Session 1060 (Paper)

DEMENTIA AND COGNITIVE IMPAIRMENT: POLICY AND PROGRAMS

BUILDING A MODEL OF ADVOCACY: IMPROVING THE DEMENTIA CAPABILITY OF MANAGED CARE HEALTH PLANS IN CALIFORNIA

Brooke Hollister,1 Jarmin Yeh,2 Leslie Ross,2 Jennifer Schlesinger,3 and Debra Cherry,1 1. University of California, San Francisco, California, United States, 2. University of California, San Francisco, San Francisco, California, United States, 3. Alzheimer’s Los Angeles, Los Angeles, California, United States

Given the growing prevalence of Alzheimer’s Disease and related dementias, and the intensity of this population’s care needs, it is imperative that health plans (HPs) increase their dementia-capability. The Dementia Cal MediConnect (Dementia CMC) project proposes an innovative model of health care advocacy that can create dementia-capable systems change. The Dementia CMC project was a partnership (2013 – 2018) between local Alzheimer’s organizations and ten managed care HPs in California. It used the following model of health care advocacy: 1) Identify dementia-capable best practices to set as systems change indicators; 2) Identify and leverage public policies in support of systems change indicators; 3) Identify and engage champions; 4) Develop and advocate for a value and business case to improve dementia care; 5) Identify gaps in dementia-capable practices; 6) Provide technical assistance, tools, and staff training to address the gaps in dementia-capable practices; and 7) Track systems change. Systems change data was collected through participant observation with HPs and interviews with key informants. HPs reported making systems changes toward more dementia-capable practices such as: better pathways for identification and diagnosis; better identification, assessment, support, and engagement of caregivers; and improved systems of referral to Alzheimer’s organizations. Some indicators of systems change were inconclusive as a result of variability in HP practices and the lack of common record systems between HPs and providers. The application of this advocacy model has led to systems changes that can be replicated to improve care for people living with dementia and their caregivers.

COGNITIVE IMPAIRMENT TRENDS AMONG OLDER ADULTS IN A MEDICAID HOME AND COMMUNITY-BASED SERVICE PROGRAM

Richard Fortinsky,1 Julie Robison,2 David Steffens,1 James Grady,3 and Deborah Migneault,1 1. University of Connecticut School of Medicine, Farmington, Connecticut, United States, 2. University of Connecticut, University of Connecticut, Connecticut, United States, 3. UConn Health, Farmington, Connecticut, United States

Cognitive impairment (CI) is an important risk factor for nursing home admission, but little is known about CI among older adults in Medicaid HCBS programs. Racial and ethnic group CI disparities are found among community-dwelling older adults, but these CI trends have not been explored in Medicaid HCBS populations. In this study, we determined how CI is associated with older adults’ racial and ethnic group identification and educational attainment in Connecticut’s Medicaid HCBS program. The study cohort includes program enrollees age >65 during January–March 2019 (N=3,520). CI measures include: Cognitive Performance Scale (CPS), ranging from 0-8 (cognitively intact to very severe impairment); and a dichotomous measure incorporating Alzheimer’s disease or other dementia diagnosis (ADRD) and CPS score signifying moderate or severe CI. Study cohort characteristics: 75.7% female; age, mean(sd)=79.1(8.2); Non-Hispanic White=47.8%; Non-Hispanic Black=15.9%; Non-Hispanic Other=2.7%; Hispanic=33.6%; HS education=21.7%; mean(sd) CPS score=2.7(1.9); 36.1% with ADRD/high CPS2 score. In multivariate regression models adjusting for age and sex, CPS scores were not independently associated with race and ethnicity, and the likelihood of having ADRD/high CPS scores did not differ by race and ethnicity (all p-values >0.05). In these same models, persons with more than high school education had significantly lower CPS scores (b=-1.12; p<.001), and significantly lower likelihood of having ADRD/high CPS scores (AOR=0.61; p<.001), than persons with less than high school education. We conclude that educational level is independently associated with CI, but race and ethnicity are not in this cohort. Policy and practice implications will be discussed.

DO INDIVIDUALS SKIMP ON HEALTH CARE AFTER SPOUSE’S DEMENTIA DIAGNOSIS?

Yi Chen, University of Southern California, Irvine, California, United States

Dementia is a costly disease that places great burden on individuals and families. The substantial time and financial resources taken away by living with persons with dementia (PWDs) may make their spouses forgo essential health care, thus deteriorating long-term health and increasing downstream healthcare costs. However, such negative externality is understudied. This paper studied the impacts of spouse’s incident dementia diagnosis on an individual’s use of needed care, defined as annual flu shot and regular doctor visits for those with preexisting conditions. Using HRS linked to Medicare claims, I employed a fixed effects approach to compare the use of flu shot and doctor visit during 1 year before and after the index, for individuals whose spouse had dementia (N=691) and otherwise similar controls (N=5,073). After adjusting for time-varying health, caregiving roles, and other socio-demographic factors, spouse’s dementia onset was associated with greater likelihood of getting flu shot and seeing doctors. Among those transitioning into caregiving, spouses of PWDs had a marginally higher risk of skipping on doctor visits, compared to controls (p=0.053). In this broadly representative sample, there lacks evidence for rationed health care ensuing spouse’s dementia incidence, at least within a 1-year time frame. However, for new spousal caregivers, the impact of dementia is more profound and complex than deprivation of time. This group may face a trade-off between caring for spouses with dementia and caring for themselves, for whom policy support merits further study and consideration.