HOME-BASED SOLUTIONS

STAKEHOLDER PLANNING SUMMIT ~ FEBRUARY 27, 2024

ENHANCING THE CONTINUUM OF CARE FOR PERSONS WITH DEMENTIA, IMPROVING HEALTH OUTCOMES AND REDUCING CAREGIVER BURDEN

#HBSStakeholder

nevadaseniorservices.org/hbs

Call to Order and Welcome

Jeffrey B. Klein, FACHE

President & CEO Nevada Senior Services

TODAY'S AGENDA

8:00 Registration Opens, Networking, Coffee

8:30 Call to Order Jeff Klein & Welcome

8:45 Introduction Keynote Speaker: Darrick Lam: Health Related Social Needs & Aging

9:15 Keynote: Q & A

9:30 **Reflections on the Theme – Mike Splaine**

10:00 Break & Visits to Collaborating Partner Information Tables

10:30 **Community Report: Hospital2Home & HBS – Jeffrey Klein, FACHE**
Hospital2Home – Betty Russell, LCSW
COPE – Marie Llanos, OTD, MHPEd, OTR/L
HomeMeds – Marie Llanos, OTD, MHPEd, OTR/L
ID/D & Community Education – Jennifer Ruiz, BS

11:30 **A Pivot to Prevention**
Michigan age in place poll results
https://www.healthyagingpoll.org/reports-more/report/older-adults-preparedness-age-place
NOTE DIVERSITY NUMBERS
Reflections Ginna Baik: Living Our Best Lives; Aging, Prevention, Loneliness and the Home

12:30 Lunch

1:30 Short table sharing exercise to identify facilitators and barriers to taking on a prevention mindset (Report out on flip chart posters)

2:30 Breakouts: How can we be about care/support and prevention?
Policy
Programs
Community engagement

3:30 Report out – Mike Splaine

4:00 Wrap Up & Concluding Remarks – Jeffrey Klein

This year's theme: Health Related Social Needs: How do we get in front of the wave? Prevent the hospitalization, the dire loneliness, the need to access basic human needs services on an emergency basis, the coming crisis in housing/live alone households.

Event Host Overview

Michael Splaine, Splaine Consulting

This year's theme:

- **Health Related Social Needs: How do we get in front of the wave? Prevent the hospitalization, the dire loneliness, the need to access basic human needs services on an emergency basis, the coming crisis in housing/live alone households.**

Session 1

POLICY

Brainstorm and discuss potential actions by county government or state legislature to support the shift toward prevention.

Session 2

PROGRAMS

What are the existing programs/agencies in our community that work to get ahead of social or health care problems? Is there need for something new in the community? And what are unique channels for communication that we can access?

Session 3

COMMUNITY ENGAGEMENT

How can we continue to bring the lived experience of persons with dementia and family caregivers into the early planning/thinking conversations? How can we assure that we engage language or cultural groups outside the mainstream?

BREAKOUT SESSIONS
2:30 to 3:30 PM

Health-Related Social Needs & Aging

Darrick Lam, MSW, MBA
Regional Administrator
San Francisco Local Engagement & Administration
Office of Program Operations & Local Engagement
Centers for Medicare & Medicaid Services

February 27, 2024

Disclaimer

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Quick Overview

CMS Leadership

CMS Leadership

Administrator

Chiquita Brooks-LaSure

Administrator

Chiquita Brooks-LaSure is the Administrator for the Centers for Medicare and Medicaid Services (CMS), where she will oversee programs including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Affordable Care Act (ACA) health insurance Marketplaces.

A former policy official who played a key role in guiding the ACA through passage and implementation, Brooks-LaSure has decades of experience in the federal government, on Capitol Hill, and in the private sector.

As deputy director for policy at the Center for Consumer Information and Insurance Oversight within the Centers for Medicare & Medicaid Services, and earlier at the Department of Health & Human Services as director of coverage policy, Brooks-LaSure led the agency's implementation of ACA coverage and insurance reform policy provisions.

Earlier in her career, Brooks-LaSure assisted House leaders in passing several health care laws, including the Medicare Improvements for Patients and Providers Act of 2008 and the ACA, as part of the Democratic staff for the U.S. House of Representatives' Ways and Means Committee.

Brooks-LaSure began her career as a program examiner and lead Medicaid analyst for the Office of Management and Budget, coordinating Medicaid policy development for the health financing branch. Her role included evaluating policy options and briefing White House and federal agency officials on policy recommendations with regard to the uninsured, Medicaid and the Children's Health Insurance Program.

Administration

Jonathan Blum
Principal Deputy Administrator & Chief Operating Officer

Erin Richardson
Chief of Staff

John Czajkowski
Deputy Chief Operating Officer

Components

Offices

- Office of the Actuary
- Office of Burden Reduction & Health Informatics
- Office of Communications
- Office of Enterprise Data & Analytics
- Office of Equal Opportunity & Civil Rights
- Federal Coordinated Health Care Office
- Office of Legislation
- Office of Minority Health
- Office of Program Operations & Local Engagement
- Office of Strategic Operations & Regulatory Affairs

Operations

- Chief Operating Officer
- Digital Service at CMS
- Emergency Preparedness & Response Operations
- Office of Acquisition & Grants Management
- Office of Financial Management
- Office of Hearings & Inquiries
- Office of Human Capital
- Office of Information Technology
- Office of Security, Facility & Logistics Operations
- Office of Strategy, Performance & Results

Centers

- Center for Clinical Standards & Quality
- Center for Consumer Information & Insurance Oversight
- Center for Medicaid & CHIP Services
- Center for Medicare
- Center for Medicare & Medicaid Innovation
- Center for Program Integrity

https://www.cms.gov/About-CMS/Leadership

Our Vision

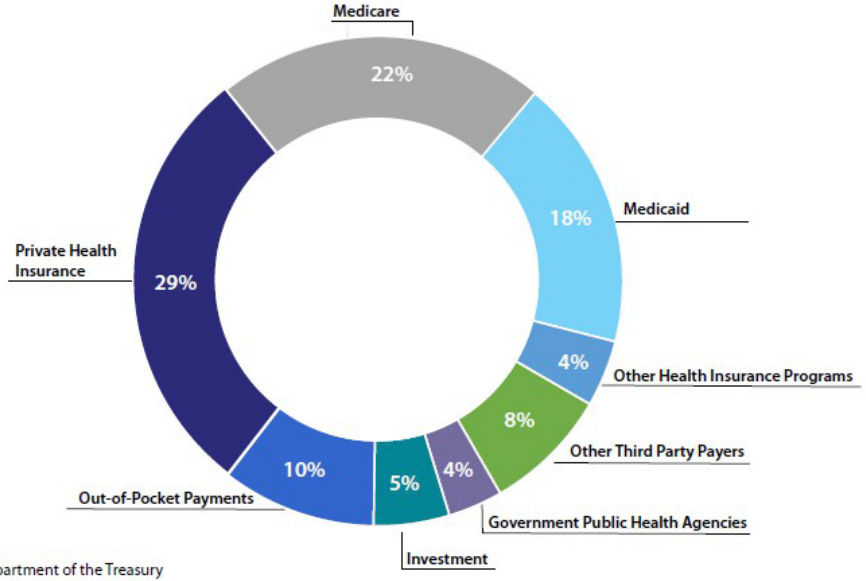
CMS serves the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes.

OVERVIEW

As the largest single health payer in the U.S., CMS administers Medicare, Medicaid, CHIP, the federal Marketplace, and the *Clinical Laboratory Improvement Act of 1988* (CLIA) program. CMS now maintains the nation's largest collection of healthcare data.

According to 2023 projections[1], Medicare and Medicaid (including state funding) represent 40 cents of every dollar spent on healthcare in the U.S.— or looked at from three different perspectives: 50 cents of every dollar spent on nursing homes, 46 cents of every dollar received by U.S. hospitals, and 40 cents of every dollar spent on physician services.

The Nation's Healthcare Dollar Fiscal Year 2023



Source: U.S. the Department of the Treasury

1 CMS, National Health Expenditure Projections, 2022-2031. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected

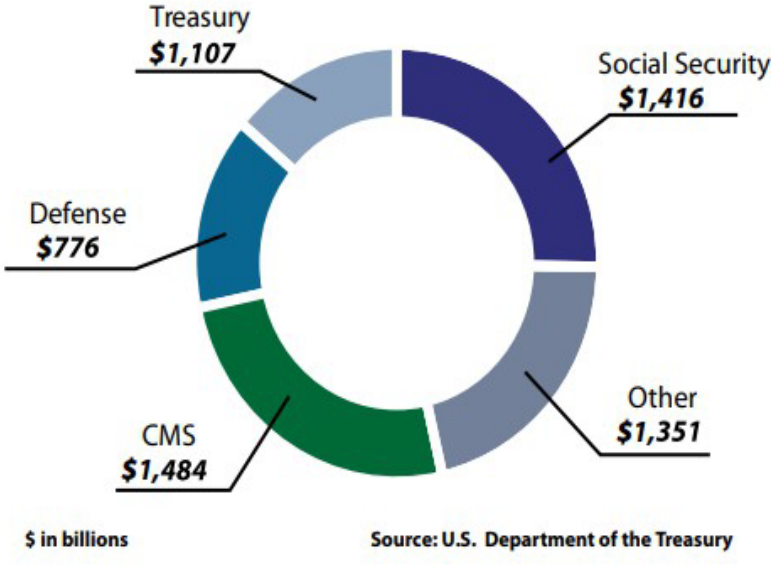
Annual Financial Report

https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2023.pdf-0

Annual Financial Report

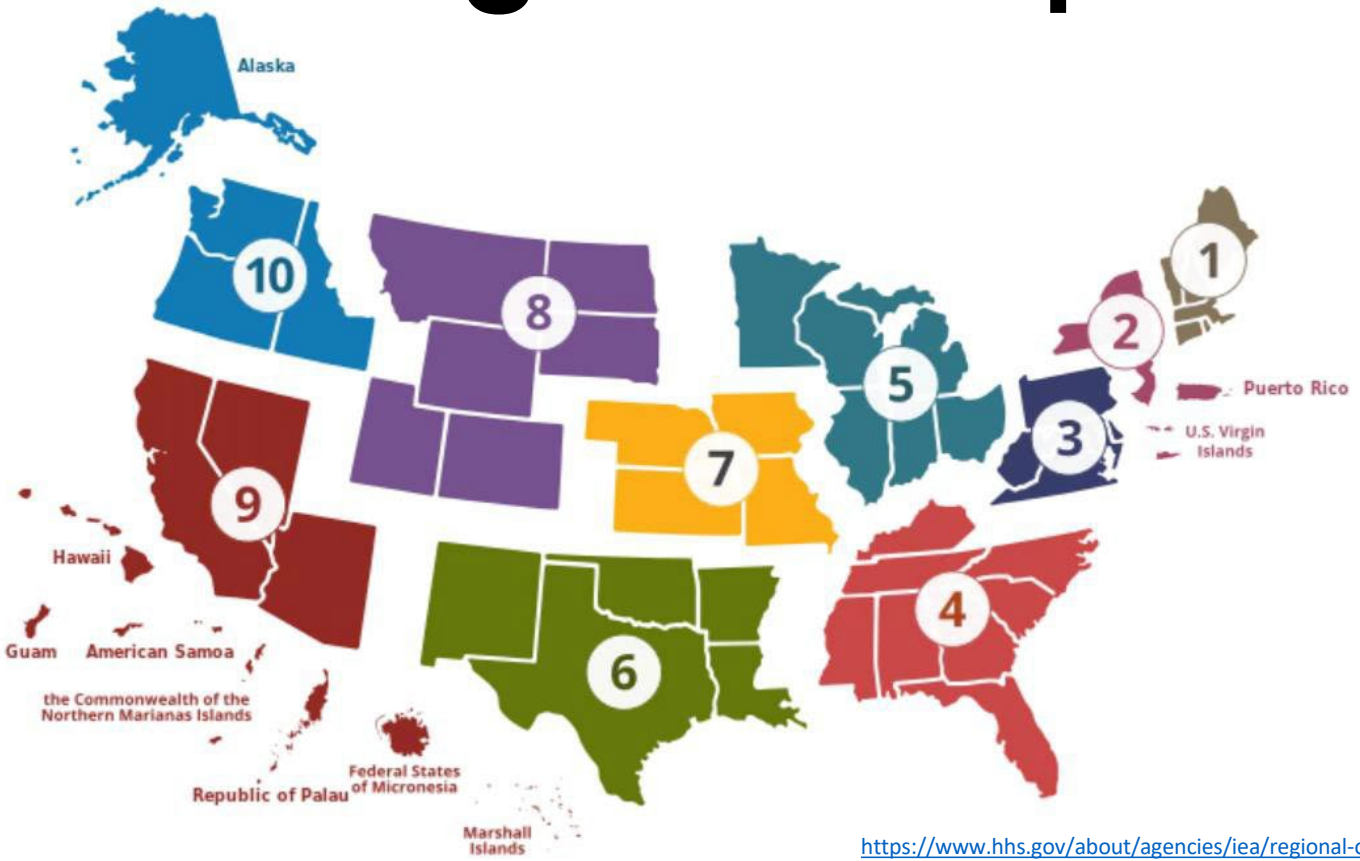
2023 FEDERAL OUTLAYS

CMS has outlays of approximately $1,484 billion (net of offsetting receipts and payments of the Healthcare Trust Funds) in fiscal year (FY) 2023, approximately 14 percent of total Federal outlays. CMS employs approximately 6,700 Federal employees, but does most of its work through third parties. CMS and its contractors process over one billion Medicare claims annually, monitor quality of care, provide the states with matching funds for Medicaid benefits, and develop policies and procedures designed to give the best possible service to beneficiaries. CMS also assures the safety and quality of medical facilities, provides health insurance protection to workers changing jobs, and maintains the largest collection of healthcare data in the United States (U.S.).



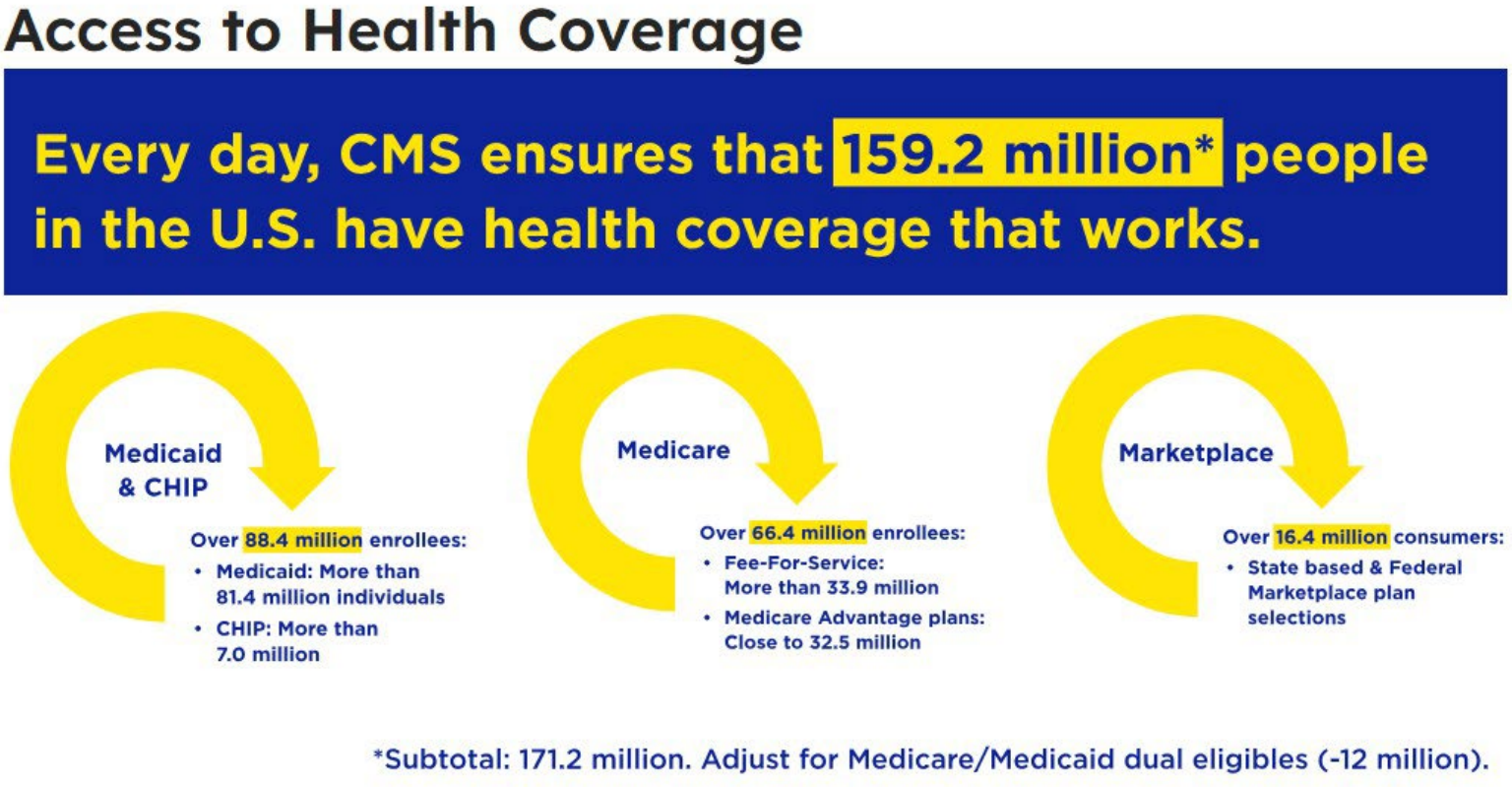
https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2023.pdf-0

Regional Map



https://www.hhs.gov/about/agencies/iea/regional-offices/index.html

The 3 Ms



https://www.cms.gov/pillar/expand-access, last modified 12/28/2023

CMS Strategic Plan

CMS Strategic Plan

CMS serves the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes.

STRATEGIC PILLARS

ADVANCE EQUITY

Advance health equity by addressing the health disparities that underlie our health system

Health Equity Fact Sheet

EXPAND ACCESS

Build on the Affordable Care Act and expand access to quality, affordable health coverage and care

2023 Marketplace Open Enrollment Data Snapshot

ENGAGE PARTNERS

Engage our partners and the communities we serve throughout the policymaking and implementation process

DRIVE INNOVATION

Drive Innovation to tackle our health system challenges and promote value-based, person-centered care

PROTECT PROGRAMS

Protect our programs' sustainability for future generations by serving as a responsible steward of public funds

FOSTER EXCELLENCE

Foster a positive and inclusive workplace and workforce, and promote excellence in all aspects of CMS' operations

Diversity, Equity, and Inclusion Strategic Plan

https://www.cms.gov/cms-strategic-plan
https://www.cms.gov/files/document/strategic-plan-overview-fact-sheet.pdf

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CMS National Quality Strategy

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/CMS-Quality-Strategy

ADVANCE EQUITY

Advance health equity by addressing the health disparities that underlie our health system

CMS defines health equity as the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes.

CMS is working to advance health equity by:

- Designing, implementing, and operationalizing policies and programs that support health for all people served by our programs
- Incorporating the perspective of lived experiences
- Integrating safety net providers and community-based organizations into our programs.

https://www.cms.gov/files/document/health-equity-fact-sheet.pdf

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CMMI Model Updates

Innovation Center Strategic Refresh

Created for the purpose of developing and testing **innovative health care payment** and **service delivery models** within Medicare, Medicaid, and CHIP programs nationwide.

Innovation Center Priorities and Strategic Refresh

For more information, the Innovation Center Strategic Refresh White Paper is available on the CMS website.

CMS defines health equity as: The attainment of the highest level of health **for all people**, where everyone has a **fair and just opportunity** to **attain their optimal health** regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

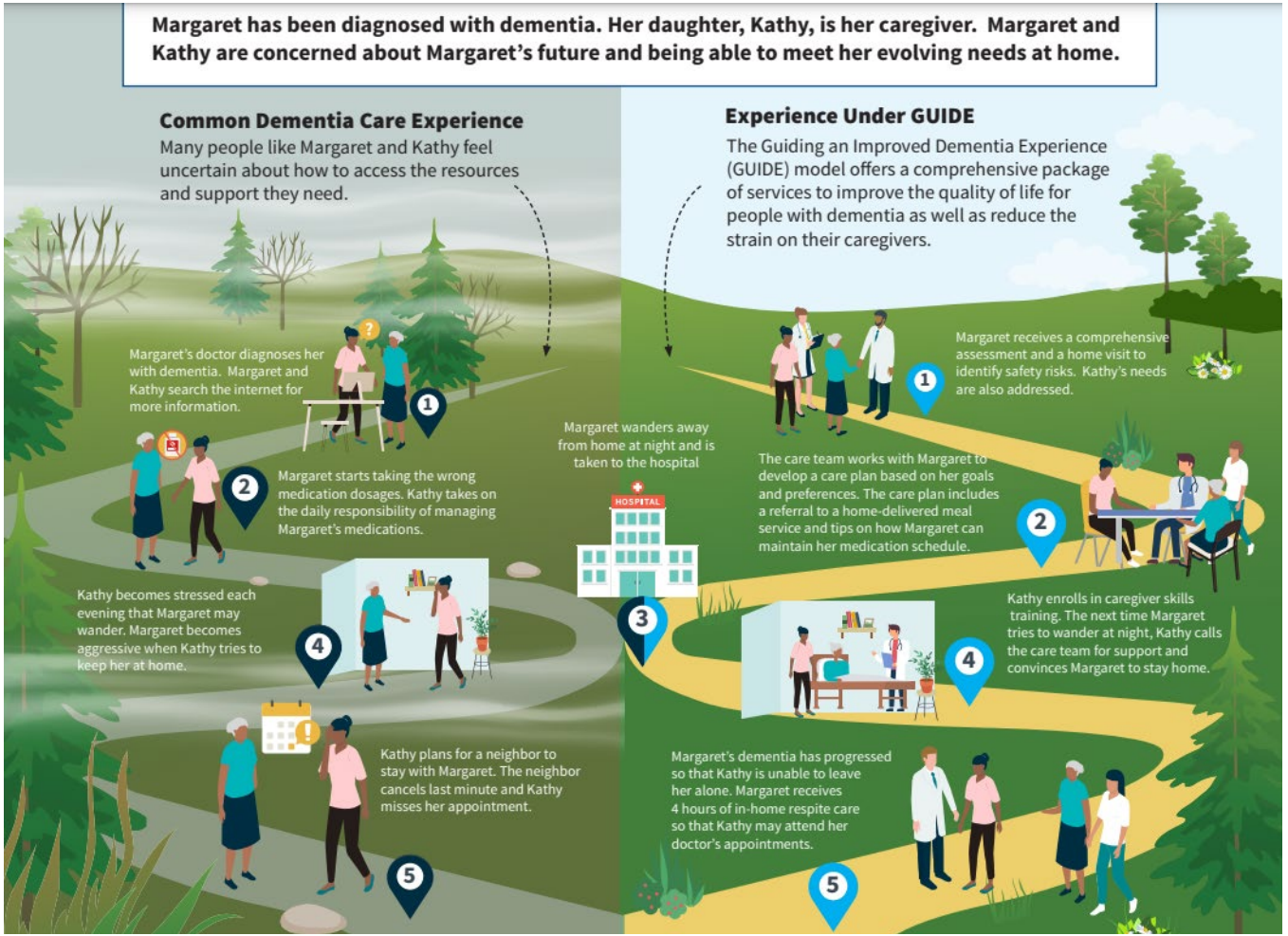
https://www.cms.gov/priorities/innovation/overview

The GUIDE Model

The GUIDE Model

Guiding an Improved Dementia Experience

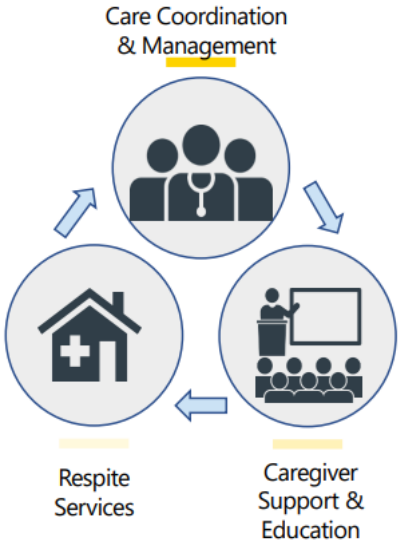
https://www.cms.gov/priorities/innovation/innovation-models/guide



The GUIDE Model

Model Purpose and Overview

The GUIDE Model will test whether a comprehensive package of care coordination and management, caregiver support and education, and respite services can **improve quality of life for people with dementia and their caregivers** while **delaying avoidable long-term nursing home care** and **enabling more people to remain at home** through end of life.



Care Coordination & Management

Beneficiaries will receive care from an **interdisciplinary team** that will develop and implement a comprehensive, person-centered care plan for **managing the beneficiary's dementia and co-occurring conditions** and provide **ongoing monitoring and support.**

Caregiver Support & Education

GUIDE participants will provide a **caregiver support program**, which must include caregiver skills training, dementia diagnosis education, support groups, and access to a personal care navigator who can help problem solve and connect the caregiver to services and supports.

Respite Services

A subset of beneficiaries in the model will be eligible to receive payment for respite services with no cost sharing, up to a cap of **$2,500 per year**. These services may be provided to beneficiaries in a variety of settings, including **their personal home, an adult day center, and facilities that can provide 24-hour care** to give the caregiver a break from caring for the beneficiary.

https://www.cms.gov/priorities/innovation/innovation-models/guide

Example Beneficiary Persona

The GUIDE Model

Margaret Smith

Situation: Margaret, 82, was diagnosed with Alzheimer's disease by her primary care physician (PCP) two years ago. She now experiences moderate symptoms. Her daughter, Kathy, visits her daily at her home but is unable to provide the increased level of attention she now requires. Margaret is unsure how to access support, and her PCP is not equipped to provide the necessary guidance.

Key Information

Location: Atlanta, Georgia

Family: 2 children, 4 grandchildren

Medical Utilizations in Last Year: 1 Emergency Department visit followed by post-acute care at home

Income: $1,700 per month

Margaret's Needs

- Culturally competent, coordinated care.
- Financial support for out-of-pocket medical costs.
- Support for household and personal tasks, such as cooking, cleaning, bathing, and maintaining a medication schedule.
- Assistance with light activity, such as short walks or physical therapy.

Margaret's Challenges

- Lack of savings for in-home care services and medical costs.
- Suffers from sundowning every evening and often forgets to take medications on time.
- Lives alone in a home with steps, which have caused 2 falls in the last 6 months.
- Struggles with Type 2 Diabetes and impaired vision that limits her ability to drive a vehicle.

Margaret's Experience in the GUIDE Model

Comprehensive Assessment and Care Plan

Margaret receives a comprehensive assessment and develops a care plan with her care team, which addresses her safety walking down stairs.

Ongoing Monitoring and Support

Care navigator checks in with Margaret monthly. Kathy also calls care navigator for suggestions on how to cope with sundowning.

Medication Management

Margaret's care navigator provides tips for Margaret to maintain her correct medication schedule.

Referral and Coordination

Care navigator refers Margaret to a community-based organization that helps her identify service providers.

Program of All Inclusive Care for the Elderly (PACE)

Program of All-Inclusive Care for the Elderly (PACE)

- What's PACE and how does it work?
- PACE provides comprehensive care.
- PACE supports family caregivers.
- PACE provides services in the community.

https://www.medicare.gov/publications/11341-Quick-Facts-PACE.pdf

To Qualify for PACE

Be 55 or older

Live in the service area of a PACE organization

Need a nursing home-level of care (as certified by your state)

Be able to live safely in the community with the PACE services

https://cmsnationaltrainingprogram.cms.gov/sites/default/files/shared/Getting%20Started%20With%20Medicare_2023_2024%20Amounts_101823.pptx

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About PACE Coverage and Premiums

If you have Medicare, but not Medicaid, you'll be charged a monthly premium to cover the long-term care portion of the benefit and a premium for Medicare Part D drugs.

If you have Medicaid, you won't have to pay a monthly premium for the long-term care portion of the benefit.

https://cmsnationaltrainingprogram.cms.gov/sites/default/files/shared/Getting%20Started%20With%20Medicare_2023_2024%20Amounts_101823.pptx

Physician Fee Schedule

2024 Physician Fee Schedule

Some of the topics covered in the final rule include:

- CY 2024 PFS Rate-setting and Conversion Factor
- Evaluation and Management Services
- Behavioral Health Services
- Dental and Oral Health Services
- Telehealth Services
- Caregiver Training Services
- Social Determinations of Health (SDOH) Risk Assessment
- Community Health Integration (CHI) and Principal Illness Navigation (PIN) Services

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

2024 Physician Fee Schedule – Health Equity

Caregiver Support

- For CY 2024, CMS will make payment when practitioners train caregivers to support patients with certain diseases or illnesses (e.g., dementia) in carrying out a treatment plan.

- Medicare will pay for these services when furnished by a physician or a non-physician practitioner (nurse practitioners, clinical nurse specialists, certified nurse-midwives, physician assistants, and clinical psychologists) or therapist (physical therapist, occupational therapist, or speech language pathologist) as part of the patient's individualized treatment plan or therapy plan of care.

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

2024 Physician Fee Schedule – Health Equity (2)

Social Determinants of Health (SDOH) Risk Assessment

- We finalized coding and payment for SDOH risk assessments to recognize when practitioners spend time and resources assessing SDOH that may be impacting their ability to treat the patient.

- We are finalizing the addition of the SDOH risk assessment to the annual wellness visit as an optional, additional element with an additional payment and no patient coinsurance nor deductible (when provided with the annual wellness visit).

- We also finalized codes and payment for SDOH risk assessments furnished with an evaluation and management or behavioral health visit.

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

2024 Physician Fee Schedule – Health Equity (3)

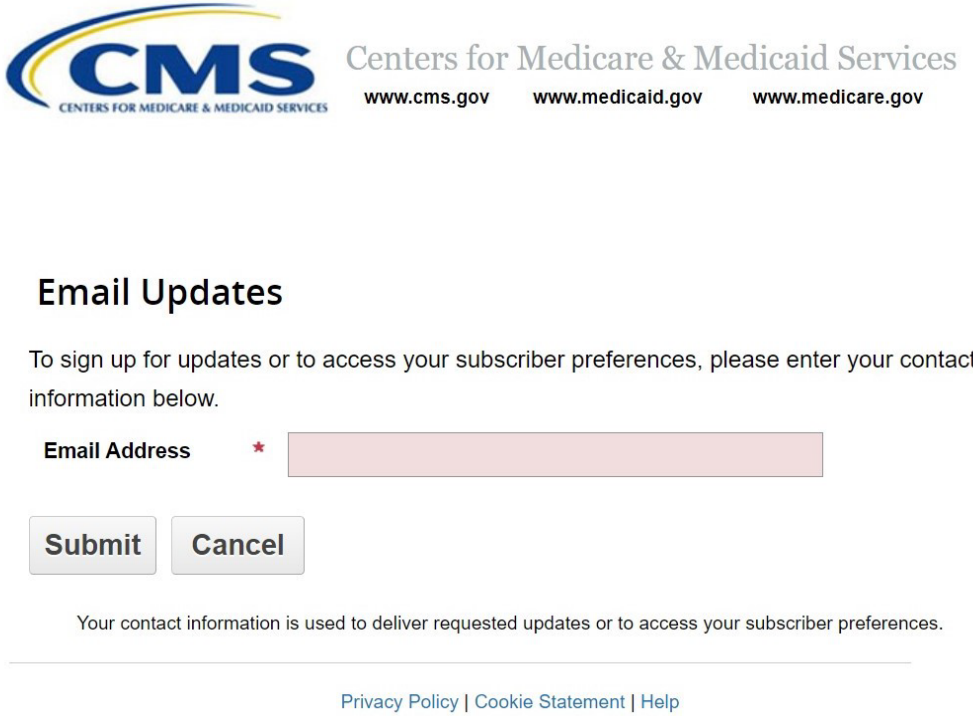
Community Health Integration (CHI) and Principal Illness Navigation (PIN) Services

- For CY 2024, we finalized **specific coding and payment** for monthly community health integration and principal illness navigation services to account for **when clinicians involve auxiliary personnel such as community health workers and care navigators to support patients who have unmet SDOH needs** that affect the diagnosis and treatment of their medical problems and when certain patients with high-risk conditions need assistance connecting with appropriate clinical and other resources.
  - We also finalized a new set of additional PIN codes that practitioners may bill when specifically supervising auxiliary personnel such as peer support specialists to support patients with behavioral health conditions that meet the qualifications of a serious, high-risk illness as outlined in PIN.

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

Stay Connected

CMS Updates



https://public.govdelivery.com/accounts/USCMS/subscriber/new

Medicaid Outreach

Connect with HHS Region IX on Medicaid Outreach

Thank you for your interest in helping Nevadans get and stay covered! Please fill out the information below to be added to communications from the HHS Region IX Office on how you can help the effort.

Sign in to Google to save your progress. Learn more

* Indicates required question

bitly

Region9ORD@hhs.gov

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Appreciate
Your Feedback

Please take the time to complete the post-engagement evaluation form, using the hyperlink or QR code:

https://cmsgov.force.com/act/Evaluation

Activity Name: "9-CMS San Francisco Joins Nevada Senior Services"

Contact Information

Darrick Lam, MSW, MBA
Regional Administrator

Local Engagement & Administration
Office of Program Operations and Local Engagement
Centers for Medicare & Medicaid Services

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(415) 769-1766


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Community Report:

Overview

Jeffrey B. Klein, FACHE

President & CEO Nevada Senior Services

The BIG IDEA

BUILD A CONTINUUM OF SERVICES TO SUPPORT AGING IN PLACE

Design a dementia capable system to deliver the right services at the right time.

Building Dementia Capability

- 2017 - Awarded Alzheimer's Disease Program Initiative Grant through the Administration on Aging #NV90ALGG0015 – H2H
- 2021 – Awarded a second ADPI grant through the ACL #NV90ADPI0067– Home Based Solutions
- 2017 – 2024 – Implement sustainability plan

H2H, COPE, HomeMeds and Education

- Reduce hospital readmissions
- Improve health outcomes
- Reduce caregiver burden
- Increase dementia capability within the community

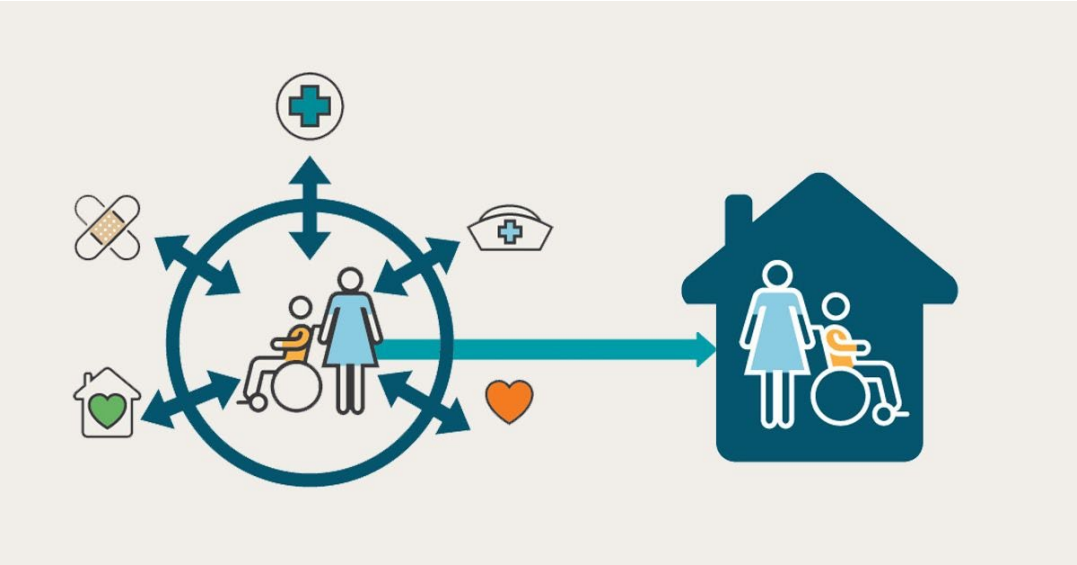
Community Report:

HOSPITAL 2 HOME
PROGRESS UPDATES

Betty Russell, LCSW

Clinical Director, Nevada Senior Services

Client #1's Journey-
From the **Hospital** to his new **Home**



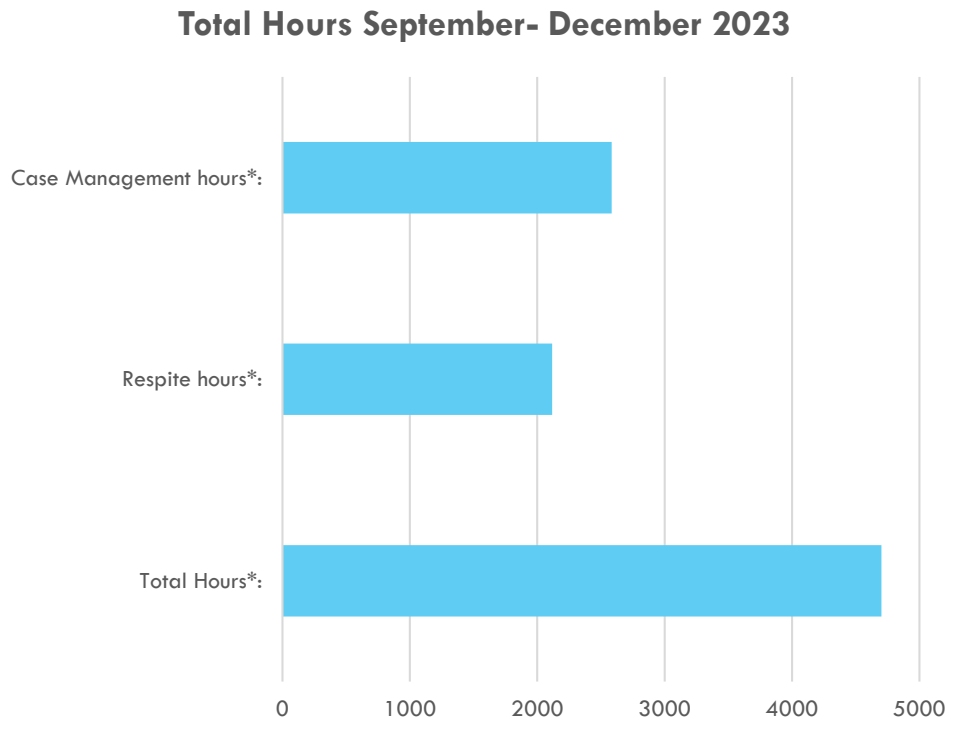
Client was discharged from the hospital to a long term care facility for two years recovering from a heart attack. Client was previously homeless and unable to be discharged home. The H2H team worked with his family out of state and countless community partners to secure the clients new housing. Client is now happily recovering in the comfort of his new apartment with continued H2H support!

Where Hospital 2 Home Started

- The H2H program was an ACL Grant funded program brought to Nevada Senior Services in 2017.
- This program was created and researched by the Rush Hospital in Chicago.
- NSS intentionally targeted and included the dementia population.

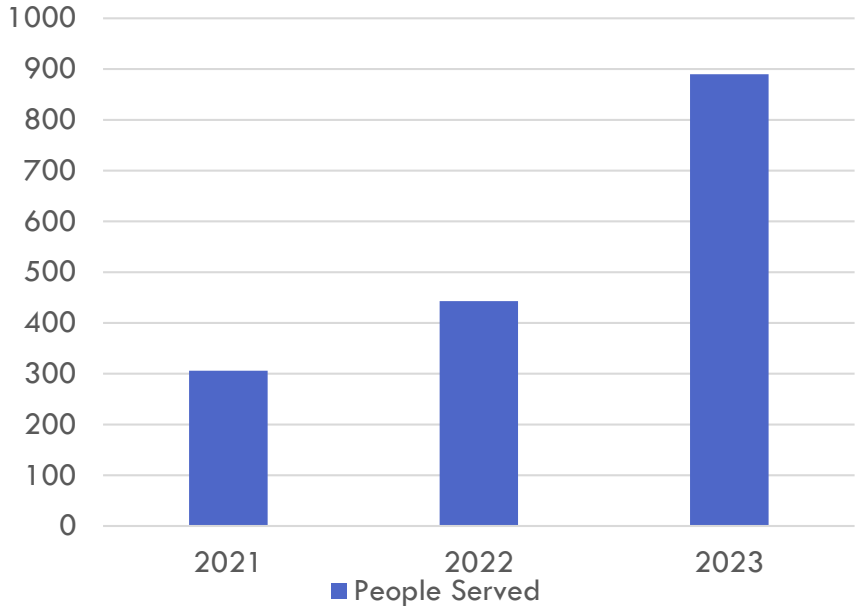
Impact

- New Community Partners
- Ability to serve new vulnerable populations due to community partnerships
- Increase in clients able to serve and hours of service able to provide



Let's Talk Numbers!

- People Served Prior to 2021- **900**
- People Served in 2021- **306**
- People Served in 2022- **443**
- People served in 2023- **890**

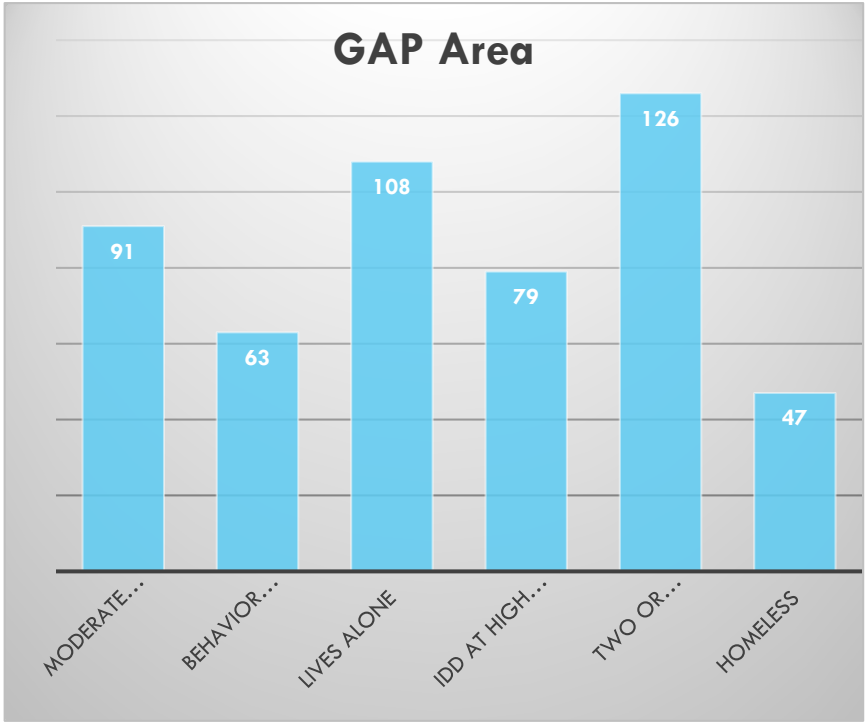


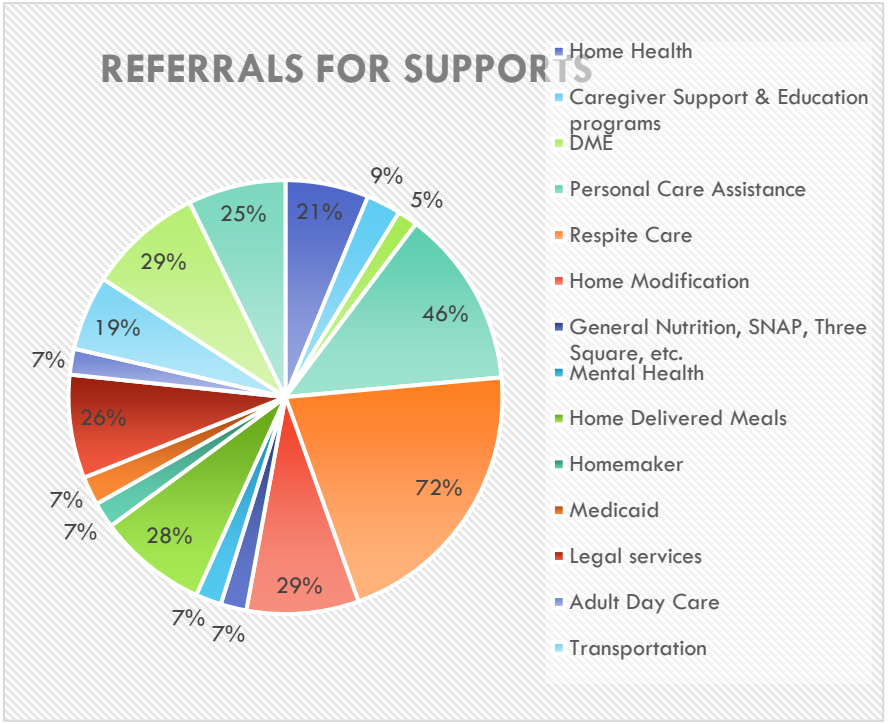
Community Partners

- Accessible Space
- Aging and Disability Services
- Adult Protective Services
- Archwell
- Boulder City Hospital
- Caremore
- Centennial Hills Hospital
- Clark County Social Services
- Clark County Public Guardian
- Cleveland Clinic
- Crisis Response Team of LV
- Desert Regional Center
- Desert Springs Hospital
- Dignity Rehab
- Encompass Rehab
- Henderson Hospital
- Horizon Rehab
- Intermountain Hospitals
- JFSA
- LV Fire & Rescue
- Medicaid/FOCIS
- MGM Resorts International
- Mobile Crisis Unit of Henderson
- Mountain View Hospital
- Mountain Vista Medical Center
- North Las Vegas Fire Department
- Omnicare Home Health
- Optum
- P3 Health
- Sage Creek
- Skilled Nursing Facilities of Clark County
- Southern Hills
- Southwest Medical
- Spring Valley Hospital
- St. Rose Hospital
- Summerlin Hospital
- Sunrise Hospital
- Trellis Rehab
- United Health Care
- University Medical Center
- Valley Hospital

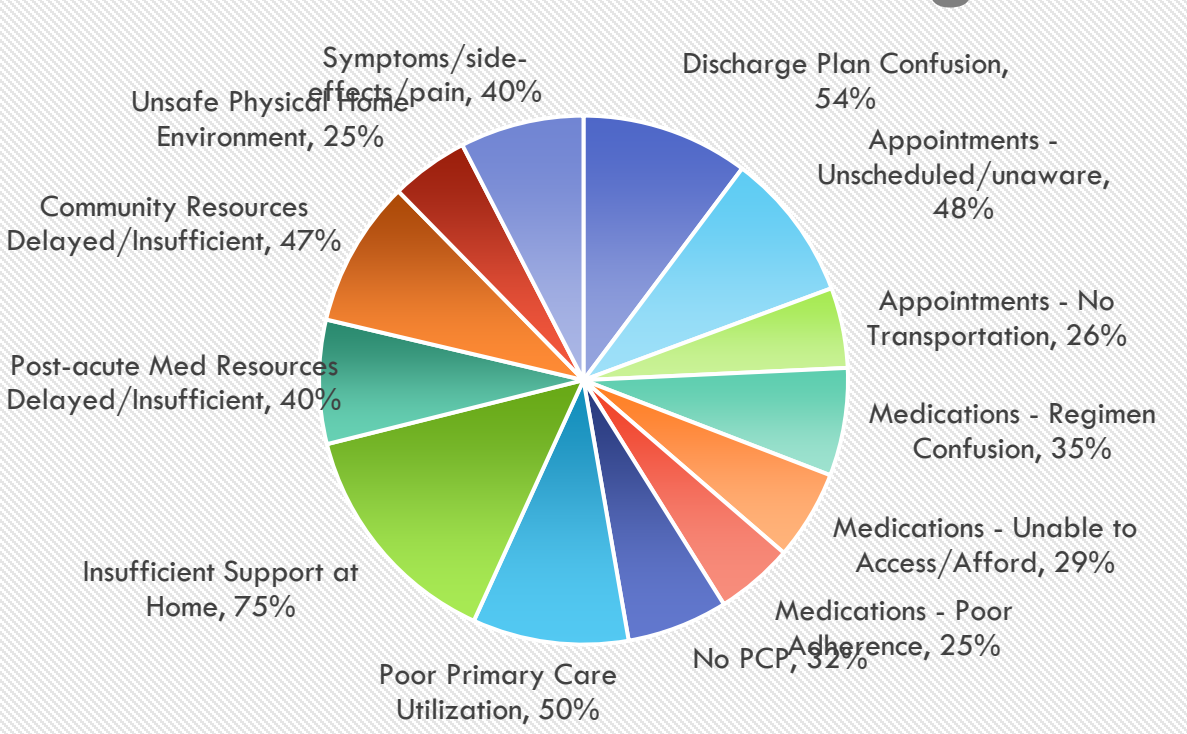
Identifying the Concern and the Resources Used to Address Those Identified Concerns

Data from September-December 2023



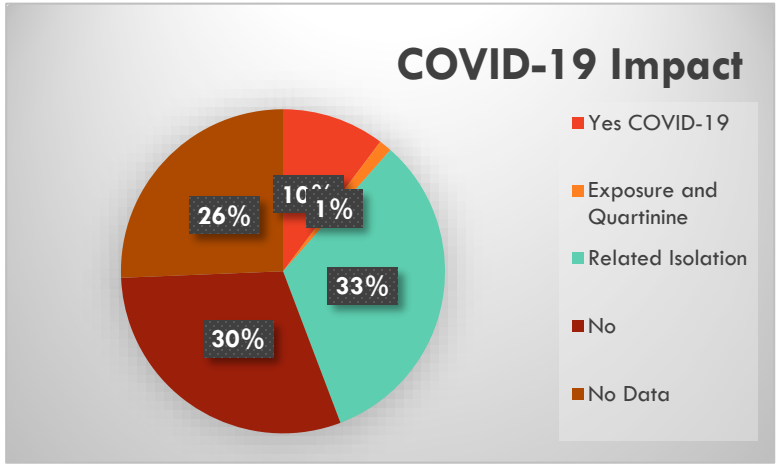


Discharge Challenges



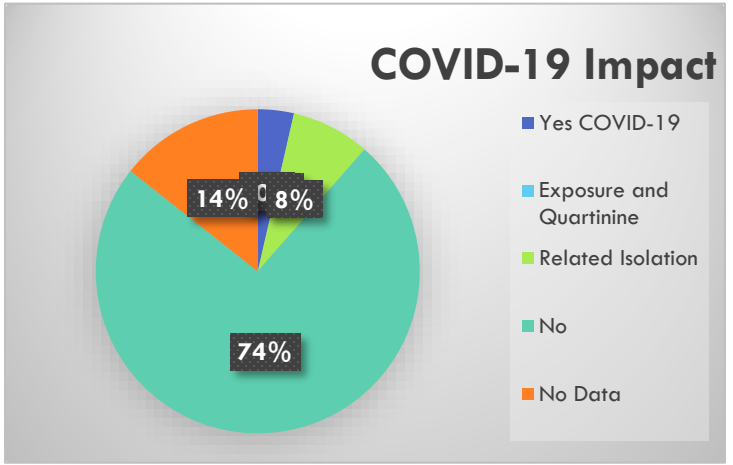
COVID Impact and Comparison

2022



COVID-19 Impact	
Yes COVID-19	16
Exposure and Quartinine	2
Related Isolation	51
No	47
No Data	40

Present Day



COVID-19 Impact	
Yes COVID-19	11
Exposure and Quartinine	0
Related Isolation	24
No	227
No Data	44

What We've Learned

- Working with humans is complex, challenging and the most rewarding thing on planet earth
- Fitting client with their support team (complex case manager and respite coach) based on need, cultural context, and demographic requests
- Outreach to the community can happen in unusual ways (Spanish speaking radio, word of mouth)
- Partnerships and collaborations in the local community allow H2H to reach clients that are not easily accessible

Team Goals

- Quick response time and immediate case management and respite in the home
  - Immediate referrals both within NSS and the community to address identified needs
- Decrease COVID & flu exposure
- More partnerships throughout the state, county and city
- Personal growth amongst Hospital 2 Home team members
  - Educational opportunities
  - Professional growth opportunities
  - Awareness of self care needs

What's New with Hospital 2 Home

- Direct Adult Day Care Admit
  - What is it?
  - Why it works?
- Clark County Collaboration
- UMC and all Valley Hospitals and Rehabs

Goal:
Support older adults and those with disabilities and unsupported document status to live safely in the local community with the services they need.

What's Next with Hospital 2 Home

- Clinical Director Goals
  - Expand Hospital 2 Home geographically
  - Imbed Hospital 2 Home in more local hospitals (as at UMC)
  - Add additional staff and minimize response time
  - Continue adding programing as we see the needs of the community
  - Taking care of the staff so the staff can care for the clients

Betty Russell, LCSW
Clinical Director of Nevada Senior Services

Thank You!

Collaborators, Community Partners and H2H Team Members

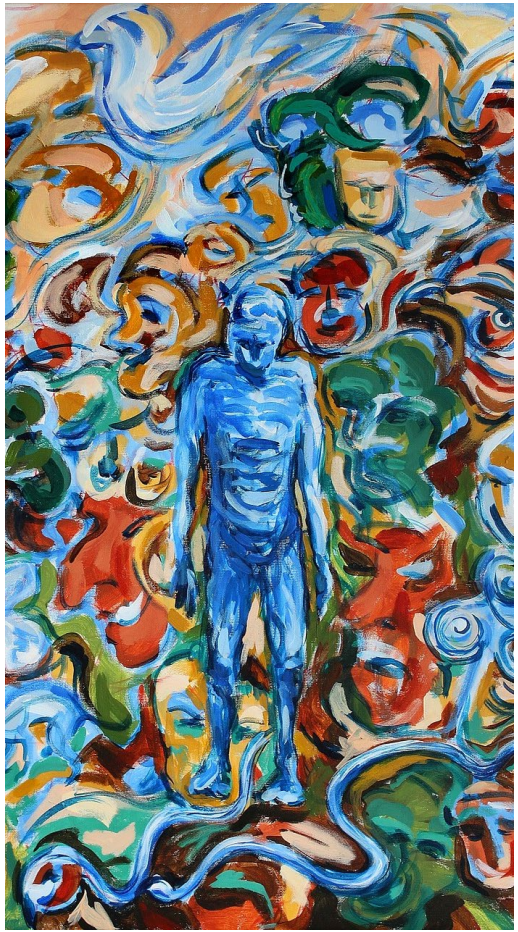
Community Report:

COPE

Marie Llanos, OTD, MHPEd, OTR/L, CAPS, ECHM, HAST

Occupational Therapist/COPE Coordinator

Care of Older People in their Environment



1

Evidence-based

Enhance well-being and quality of life of persons living with (PLWD) and caregiver

2

Delivery

Flexible approach

Up to 12 sessions

In-person, telephone or virtual

Coach or consultative model

3

Learning through doing

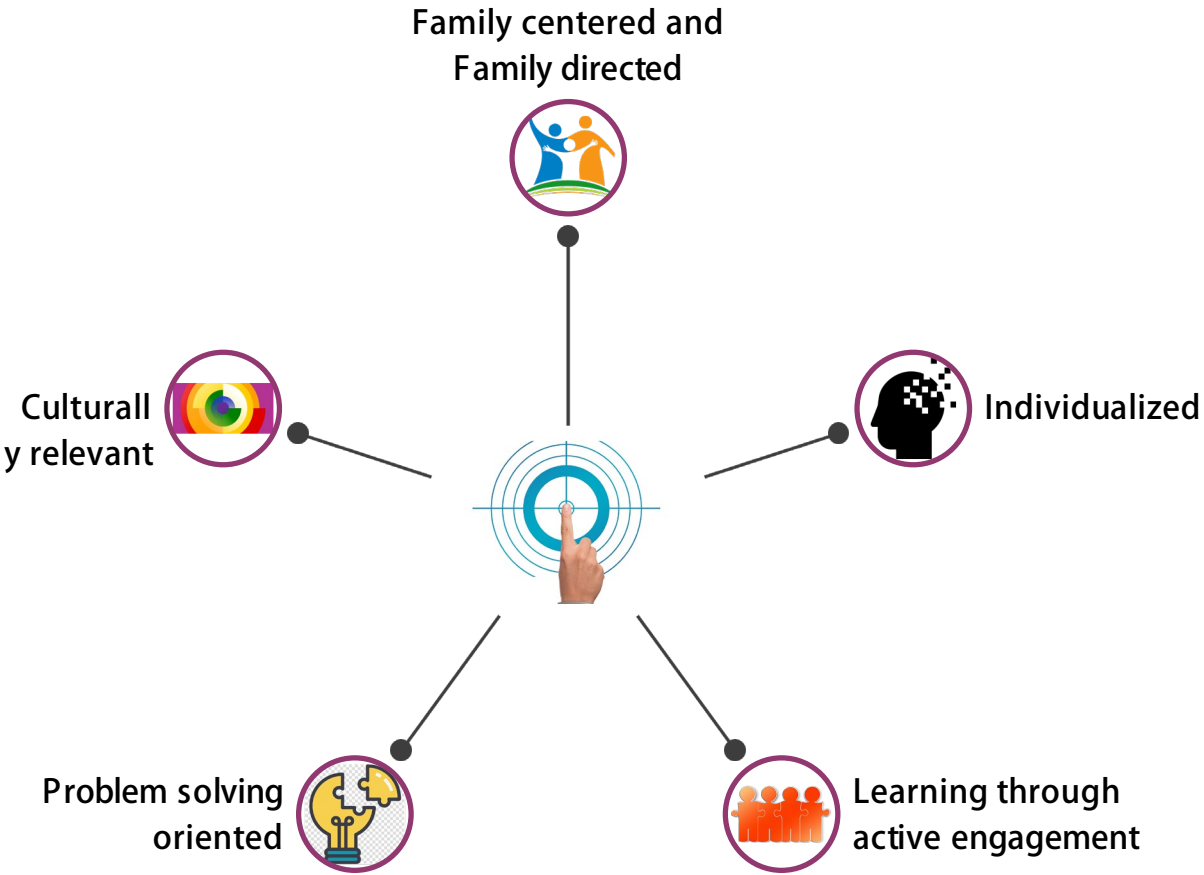
Facilitate caregiver knowledge and skills for managing daily care challenges

4

Phases

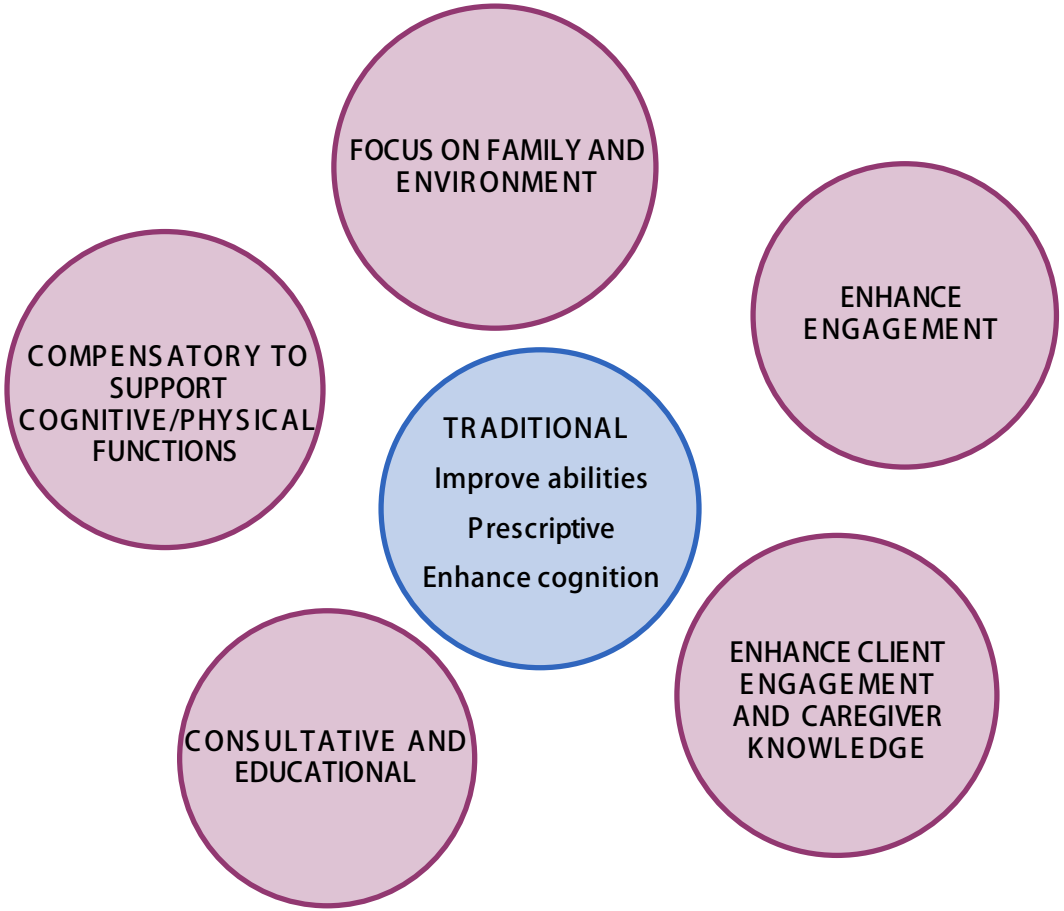
- Assessment
- Implementation
- Generalization

CORE TREATMENT PRINCIPLES



PARADIGM SHIFT

From a Rehabilitative to Habilitative focus



PROGRAM STRUCTURE

1.Who can deliver?

- Occupational therapist, nurse, or social worker
- Level of clinical exposure to working with PLWD
- Prior experience working with family members
- Able to engage family as a member of the care team
- Experience working as a member of an interprofessional team
- Comfortable with the role of coach or consultant
- Flexible which can include other team members

1.Who can benefit?

Persons living with dementia

- Functional dependence, behavioral symptoms, poor quality of life

Caregiver

- Lives with or nearby
- Has care challenges
- Distressed, overwhelmed or wants new care

NSS - COPE

Challenges

Length of time in completing the 10 modules with case studies

"Form fatigue"

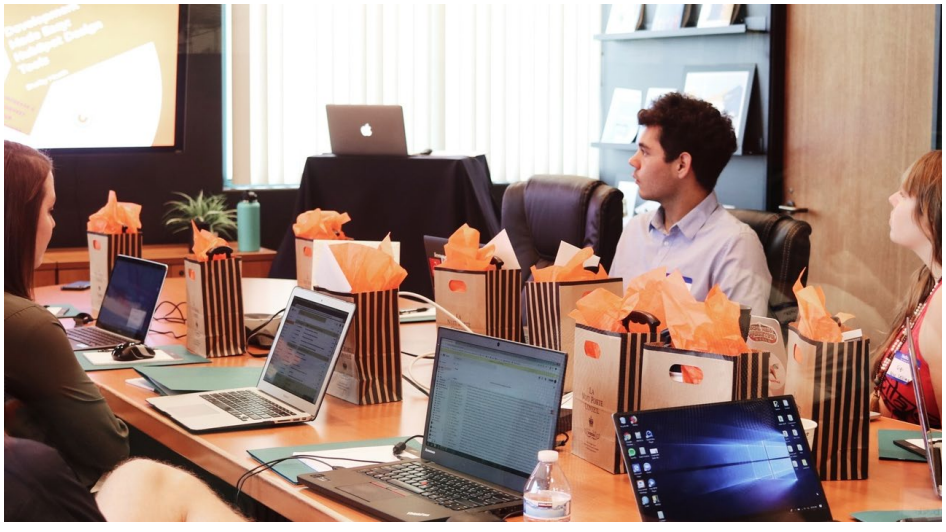
Time constraints (2-3 hrs) for the assessment phases

Infrequent scheduling (early AM, evenings or weekends)

Limited community resources

Sustainability


ALLIED
COMMUNITY
IS
STRENGTH.
BE STRONG. LET'S LOOK OUT FOR ONE ANOTHER.




INTEGRATION

Community Report:

HomeMeds

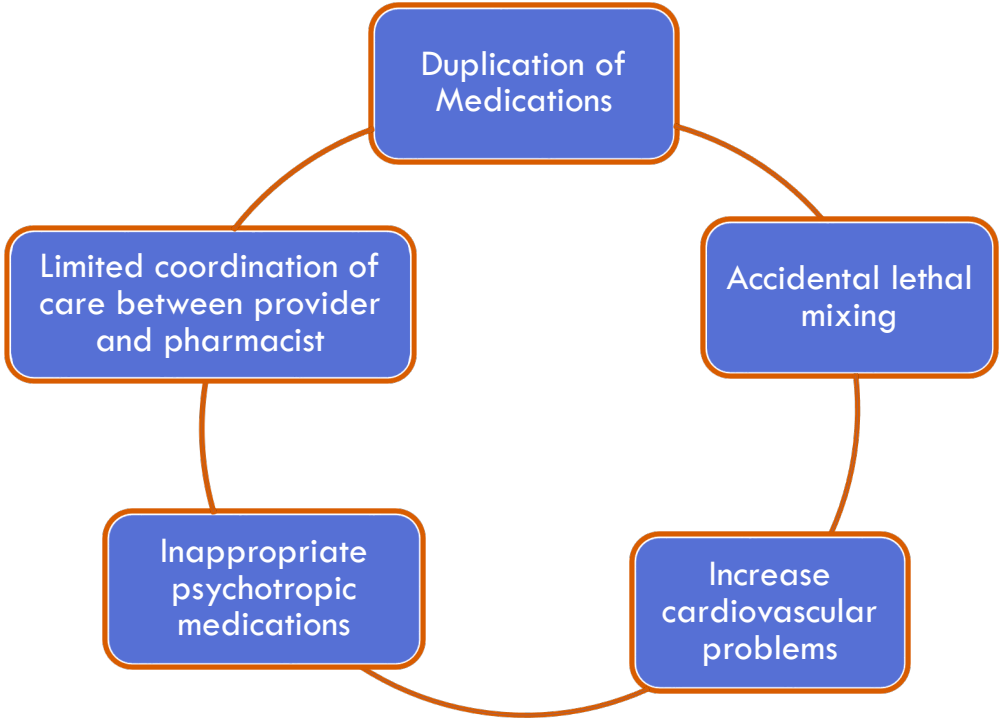
Tamra Lynn, RN

Nevada Senior Services

HOMEMEDS™

- Evidenced-based intervention
  - Support home-visit programs or agencies to keep people at home and out of the hospital by addressing medication safety.
- Proven to lower healthcare cost,
- Increase the quality of life
- Improve upon medication use.

HOMEMEDS™


Duplication of Medications
Accidental lethal mixing
Increase cardiovascular problems
Inappropriate psychotropic medications
Limited coordination of care between provider and pharmacist

HOMEMEDS

- Assessments conducted on every COPE client
- Program alerts to confirm medication issues
- “Live” pharmacist reviews and make recommendations
- Overall positive feedback

HOMEMEDS

- Increase staff training

- Hire more pharmacists

- Expand into the community within 6 mos to a year

- Integrate a falls prevention program in Q2

For any questions and further information, pls email:

tlynn@nevadaseniorservices.org

ACL/RTI

NSS Board of Directors, Administrators and Staff

Donors and supporters

Community partners

Clients, caregivers and family members

Community Report:

ID/D & Community Education

Jennifer Ruiz, BS

Director Education, Nevada Senior Services

Nevada Senior Services Education

Nevada Senior Services Education Classes

- Caring for You, Caring for Me
- Dealing with Dementia
- Thoughtful Hospitalization
- Dementia Awareness
- Medication Management

Nevada Senior Services Latest Training

- First collaboration
- Neighbor Network of Northern Nevada/N4
  - Amy Dewitt-Smith
- Desert Regional Center/DRC
  - Jazmine Smith
  - Dr. Elaine Brown
- Started August 2022

Intellectual Developmental Disability/Dementia Training

- Material: Derived National Task Group on Intellectual Disabilities and Dementia Practices (NTG)- Evidence-informed program
- Developed four core presentations- professionals (social workers, case managers, etc.), direct support staff, unpaid caregivers, and community groups
- 6 week/1 hour series for professionals, unpaid caregivers and community groups
- 1day/2 hour direct support staff with follow-up/consultation

IDD/Dementia Training Topics Include

- NAPA-National Alzheimer's Planning Act
- Dementia in ID
- Dementia Characteristics & Types
- Cultural Considerations
- Health Care Advocacy
- Caregiving & Dementia
- Communication
- Community Supports
- Nutrition
- Stage-Based Strategies
- Supporting Families
- Abuse & Safety
- Medication
- Bridging Aging & DD Services

IDD/Dementia Training Series

- Six week series includes:
  - Intro to Aging
  - Dementia 101
  - Caregiving and Dementia
  - Communicating
  - Community/Family Supports
  - Culture Considerations
  - EDSD- Early Detection Screen for Dementia
- Direct staff:
  - Environment
  - Essence/Person-Centered Planning

Results IDD/Dementia Training

- Providers are excited, feel empowered and equipped
  - Supporting the needs of people they care for
- Providers/Families know IDD, Gaining knowledge of dementia
  - Allows for other avenues to be taken for best care
- Providers learning about dementia are able to identify symptoms in the people they support much sooner
- Preparing the IDD/Dementia workforce
  - Building community service provider capacity by ensuring skilled workers can meet the needs of the people they serve
- Service coordinators
- Direct support staff

Conclusion IDD/Dementia Training

- Supports people with IDD/Dementia to age well
- Supports communities with the education needed to assist people with IDD/Dementia
- Supports **Quality** care
- Collaboration is essential
  - Knowledge on both IDD and dementia is of most importance
  - Our hope is for this training to go far and wide
  - Collaboration with DRC

Nevada Senior Services Education

- Enhancing the continuum of care for persons with dementia
- Improving health outcomes
- Reducing caregiver burden

Nevada Senior Services Education Schedule

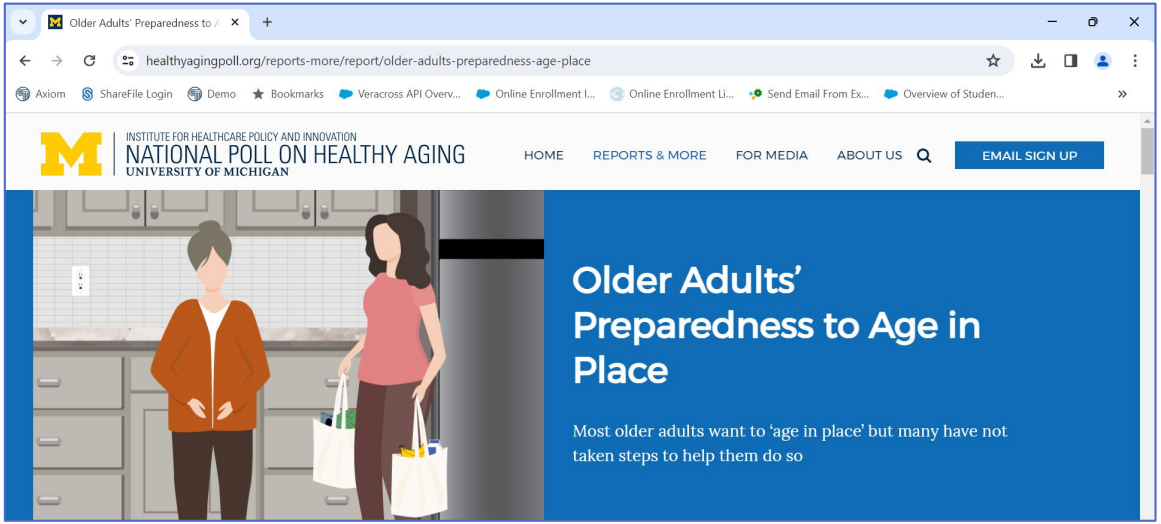
- www.nevadaseniorservices.org
- Programs and Services
- Education
- Education calendar

A Pivot to Prevention

Michael Splaine, Splaine Consulting

Michigan age in place poll results

- https://www.healthyagingpoll.org/reports-more/report/older-adults-preparedness-age-place



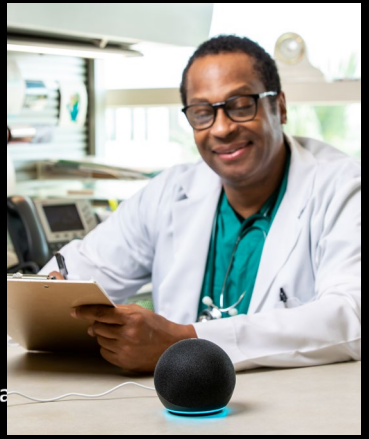
Living Our Best Lives; Aging, Prevention, Loneliness and the Home

Ginna Baik

Senior Innovation & Business Development Leader for Senior Living, Amazon


Today's
breakfast


Fresh Berry
Yogurt Parfait



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Living Our Best Lives; Aging, Prevention, Loneliness and the Home

Ginna Baik, Senior Technology Business Development Manager

@ginnabaik

The Journey of Aging

Global Tech Adoption in Fast Forward

E-Commerce

10 Years in 8 Weeks

Increase in e-commerce deliveries

Telemedicine

10x in 15 Days

Increase in virtual appointments

Streaming Video

7 Years in 5 Months

Netflix vs. Disney+ to hit 50M subscribers

Remote Learning

250 Million in 2 Weeks

Students who went to online learning

Source: McKinsey, *Meet the Next Normal Consumer*, April 2020

Intelligence of Things Gaining Momentum

AI and Machine Learning

43% of IT leaders say AI/ML matters much more than they thought as a result of the pandemic.

Source: Algorithmia, *2020 Enterprise AI/ML Trends Survey*

Robotic Process Automation

Poised to become a $2 billion global industry in 2021.

Source: Gartner

Natural Language Processing

53% of technical leaders indicated their NLP budgets were at least 10% higher compared to 2019.

Source: John Snow Labs

Cloud Computing

59% of global enterprises expect their cloud usage will be slightly or significantly higher than planned this year.

Source: Flexera, *2020 State of the Cloud report*, April 2020

Robots to the Rescue: Responding to COVID-19 Effects

Cleaning
Disinfecting floors and rooms in warehouses, retail stores & hospitals

Delivery
Delivering packages and groceries using robots and drones

Retail Inventory
Stocking shelves and identifying inventory gaps

Close Contact Tasks
Using robots to perform tasks such as cooking, food processing and recycling

Health
Checking temperatures and enabling remote clinical care

Isolation
Monitor health of at-risk individuals and facilitate communication with friends and family

Source: CTA, *COVID-19 Impact on Technology Innovation: U.S. & Europe*, September 2020

Changes in loneliness and social contacts, 2018 to 2020

AMONG ADULTS AGE 50-80

	October 2018	March–June 2020
felt a lack of companionship	34%	41%
felt isolated from others	27%	56%
had infrequent social contact	28%	46%

University of Michigan Survey June 2020 Source: University of Michigan

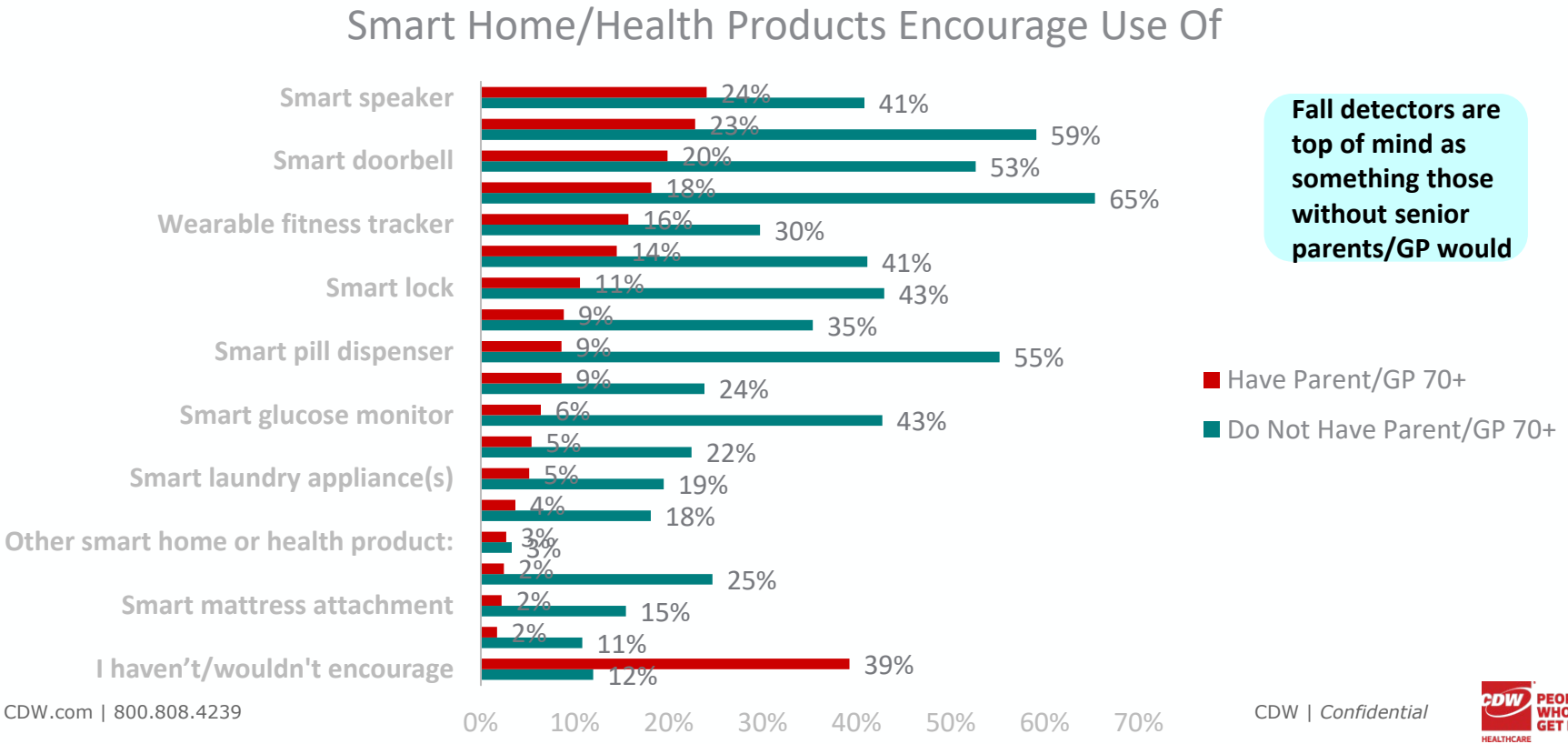
21.8 million disconnected.

CNET SMART HOME AND HEALTH STUDY FOR CDW

CBS Interactive Research, May 27, 2020

CBS Interactive

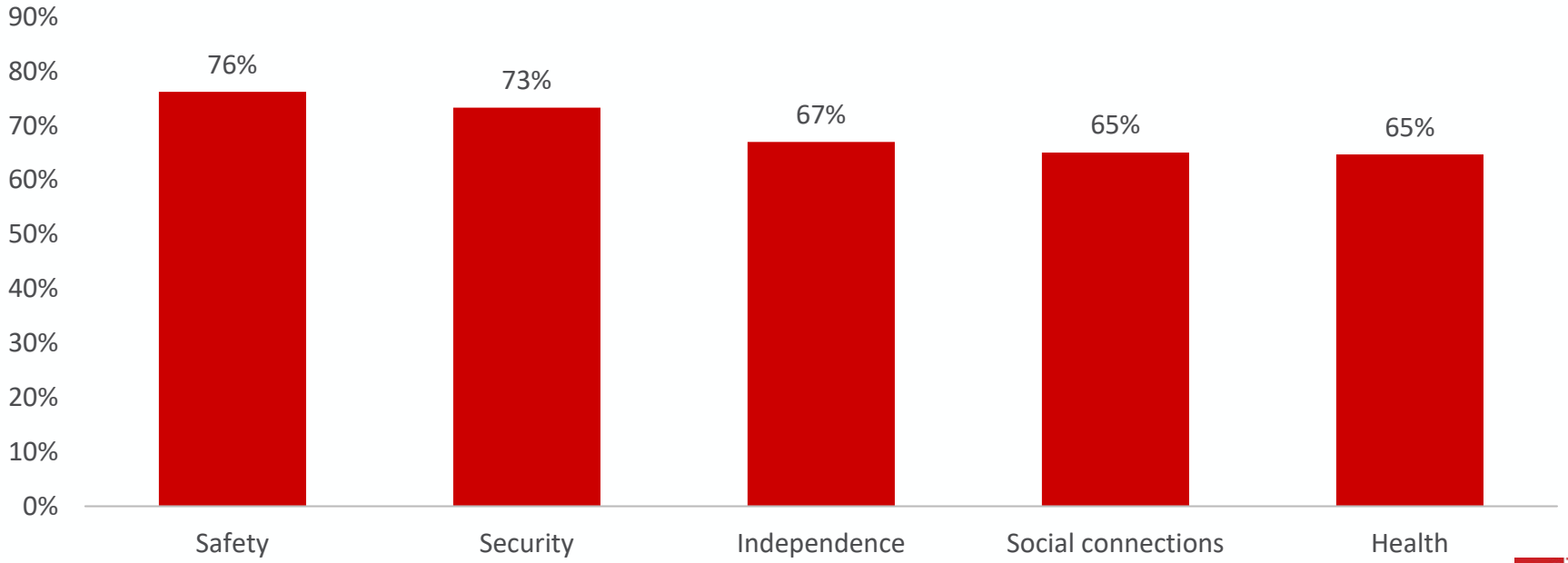
Smart speakers, Security cameras, and Doorbells top the list of encouraged products by those with senior parents/GP



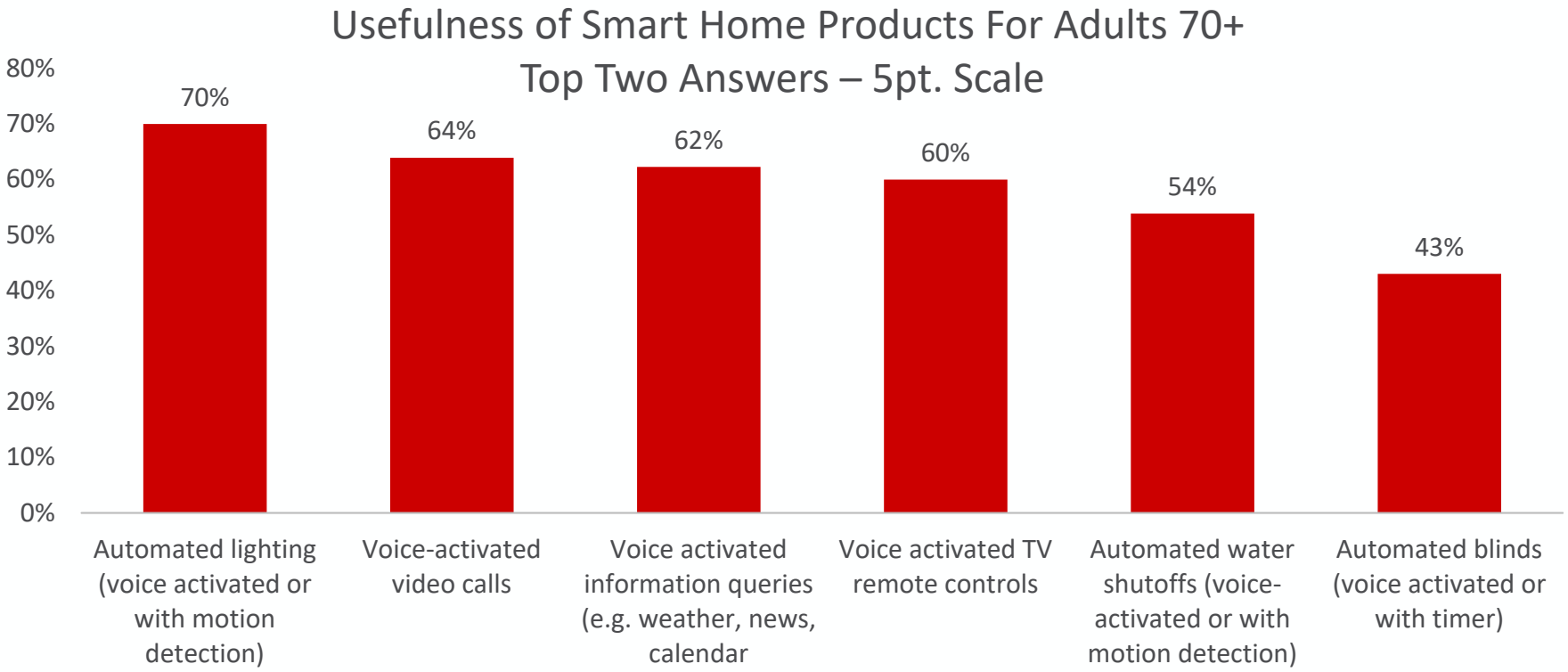
Fall detectors are top of mind as something those without senior parents/GP would

Respondents see smart tech as helping seniors live better lives in many ways

Impact Smart Home/Health Tech Has On Helping Older Adults Age Better
Top Two Answers – 5pt. Scale

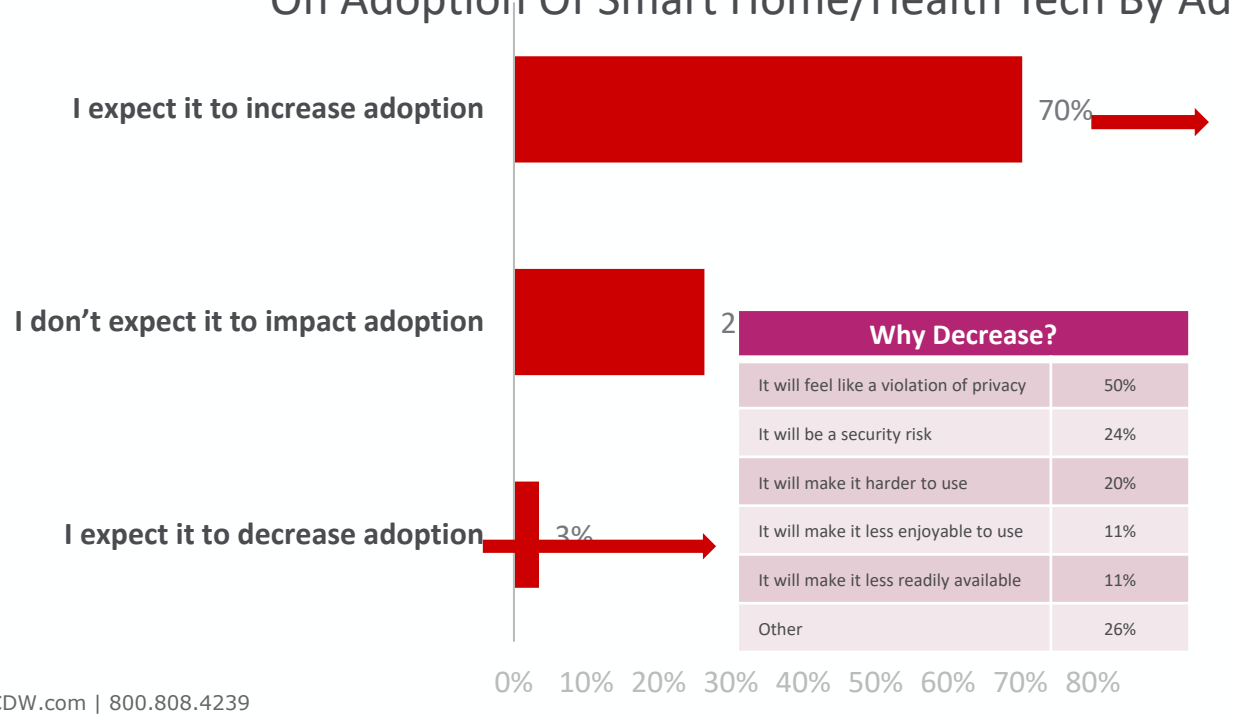


Automated lighting is seen as the most useful application for seniors



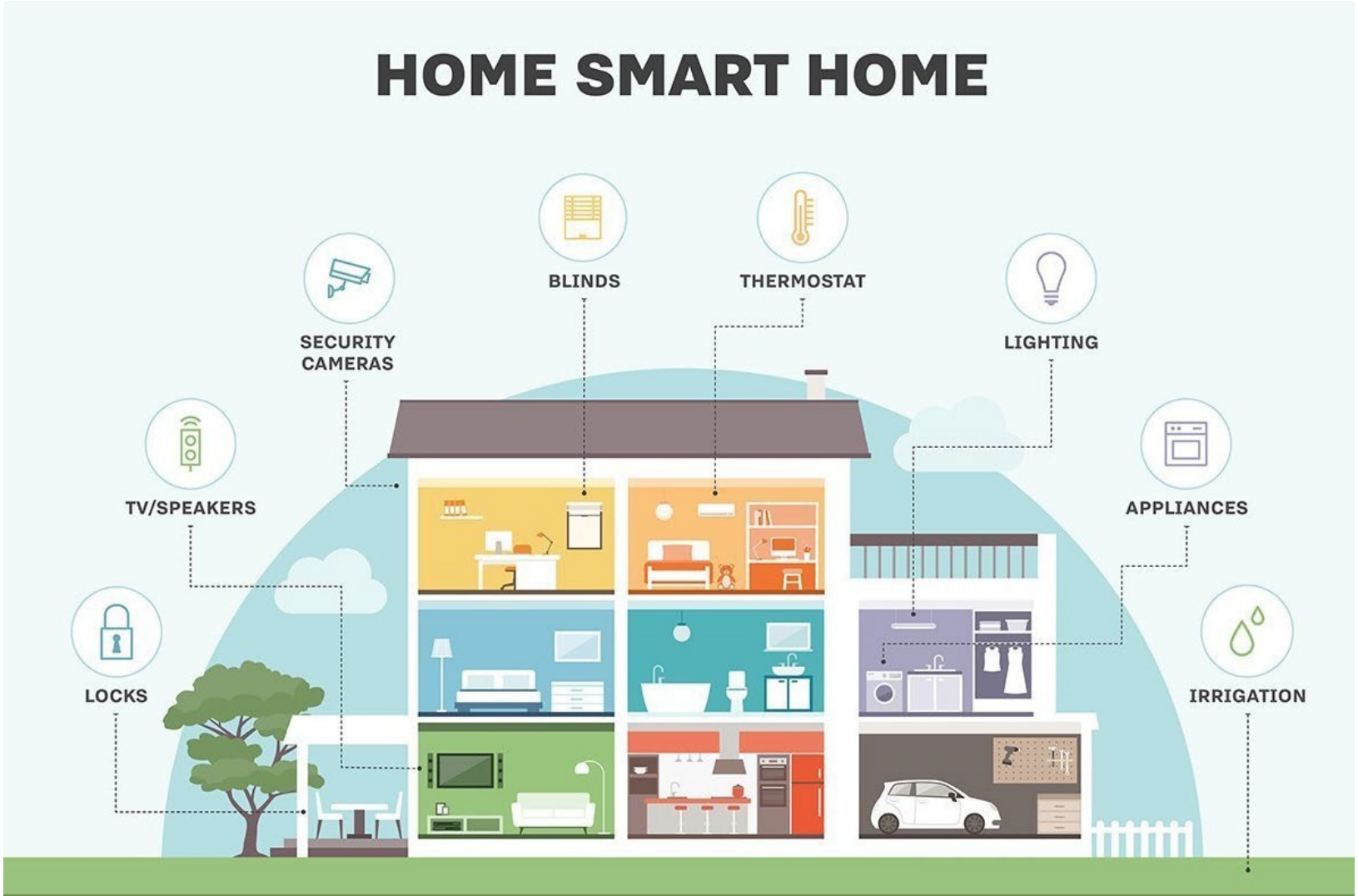
Voice control is expected to increase adoption of smart tech making it easier to use primarily

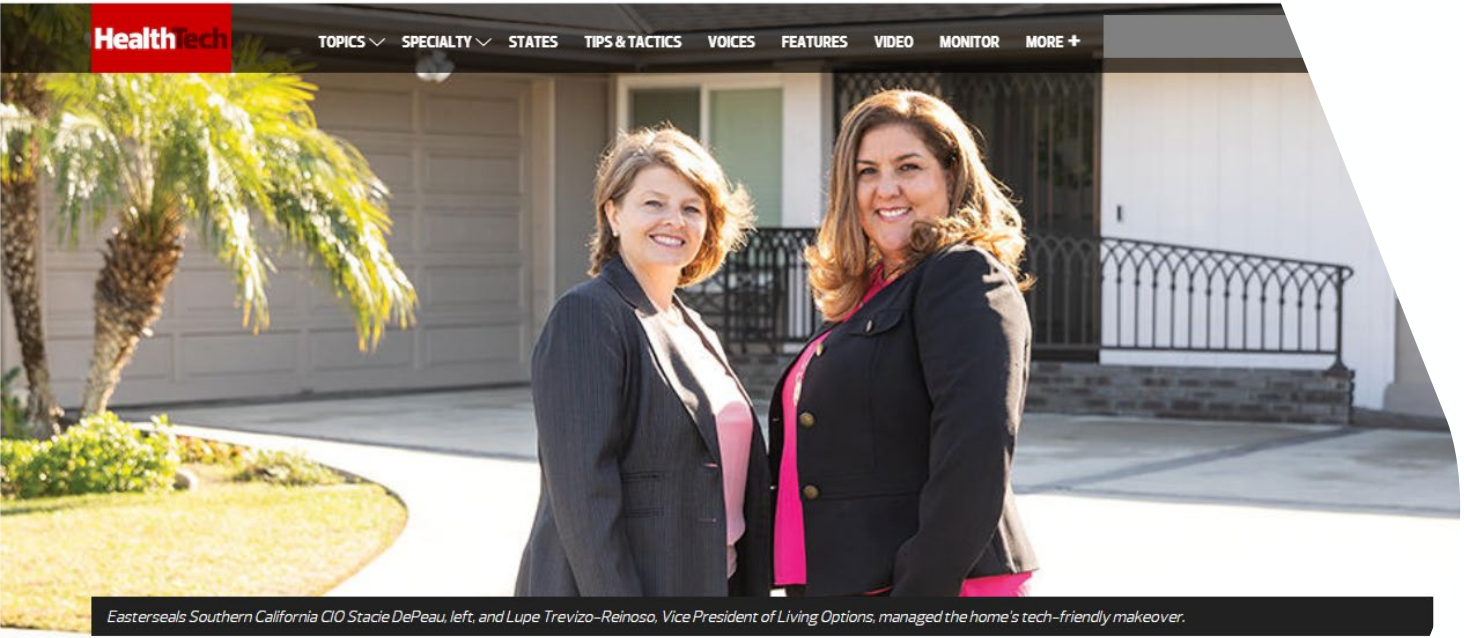
Expected Impact Of Voice Control Functionality On Adoption Of Smart Home/Health Tech By Adults 70+



Why Increase?	
It will make it easier to use	80%
It will make it more readily available	57%
It will make it more enjoyable to use	44%
Other	7%

Why Decrease?	
It will feel like a violation of privacy	50%
It will be a security risk	24%
It will make it harder to use	20%
It will make it less enjoyable to use	11%
It will make it less readily available	11%
Other	26%





Easterseals Southern California CIO Stacie DePeau, left, and Lupe Trevizo-Reinoso, Vice President of Living Options, managed the home's tech-friendly makeover.

FEB 14 2020

PATIENT-CENTERED CARE

How Easterseals Outfitted a Smart Home for Residents with Disabilities

Tablets, smart speakers and other technologies make life safer and simpler for people with special needs.

by Wylie Wong

Wylie Wong is a freelance journalist who specializes in business, technology and sports. He is a regular

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How To Simplify Print Supplies For Essential Services And The Home Office

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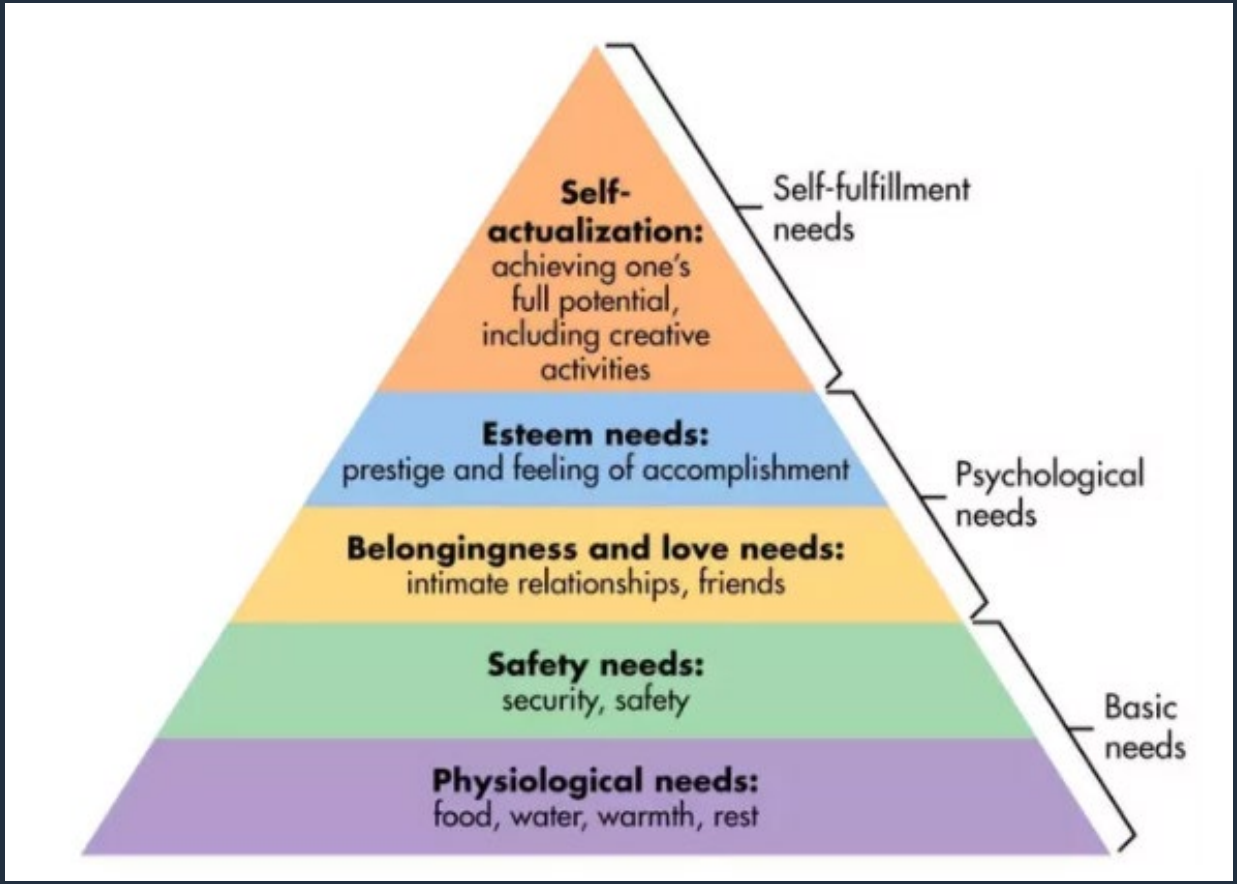

Over half a billion Alexa-enabled devices sold globally. .

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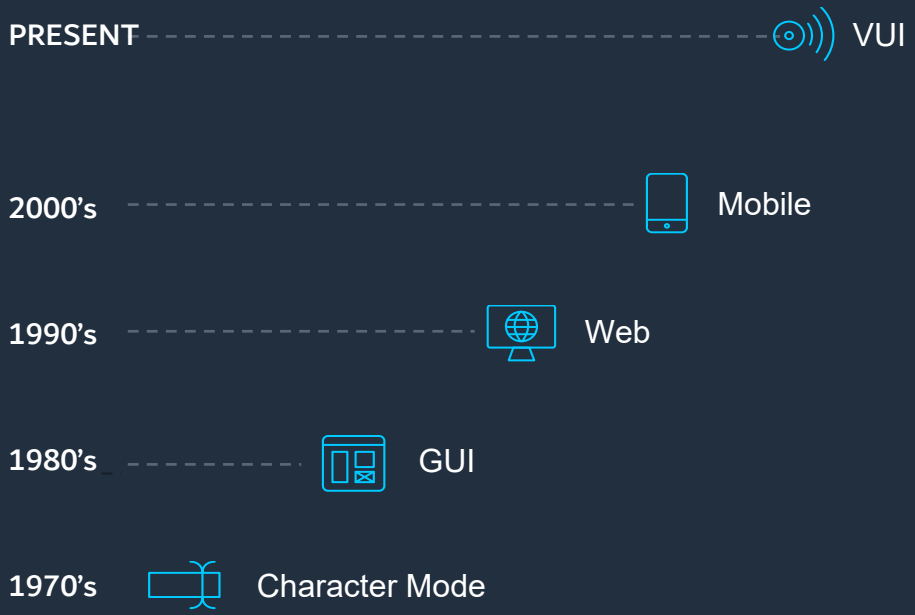
Voice-enabled technology: past and present



63%

Of the total U.S. population (18+) uses a personal voice assistant on a regular basis

Source: NPR and Edison Research 2022

What to expect next from Alexa

Alexa is becoming...

Smarter & more helpful

Use Alexa to create Automations that help your Alexa devices and smart home devices work together. For example, when you say “Alexa, I’m home”, Alexa will say, “Welcome home”, turn on all the lights downstairs, and set the temperature to 70F/21C.

Ease of use

Using Frustration Free Setup, properties can connect smart devices like the Amazon Smart Plug to their Wi-Fi network in a proactive, Alexa guided process, rather than the previous process that could take many more steps.

Seamless device support

Any device, anywhere

Mary Lou

Alexa -My AI Roommate

It has probably been a couple of years since Alexa came to live with me and I am still adjusting!

She has been quite wonderful about notifying me when an Amazon package comes, reminding me of scheduled happenings and awakening me with soothing sounds. But when will I stop feeling I really should apologize to her for asking her to turn on the light AGAIN? When will I feel comfortable not saying thank you when she reminds me to get ready to leave?

When will I stop referring to this inanimate cylinder as her, she, or any other humanistic phrase? Is it the name or the voice that humanizes this technological phenomenon?

I have so many questions. Perhaps I should just forgot worrying about my manners and simply appreciate this amazing technology that makes my life so much easier.

-Marylou
PS – AI is Artificial Intelligence

Zero-Touch Immersive Experiences

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It all started with a call from a friend to Jeff

Three Main Verticals

Hotels & Vacation Rentals

Senior Living

Hospitals & Care Facilities

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ASP Makes It Easy for Enterprises to Harness the Power of Voice

Friction-free set up and management

Flexible, simple operations

Ongoing insights

Privacy and security

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Smart Properties

Senior Living

The Senior Living Industry Is at a Turning Point

Staffing “apocalypse” as workers quit or face stress and burnout

1/5

More than 1/5 of nursing homes nationwide have been operating without enough workers since summer 2020.

Source: AARP

People are living longer as the cost of care continues to rise

85.6 Years

The average life expectancy in the U.S. will increase to in 85.6 years by 2060, compared to 76.9 in 2000.

Source: Centers for Disease Control

Baby Boomers are coming of age during an industry inflection point

73M

The Baby Boomers (born 1946-65) make up more than 73 million people. By 2030, the entire generation will be over 65.

Source: U.S. Census

Lighthouse for Older Adults: A Unique Innovation Approach

Lighthouse FOR OLDER ADULTS

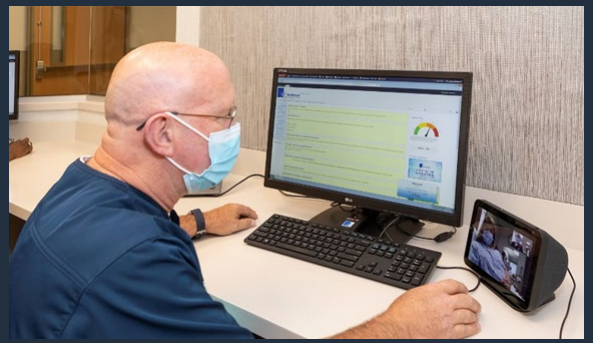
Improving Access to Technology Enabled Health & Wellbeing Support for Older Adults in Affordable Housing Communities

- Install internet, provide user friendly technology to residents, and **establish a multi-lingual digital literacy peer training and support program.**
- Conduct rigorous evaluation to measure our success, identify strengths and areas for improvement.
- Design a replicable, sustainable program that can **scale across CA and the United States.**

1st Alexa offering under HHS telehealth guidance

What did we bring to market?

- Two way voice and video communication between care team and patients being treated for Covid19 using Echo Shows
- Delighting patients with Alexa first party experiences for entertainment



Alexa and Carlton: Streamlining Staff Operations

Carlton Senior Living:

Carlton is one of Northern California's most successful senior living providers, winning national awards for its resident care, health and fitness, and staff development programs.

Goal of ASP Deployment:

Increase staff happiness and efficiency

Alexa functionality to reach goal:

Caregiver check in, alerts, reminders

Alexa and Atria: Raising the bar for Engagement

Atria:

Independent living, assisted living, supportive living, and memory care communities in more than 344 locations in 44 states

Goal of ASP Deployment:

Increase engagement of residents

Alexa functionality to reach goal:

Alerts, reminders and cards keep residents aware of community activities.

"We've seen a 50-75% increase in participation in Atria Engaged Life™ events."

– Chris Nall, Chief Technology Officer, Atria Management Company

Fellowship Square- Mesa: Meeting Challenges with Tech

Fellowship Square-Mesa: Owned by Christian Care, the largest provider of non-profit senior housing and healthcare services in Arizona

Goal of ASP Deployment:

Increase safety of residents and increase staff efficiencies

Alexa functionality to reach goal:

Alexa voice technology and smart home applications

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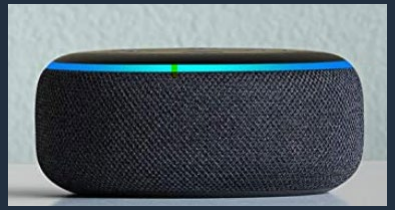
Life Safety



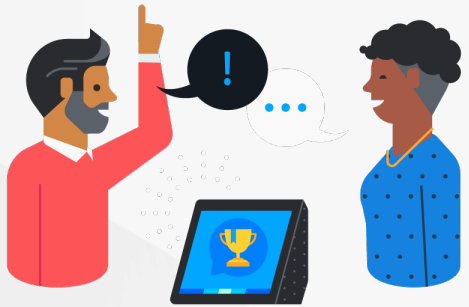
John and Ginna,

On another note, one of our residents made me promise to share her recent experience with Alexa. About a week ago, she had a horrific fall in her Independent living apartment. In her words, she “shattered her femur to smithereens”. While laying on the floor in pain, immobile with no cell phone or pendant in reach, her first and only thought was to call Alexa. She said call Front Desk and Alexa did. She went on to say how cute the EMTs were too. She is now back at The Admiral in rehab starting a long recovery period; likely 6 months or longer. She also made me promise to get the echo from her IL apartment and bring it to her rehab room. Of course, I did. Thought you would appreciate this.

Lj –IT Director, Admiral at the Lake, a Kendal Community, 9/30/21

Pandemic Tech Lessons Learned with Older Adults

- Technology secured wireless infrastructure is a **MUST HAVE**
- Tech through voice **empowers care and independence for older adults**
- Voice **increases adoption** of tech especially with older adults
- **Video chat** is the best alternative to in person meetings
- **Telehealth** is a game changer with older adults



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11/8/20


We need technology to remind us of who we are and what we have gained, not what we have lost.

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Thank you

Ginna Baik
Senior Living Lead for Alexa Smart Properties
gbbaik@amazon.com

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Session 1

POLICY

Brainstorm and discuss potential actions by county government or state legislature to support the shift toward prevention.

Session 2

PROGRAMS

What are the existing programs/agencies in our community that work to get ahead of social or health care problems? Is there need for something new in the community? And what are unique channels for communication that we can access?

Session 3

COMMUNITY ENGAGEMENT

How can we continue to bring the lived experience of persons with dementia and family caregivers into the early planning/thinking conversations? How can we assure that we engage language or cultural groups outside the mainstream?

BREAKOUT SESSIONS
2:30 to 3:30 PM

APPRECIATE

THANK YOU!

Please watch your email for updates!

POST EVENT SURVEY:

https://www.surveymonkey.com/r/NSSStakeholderSummit

HOME-BASED SOLUTIONS

STAKEHOLDER PLANNING SUMMIT ~ FEBRUARY 27, 2024

ENHANCING THE CONTINUUM OF CARE FOR PERSONS WITH DEMENTIA, IMPROVING HEALTH OUTCOMES AND REDUCING CAREGIVER BURDEN.

#HBSStakeholder

nevadaseniorservices.org/hbs