that specializes in dementia day care and that means that is part of the criteria to come in through the door; you have to have a diagnosis of dementia of some type of dementia confirmed by a physician.

Now our program is primarily operated through private-pay and some contracts with our local Area Agency on Aging as well as our VA program. That is because we unfortunately cannot contract with Medicaid because we do restrict based on diagnosis. However, our day center operations are similar to a lot of the other day center operations across the state and country. We are open multiple days a week. Individuals can come during the day. There is no residential stay and our programming is very tailored to individuals with dementia. So we understand some of the challenges that come with their cognition, the short attention span, so we create programming that's designed for that.

Caroline Loeser: Great. Thanks Katie. Dr. Callahan, I think we have one more question. This one was directed to you and what your experience is training providers to increase their diagnostic acumen around dementia.

Christopher Callahan: You know a lot of my response to a question like that comes from our work with late life, depression and depression in primary care as well as dementia in primary care. Really you have to think about this is a whole chain of events that you are going to screen people because those people who screen positive are going to get a formal evaluation. After that formal evaluation these kind of consequential events are going to happen much like you heard from the experience and the programming in California, in Texas. Those providers need that expectation that that whole chain is going to happen else why would I be looking for this? Or why would I find something that I'm pessimistic about it being helpful? I think that is one of the things that a lot of these models of care try to string together in a systematic way. Once you've done that, I think the positive feedback that these providers get from their families and their patients and the positive feedback they themselves get from seeing their patients improve is enough for that to happen.

We see that happen with other conditions. I brought up dementia and depression and we think about being brain conditions but for those of us that have been around for a few decades this was the story with hypertension and cholesterol screening as well about really understanding the importance of it and that good outcomes are going to happen from entering a patient into this chain of events. Having done that these are relatively simple instruments.

We have trained care coordinator assistants to do the screening instruments. The real question from a system level is, "Do you want your primary care provider to be the person that goes to the next step for the diagnosis?" And for some programs the answer is yes. For some programs the

answer is there is no one else so it has to be the primary care doc. Then for others they have put a system in place to say, "Well, when there's a positive screen, we're going to have someone else step in and do a more formal evaluation." So I don't think there's a competency problem so much as there is a system problem to put all of those necessary ingredients into play so there would be a reason to enter a patient into that pathway.

Caroline Loeser: Great. Thank you Dr. Callahan. I will add too, if you want to go to the next slide, that the Resources for Integrated Care at the end of July, July 30th, we will be hosting a webinar on diagnosis and treatment of dementia and current best practices. So our individuals interested in learning more on that topic, please save the date. At this time if you have any additional questions or comments please email our RIC@lewin.com for more information. You can also find a list of resources mentioned during this presentation on the last few slides of this presentation.

We can go to the next slide. So Alzheimer's Los Angeles has several resources that were mentioned throughout this presentation available to download on their website, including caregiver tip sheets, dementia screening tools, training curricula for care managers and more. Please feel free to check out those resources.

The first link on this slide will direct you to direct you to tip sheets for care coordinators, case managers, and other nonclinical staff who support individuals with dementia.

The slides for today's presentation, a recording and a transcript will be available on the resources for integrated care website shortly. As a reminder, additional guidance about obtaining credits and accessing the links to the post-test can be found within the Continuing Education Credit Guide in the Resource Guide on the left hand side of your screen or at the Resources for Integrated Care website.

Thank you so much for joining us today. Please complete our brief evaluation of our webinars so that we can continue to deliver high quality presentations. If you have any questions for us, again, please email us at RIC@lewin.com. Thanks again to all of the speakers. Have a wonderful afternoon and thank you so much for your participation.