

NWX-HHS-AOA-1 (US)

Moderator: Amy Wiatr-Rodriguez
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12:30 pm CT

Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen-only mode. During the question and answer session, please press star and 1 on your touchtone phone. Today's conference is being recorded. If you have any objections, you may disconnect at this time.

I will turn the meeting over to Ms. Amy Wiatr-Rodriguez. You may go ahead.

Amy Wiatr-Rodriguez: Great, thank you. I am Amy Wiatr-Rodriguez with the Administration on Aging within the Administration for Community Living, and I'll be moderating today's webinar, Community Collaborations for Assisting People with Alzheimer's and Dementias: The Steps to Success, which is the second webinar in our three-part series this year.

Before our speakers begin, we have a few housekeeping announcements. First, if you have not done so, please use the link included in your email confirmation to get on to WebEx so that you can not only follow along with the slides as we go through them, but also ask your questions when you have them through the chat feature. If you don't have access to the link we emailed

you, you can also go to www.webex.com. Click on the “attend” button at the top of the page and then enter the meeting number, which is 660647118.

Please use the name and email address you used to register. If you have problems with getting into WebEx, please call WebEx technical support at 866-569-3239.

As our operator mentioned, all participants are in listen-only mode; however, we welcome your questions throughout the course of this webinar. There are two ways that you can ask your questions. One is using that chat function in WebEx. You can type your questions and we will sort through them and answer them as best we can when we reach our Q and A portion. In addition, after the presenters wrap up, we’ll offer you a chance to ask your question through the audio line. When that time comes, the operator will give you instructions how to do that.

If there are any questions we can’t answer during the course of this webinar, we’ll follow up with you. And if you think of any questions after the webinar, you can send them to us at my email address, which is amy.wiatr@acl.hhs.gov or to any of the email addresses that are included in the PowerPoint slides that are the basis for this webinar.

As the operator mentioned, we are recording the webinar. We will post an audio recording and transcript on the AOA Web site as soon as possible. And I’m pleased to announce that in response to feedback, we were able to post the slides for today’s webinar in advance to our Web site; and to those of you using the chat features on the WebEx, I’ve posted information on that chat side to the link where the slides for today’s session are posted.

Additionally, new this year and based on attendee feedback, we are able to offer free continuing education. This slide includes the accreditation statements, and I'm going to move to that in just a second. Here we go - the accreditation statements for CNE, CEU, and CECH continuing education.

The next slide here includes the applicable disclosure statements.

And this slide provides the Web links you need to access in order to complete the evaluation and post-test to get your continuing education. Please note that these are free. There are no fees to receive this continuing education.

The next slide -- and I'm just pointing out here that they are on the slides that are available for download. I'll give instructions for how to request the - how to access the continuing education website.

And then this next slide here includes contact information on how you can receive help with any questions you might have in accessing the continuing education.

Our topic today is community collaborations. You will hear a variety of approaches and focus areas from our three featured speakers. Before we go to their presentations, I'd like to highlight some federal level collaboration among ACL, CDC, and NIA. As you may know, this webinar series is one output of our collaboration. And another that we'd like to highlight is ROAR - - Recruiting Older Adults into Research.

With ROAR, we see that the aging services and public health networks can help to share research participation information with older adults and families in some very simple ways. One simple step that we are asking those of you on today's webinar to take is to place a link to Researchmatch.org/ROAR or your

local Alzheimer's disease center or other dementia research awareness information on your organization's website.

Other easy steps you could take would be sharing a brief blurb of prepared information in your newsletters or on your Facebook page and distributing a flyer encouraging research participation at any local health and information fairs or events that you might have. We look forward to sharing more information on ROAR in our September webinar.

By getting this critical information out through trusted aging services and public health networks, we can accelerate scientific discovery to benefit older adults, families, and communities.

To hear about some impactful community collaborations underway, I'm please to introduce our speakers today. They include Olivia Mastry, JD and MPH Executive Lead with Act on Alzheimer's; Raj Shah, MD, Associate Professor, Family Medicine and Rush Alzheimer's Disease Center with Rush University Medical Center; and Adam Frank, BA, Grant Coordinator with the Massachusetts Executive Office of Elder Affairs.

At this point, I'd like to turn it over to Olivia with Act on Alzheimer's in Minnesota. Olivia?

Olivia Mastry: Thank you, Amy, and thank you for the opportunity to share Minnesota's work today. If I could have the first slide...

During my presentation, I'll be providing a quick overview of how Minnesota is implementing its state Alzheimer's plan, with particular focus on how we are engaging and equipping communities to carry out critical state plan goals. Next slide.

ACT on Alzheimer's is a statewide, volunteer-driven collaboration that involves over sixty public and private organizations and hundreds of individuals who are seeking to achieve a common agenda of addressing the budgetary, the social, and the personal impacts of Alzheimer's disease.

No single organization owns or finances or controls the collaboration, but instead we all hold it up together. ACT was convened after Minnesota adopted a state Alzheimer's plan in 2011. So ACT is really about implementing our state plan. Next slide.

ACT on Alzheimer's shared goals -- or common agenda, as we call it -- is focused on five interconnected goals that are closely aligned with all except the research goal of the National Alzheimer's Project Act Plan. To make progress towards these goals, ACT is organized into leadership groups that include about twenty-five to thirty individuals who are experts in each goal area.

And our goals are to identify and invest in promising approaches of care and support that slow the growth of costs while improving quality of health and life; to increase detection of Alzheimer's disease and improve care; to sustain caregivers with information, resources, and in-person support; to equip communities to support their residents touched by the disease; and to raise awareness and reduce stigma surrounding dementia.

We're also embedding a health equity focus into each of our goals to ensure that any system improvements that arise out of ACT benefit all rather than only some populations, and this is reflected in our goals visual by the outer ring. We've developed a call to action and guiding principles and practices for

all ACT participating organizations that relate specifically to health equity.

Next slide.

I'd like to tell you just a little bit about our first three goals and then I'll go much deeper into the last two goals that relate more specifically to community activity. In our first goal -- "identify and invest in promising approaches" -- ACT commissioned an economic model on what the potential cost savings would be if an evidence-based caregiver support intervention was made available to all eligible individuals on a statewide basis.

The model's analysis -- which was based on Minnesota data -- and the results are reflected in a Health Affairs article that was published in April along with a subsequent article around net savings analysis. Details of both are available on the ACT website, which is cited on the slide here.

But suffice it to say that caregiver support has potential to significantly slow the growth of Alzheimer's costs by enabling people with dementia to remain in community longer. And it's a good place for state and health system investment, and that's what the subject of our reports were focused on. Next slide.

In our next goal area, "increasing detection and improving care," ACT has created practice tools that provide guidance in assessing and serving clients with cognitive impairment. ACT has also created an interdisciplinary curriculum for professionals in training as well as professionals in the field who want to learn more about Alzheimer's disease and optimal care practices. Next slide.

ACT's practice tools were developed for a diversity of audiences, and they range from primary care providers and medical homes to care coordinators,

community-based organizations, and direct care service staff. The tools are designed to address the full continuum of the disease from early screening and detection to preparation for hospice. We have also developed an electronic medical record decision support tool and implementation guide to enable health systems to embed the practice tools into their EMR's. Next slide.

And our third goal -- "sustaining caregivers" -- ACT has provided expert input into the development of dementia capability training for Minnesota's caregiver consultants as well as provided training and support to the in-person help line in Minnesota called Senior Linkage Line.

ACT has also developed a consumer resource entitled "After a Diagnosis," and this resource is really a roadmap for the person in early stage dementia as well as their caregiver, and it aligns with the recommendations in the professional practice tools, offering tips and suggestions for the person with the disease, their caregivers, and family members after receiving a diagnosis. This allows those with the disease and their caregivers to be equipped with the same optimal care practice roadmap as their providers. Next slide.

And our last two goals combine naturally, and they're about raising awareness and reducing stigma by engaging and equipping communities to be dementia capable, so that they can support residents who are touched by Alzheimer's disease and related dementias. This includes most residents, not just those with the disease. In order to make progress towards this goal area, ACT has developed the dementia-friendly communities toolkit and provided some seed funding to communities to implement the toolkit across the state. Next slide.

We offer communities two types of support in their work. First we offer them content support about what it means and how community sectors can step up and become dementia-friendly. And by the way, we use the terms "dementia-

friendly” and “dementia-capable” synonymously in our work. Secondly, we offer process support about how to move towards dementia-friendly as a community.

On the content side of our support, we first define dementia-friendly as informed, safe, and respectful of individuals with the disease and their caregivers and fostering quality of life and health. With respect to our content support, each cloud on this dementia-friendly visual reflects a different sector of community.

And if one were to be on our Web site where you could find this visual with the clouds, and you clicked on any of the clouds, you’d be provided with a one- to two-page guide or checklist that identifies how each unique sector can become dementia-friendly.

And then that checklist links one to state, national, and international resources for moving towards dementia-friendly in the particular sector. We developed our sectors using World Health Organization age-friendly criteria, and then used a multitude of state, national, and international resources to add a dementia specialty to how the sector can step up and support people with dementia and their caregivers.

So, for example, a government planning organization can access guides and checklists for transportation, public space planning, disaster planning, and emergency preparedness. All of these are found on the website and they’re downloadable and free. Next slide.

In addition to the content support we offer for seeking dementia-friendliness, ACT also offers process support. We looked about thirty years of research which showed us that if communities engage leadership that’s reflective of the

broader community and they organize under a clear structure with shared goals, roles, and responsibilities and then they create a shared plan of action -- that community will produce more effective, sustainable change both within and -- as importantly -- across sectors of the community. Next slide.

Through using this research, ACT created a process support tool that is a four phase toolkit that guides communities in their work. The phases are convene, assess, analyze, and act together, and I'll say a little bit about each one of these phases. Next slide.

In the first phase, communities convene an action team. Ideally, the action team is a mirror of the community and at the center is people with dementia and their family caregivers. Communities can be defined geographically or by interest. The broader the community action team, the more influential it will be in effecting change. The action team is the core resource in raising awareness, engaging community, and effecting change at the local level. Next slide.

Once an action team is convened, the next phase is to assess the community. Assessment is really a conversation that the action team takes to the broader community. It's not a research study. It's gauging three principal issues for the local community -- it's trying to gauge what's the awareness in our community of dementia and the impact that it has on all of us, what's the comfort level throughout our community with effectively responding to and interacting with people with dementia and their caregivers, and what are our current strengths and gaps in providing supportive community resources around dementia.

These questions are asked differently in different sectors, and those questions are based on best practices for dementia capability in each sector. So the

answers to the questions will vary depending upon the sector in which they're asked because there are different levels of professional knowledge and expertise needed in each sector. For example, expectations for effective responses to someone with dementia is different for a clinical provider or a memory loss center than it would be for a faith community, a store clerk, or a neighbor.

So the assessment gauges dementia-readiness, dementia awareness, and dementia responsiveness across sectors and it's a great way to get an overall snapshot of community capability regarding dementia. And it's an awareness-raising activity unto itself. Next slide.

In the third phase, a community analyzes the community response to the assessments by plotting the responses on a grid. Communities want to watch for those areas of need that are high priority in the community, but have low activity levels. This is really the sweet spot that shows what the community thinks is important to work on and they have momentum and passion around it. And it's a great place to start in phase four. Next slide.

Phase four -- "acting together" -- communities select shared cross-sector goals and they implement those goals together. By phase four of the process, ideally a community has engaged specific sectors to take on activities to become dementia-friendly in their sectors, and the communities are also undertaking a shared goal which is often cross-sector. Examples of shared goals include things like creating dementia-friendly businesses whereby business owners agree to or commit to train their staff to be dementia-friendly and supportive of those customers through some shared training programs and resources.

Another is training individuals who would be considered neighbors or friends -- just a regular person through a program adopted from the UK called

Dementia Friends. There are also communities that have developed rabbinical trainings in a faith-based community or training teams within the Jewish community; training government planners, emergency responders; and creating memory cafes. Next slide.

We currently have thirty-two communities acting across the state from rural to metro, including cultural, ethno-racial, and faith communities. Each of these communities have defined their own scope, they gauge their own needs, and they're implementing dementia-friendly changes within and across sectors of their community. They receive technical assistance in their efforts from our statewide area agencies on aging and our Alzheimer's Association chapter. Next slide.

We're nearing three years into our implementation work in ACT on Alzheimer's and our formal collaboration structure will end or transition at the end of 2015. We're conducting a formative evaluation and early feedback has given us some of the ingredients for success from the perspective of our ACT participants and community members.

The success factors that they've identified to date that is leading to some of the progress and the accelerated momentum that we've experienced include the fact that this is collaborative in nature and there's no one owner; but with that said, they've also valued the fact that there is consistent project support and coordination and communication across the entire initiative.

Participants have appreciated and been helped by the collective impact structure which we are using, which is that common set of goals that mutually reinforce each other. They've appreciated the transparency. We have cloud-based information sharing, so everything that's done around the initiative is

shared with everyone, and anyone is welcome to join and contribute in the way they best can.

We've also been working hard especially through our health equity leadership group to ensure that our participation is diverse and our funding is diverse.

And lastly, whenever we make progress, we do our best to communicate it through multiple mechanisms and vehicles, which in itself has fostered engagement and increased momentum. Next slide.

You can find more out about us as well as download any of the tools I've mentioned in my presentation through our website, which is Actonalz.org. And if you have any follow-up questions after today's presentation, you can also reach us by email. I'll be happy to take questions after all of the presentations. Thank you again for the opportunity to present.

Amy Wiatr-Rodriguez: Great, thank you so much Olivia. Next we will hear from Raj Shah) at Rush University Medical Center in Illinois. Raj?

Raj Shah: Hi, thank you Amy, and thanks for having invited me to represent the Illinois Cognitive Resources Collaboration Network in Illinois and our efforts here. It was a pleasure to follow Olivia and her wonderful presentation about efforts in Minnesota, and I'm looking forward to hearing the following presentation about efforts in Massachusetts.

So the Illinois Cognitive Resources Network - next slide please. I wanted to at least first start by presenting what our current vision and mission is and how we're organized, and then talk about some of the drivers for why we came into existence, a little bit about how we held together, and then to talk about

some of our outcomes and projects that have worked towards fruition over the last two years of our existence.

So it took us a while to get us a group and to even figure out a name for ourselves - took about three months of constant talk and collaboration, and finding the right language. But I think our vision is really to make Illinois a national leader in the development and implementation of community-based models for adults to participate in research, education, and training and support services to promote cognitive health and quality of life.

And how we're trying to achieve that vision of making Illinois a national leader in some of these community-based models around cognitive health was to leverage the strengths of various organizations providing services in Illinois, including voluntary health associations represented by the Alzheimer's Association chapters, the Alzheimer's Disease Assistance centers, which were academic centers sponsored by the state to facilitate assistance around Alzheimer's disease; and then organizations and the aging disability and public health networks to really think about optimizing cognitive and functional well-being for Illinois residents and their families. Next slide, please.

And how we organize this was to think about the Illinois families, individuals at risk for memory loss and the families that support them at the center of our activities, with surrounding work by various organizations representing the three large networks -- the disability network, the aging network, and public health network -- as far as providing social service infrastructure along with the Volunteer Health Organizations and the health service providers.

And really, as we started, one of our founding models was to focus on the idea that each group will give something of value to help other collaboration

members and the residents of Illinois they serve, and each group will receive something back to meet its individual goals so that there would be this mutually-beneficial relationship over time that would be developed based on group strength and resources and shared capacity.

And so as I mentioned, with that model in mind, the Illinois Cognitive Resources Network - our vision and our mission and our organization - I want to try to tease out some of the reasons, looking back, of why we came together, what has kept us together, and what our progress has been to date. So, next slide please.

So the “why” which is probably the most important thing -- as we talked and as a provider, as a clinician and a tertiary care memory center, what was commonly a message we heard in providing care was that individuals with memory loss or a recent diagnosis of dementia due to Alzheimer’s disease or another cause of dementia and their families felt sort of isolated and disconnected.

They kept saying to us, “We feel alone. There’s nobody there we can turn to and get help and we’re a little bit scared about reaching out to people further than who’s in immediate family,” because of the stigmas associated with memory loss and loss of socialization and integration in communities.

Then as we started talking with the various service providers, there was a sense of disconnect in there too, a disconnection from other service providers -- so somebody came to me and asked for resources around a diagnosis. I could provide that, but then how would I go about connecting them to, say, a homemaker service in the community or to provide caregiver support groups for an individual - families that were trying to learn to take care of somebody

with memory loss? So there was a feeling of barriers towards making connections between service providers.

And then there's also feeling that we have our doors open. We're committed, we have passionate professionals who want to help people that are having memory concerns, and to provide them and connect them to services. But we're just not - the door is open but nobody's really walking in, and not as much as we had hoped. So our services are not being fully utilized, and as a result it puts pressures on us to be able to continue to offer services.

And that what started happening is conversations were changing on the national agenda -- some of the ones that Amy alluded to -- and then I'll talk a little bit briefly about. And the efforts that were happening statewide - it was hard to always imagine how to translate these large scale efforts at a national and statewide level into a local level and to use a network that could be the middle man that would provide, essentially, the understanding and support to deal with the national message and to be able to work on it and translate it so that it could go out and be available to local communities. To have some ways of implementation and support and building capacity was something that was not worked out well and as a result, these disconnects were starting to happen.

And so the next slide - I just wanted to share some of the things that are driving a national agenda that influenced us to come together and to think more in a collaborative manner. So Healthy People 2020 - so the public health efforts on the nation in the last iteration for 2020, you had some development goals for individuals with dementia and Alzheimer's disease. And those goals focused on the idea of increasing the number of individuals that would be aware of their diagnosis of memory loss. And then the second outcome is reducing the amount of iatrogenic or preventable hospitalizations associated with somebody that might have dementia.

So that's always been a large public health goal and now part of a national plan, and that was put in in 2010 to try to achieve some outcomes by 2020, and to collect some information about how to meet those success metrics.

And then in 2011, the National Alzheimer's Project Act being signed into law to create a national plan to address Alzheimer's disease and the work around building the mission and vision and objectives of the national plan to address Alzheimer's disease -- including increasing and enhancing the capability of providing care and support for people with dementias due to Alzheimer's disease -- started driving conversations that brought together things like this webinar today with collaborations between the CDC, NIA, and ACL.

And then the work by the CDC along with the Alzheimer's Association around the Healthy Brain Initiative roadmap highlighted the needs from a public health sector, again, to train more individuals to provide care to individuals with memory loss and Alzheimer's disease and other dementias, and then to make our communities more capable and dementia-friendly. So, next slide please.

So those national agendas and the difficulties around connections and translating those national agendas into local things encouraged us to start - a group of us that were involved with the state plan that has been in existence since the 1980's in Illinois to think about forming a group that could meet and talk and find ways of finding common ground and solutions. And similar to some of the work that was described by Olivia in Minnesota, some of the things that have helped us stay together was to arrange for room, for space for individuals from various groups to come together in a monthly meeting forum. Some of them could make it in person, but at least over teleconference to exchange ideas and to look for opportunities to collaborate.

So a large part of our initial meetings were really to just ask each other about our organizations, what our goals were, what we were trying to achieve to find a common language. So something as simple as the abbreviation ADRC became slightly complex because in the Alzheimer's disease research world funded by the NIA, ADRC stands for Alzheimer's Disease Research Core centers -- or research centers. But in the aging community, ADRC stands for Aging and Disability Resource Centers. So we were sometimes using the same abbreviation but talking about totally different things, and it forced us to at least learn about those and to acknowledge them and to start finding a common language.

That was the second point around defining a common language, allowing for collaboration and each group to talk about what it was doing, and to share information about its struggles and where it needed help and its successes. We took a lot of time and really tried to figure out and work through the name and vision and a mission statement. It probably took about a total of about three to six months, especially with the name, to make it something simple and something that recognizes what we were trying to do, and that could be used to help brand our efforts as far as what we were trying to accomplish as a collaboration.

Probably the other thing that helped us to stay together was constant feedback from various stakeholder leadership groups around the state, including leaders from the various networks from public health to aging to disability; and then also from leaders in the medical care and provision of care, and the voluntary health organizations to keep us aligned and on track with some of the bigger goals.

And then what we really tried to do is take short term wins, to realize this was a big effort. It was a process and it would take - and we wouldn't have a success that we would all of a sudden say we're done, it's time to move on - but to really focus on the ideas that we could make small term steps, goals; meet some of those goals; build momentum and trust in our groups that we were able to exchange ideas and have small successes to help to meet those long term goals of our vision. Next slide, please.

So some of the progress in our activities is where I'd like to spend a little bit of time here, and I wanted to outline the five areas we've been touching on which has been supporting the dissemination of public surveys on aging and cognition throughout the state; looking at education and training of various providers at different levels for people with risk for memory loss and those who are experiencing it; providing input on changes that are happening in this dynamic transitional point around state programs and services through the social services network and the medical networks; and then dissemination of our progress to date at various national and state meetings; and then looking at ways for the state to support their efforts at obtaining innovation funds to develop a more capable state and helping people that had memory loss or are living with dementia. Next slide, please.

So as far as supporting the state public surveys, there's a state of Illinois Alzheimer's disease annual survey that's done as part of the revised Alzheimer's State Plan Act, and this has been work done by the Alzheimer's Association of the state along with the Illinois Department of Public Health and various stakeholders. And the ICRN played a bigger role this year in using our networks to get the word out about the survey that would be filled electronically to our constituents so that there'd be a large increase in a number of responses from the prior year. We essentially achieved a five-fold

increase in the amount of survey responses, which helps the state to better gauge how well they're meeting services for people in the community.

And then also in the area around Chicago, in the metropolitan area there's been a focus in Chicago of getting recognized as an age-friendly city by the World Health Organization. And there's been some surveys around what it means to age well in an urban setting that we've been using our networks to help get information out to older adults in our communities that we know to complete those surveys so the city would have a better idea of what older adults would want. Next slide, please.

On the education and training, we've done things at the governor's conference on aging to provide presentations with other stakeholders around what it means to build a dementia-capable state and to train around the 101's of information around dementia and dementia care to various members in the aging network. We've worked closely with the aging network caseworkers that were part of the planning and service areas and area agencies on aging to listen to them about their needs in working with clients in the community, especially ones that there might be concern about memory loss, and have worked with them under their leadership to provide some expertise for a training DVD to engage clients for the first time.

So that would help caseworkers have a better chance of recognizing that there might be a problem. And now we're facilitating some work further to build some tools for caseworkers to be able to better understand dementias and to assess them, and to triage accordingly.

We've done some presentations to the Illinois Public Health Association to hit the public health networks about Alzheimer's disease, and especially issues around how to handle emergency situations and incorporate planning to help

people that might have memory loss to be put out of harm's way if a certain natural events occur - disasters occur.

We've also been presenting to our colleagues in primary care through the Illinois Academy of Family Practice and its annual meeting to encourage discussion about how to do cognitive assessments as part of the Medicare annual wellness visit. And then we've been working to help to think about ways to evaluate the ROAR project by getting opinions from various stakeholders about the ability for them to pilot this. And even today morning I was out at a presentation to senior housing leaders to talk with them and show them the presentation for recruiting older adults into research and getting their feedback on how willing they would be to provide those presentations to their community constituents.

And then the next slide about input on state programs -- I'm sure Illinois is no different than a lot of other states that are going through some transitions around dual-eligible that qualify for both Medicaid and Medicare. And there's been questions about how to improve our system and make it better and more responsive. And so the state put out a request for information about a uniform assessment tool to assess for services for home and community-based services, and the ICRN as a group provided some input on what they thought would be logical solutions there.

We also realize that caseworkers in the state of Illinois have to collect a lot of information on the eligibility assessment when they provide - look at home and community-based service eligibility. And we wanted to try to look at how that survey was done, get feedback from the individuals doing those surveys, and see how we can make that survey information more informative in triaging individuals to the right resources. So the next slide.

And dissemination at national meetings -- we've done poster presentations about our work at the Gerontology Society of America annual meeting and then we've also done some work with the American Society on Aging annual meeting with an interactive seminar about how communities and leaders can work together, similar to a model of ours to think about lowering barriers for collaboration. Next slide, please.

And then I think one of the things that we find satisfying is that when we started this process two years ago, the state of Illinois had not received any funding that was active around making things better in the aging network. And since that time, we've been part of and supported and provided letters of support and other input to help the state to achieve two funding mechanisms; one through the Illinois Department on Aging for dementia-capable state capacity building that Illinois was one of five in the country to receive through the Administration on Community Living, and then also some work with the public health network around implementation of the Healthy Brain Initiative roadmap.

And in the next slide, I just wanted to list some of the key objectives about the dementia-capable state grant objectives, including improving our access and referral services, making sure there's no wrong door to connecting people to services, looking at training various professionals in the aging network around dementia-capable services, implementing counseling so that individuals would have better ideas of services that could be provided in their home and keep them in their home rather than potentially going into long term care, providing training with evidence-based modules to help caregivers learn the Savvy Caregiver model of improving their skills and reducing their stress -- next slide please -- linking individuals to dementia and their caregiver to dementia-capable services, streamlining our programs and eligibility determinations,

looking at data and quality assurance to support these things in sustaining a dementia-capable home and community-based system.

And then the next slide on the Healthy Brain Initiative implementation - really looking at ways that the public health system -- the IDPH -- could work in updating its central public Web pages to use - provide data to enhance awareness about cognitive loss and its burdens, to develop strategies to help the public health network and others to assess their competencies and addressing issues around dementia and improving them and prioritizing some of the latest recommendations in the state plan so that as funds become available, they can be implemented in a most effective fashion. Next slide, please.

So I think in conclusion, our message is really small things by a committed group of individuals that are willing to learn from each other and have an opportunity and a space to meet can make some differences, even in a timeframe of about two years. And so diverse statewide, inclusive community of care groups are needed to best meet the needs of individuals living with or at risk for cognitive loss. For groups to really function, we have to allow for early trust building and open communication, and allow for a process of continued improvement.

And then we hope that in some ways like Minnesota and Massachusetts, our presentation today could be an example of one model that could be leveraged to be translated into other states and communities; and that we realize it's a process and we're continuing to learn and evolve together to improve the quality of life of residents in Illinois. And it requires communities and healthcare providers and persons and families with conditions such as memory loss and researchers to all work together in a more collaborative way.

Thank you for the time for the presentation. I look forward to any questions at the end.

Amy Wiatr-Rodriguez: Great, thank you so much Raj. I'm just going to move through the slides here where you have your acknowledgements for your different partners. And then, we are now ready to move it and toss it over to Adam. Adam?

Adam Frank: Hi, thank you. So the two community collaborations I am going to discuss today from Massachusetts are dementia screening tool and the rolling out of that, and our Silver Alert Project.

So the first two slides -- and I guess we can go to the first one -- they are Massachusetts Alzheimer's state plan recommendations and are standards of dementia care. And I include these both because they represent the spirit of community collaboration that we're discussing today. Both of these were developed in close partnership with the Alzheimer's Association Massachusetts and New Hampshire chapter, as well as our twenty-seven aging service access points which administer our home-care program, as well as trade associations, consumers themselves with Alzheimer's, and caregivers, and community activists and hospitals.

So the first slide - the plan recommendations - the first two address themselves towards improving services for consumers with Alzheimer's and their caregivers, which the screening tool addresses. And then the fourth one is focused on public awareness and public safety, which is a guiding goal toward the Silver Alert. Next slide, please.

And then the standards of dementia care were implemented in 2011 and they are a set of protocols for better identifying people with dementia and

improving training and quality of services throughout our home care program. And the dementia screening tool is a critical component of that. Next slide, please.

Okay. The dementia screening tool -- I think many of you are familiar with this. It's - the consumer is given three questions and then asked to draw an analog clock, and then asked to repeat the original three words. You can see on the right are some examples of clocks, the one in the top left being a very good clock which probably indicates no memory impairment; and the other three which may indicate some sort of impairment. Next slide, please.

So the people who - on this slide, I should say right up front the 25% figure is a mistake that I just caught this morning. It represents an earlier percentage. The overall number since we started administering the screening tool since spring 2011 is closer to 12%. People who score a two or lower on the screening tool are screened for depression or other possible factors that may have caused a low score. And then if we - once we've ruled that out, with the consumer's permission we send a letter to their primary care physician asking - notifying them of the results of the screening tool and suggesting that further screening may be warranted, and possible diagnosis. So far, we've screened 40,000 unique individuals since we started administering this in spring 2011 and once a person does score a two or lower, they don't receive the screening tool again. Next slide, please.

The result of the screening tool - one of the more positive results is that all of the low scores receive a risk assessment, which includes things like risk of wandering, risk of driving, home safety issues like lighting and clutter. And then an action plan is developed and the case manager from the home care program works with the family to develop the action plan and to identify resources to carry out the plan.

And then another notable thing is that the amount of services based on the cost of services provided for a consumer increased by 43%, which we believe indicates that the screening tool helped the case managers identify additional services which may be useful to a person with Alzheimer's, particularly rehabilitation therapy, occupational therapy, support of home care aide services, and adult day. Next slide, please.

So the major challenge with the screening tool that we encountered is that the letter I spoke of earlier that we send out to physicians - we really don't know what happens to it once it arrives at the physician's office, whether it's even read or it goes into the circular file. We haven't been able to facilitate much of any communication with the doctor's office. So in response to that, we have revised the letter, trying to make it a little more punchy and a little more likely to be read. We had some people on the Alzheimer's Association's Medical Advisory Board review the letter from the perspective of a physician.

And we've also identified four aging service access points who will be piloting in the coming twelve months with the Alzheimer's Association to see if we can develop some strategies to improve communications with physicians' offices based on some smaller successful efforts that have taken place over the last couple of years.

And then the other challenge we've had is we've had some indication from the home care program that twelve months may be too frequent to be administering these. Some of the consumers don't like receiving them that often and I would - at the end of this presentation, my contact information - my email address and phone number will be there and I would definitely welcome if any of you have any experiences with administering a screening tool, if you could tell me how often you administer it and how that's worked

for you, and if you have any recommendations. Next slide, please, moving on to Silver Alert.

Silver Alert was a 2010 Massachusetts law designed to help multiple local and state agencies better identify people who have wandered and become lost and developed protocols to return them home safely; and, ideally, lower their risk of wandering again. So right now, if a person becomes wandered and it is labeled by the local police force as a Silver Alert, the state police are notified. They notify us and then we connect with our protective service program and the Alzheimer's Association to see if we can - if the person is enrolled in our home care program and to see if further action from protection services is warranted, and to hopefully engage the family with the Alzheimer's Association. Next slide, please.

About a year ago, we administered - we convened a work group to see if we could make this work a little better. We have representatives from the state police, 911, the Mass Association of Chiefs of Police, and the Alzheimer's Association. And the work group is focused on improving communication among these agencies -- a lot of the times when there is a Silver Alert, we don't hear about it until the next day when the person has already been found - - improving training, and collecting data on consumers who are at risk of wandering or becoming lost. Next slide, please.

As far as training, Mass 911 and the Alzheimer's Association are developing a training right now for dispatchers. Right now in Massachusetts, I'd say most dispatchers are civilians, but a lot of them -- due to cutbacks -- are patrol officers as well, so we will actually be reaching a lot of police officers as well as dispatchers. And we will be working in the coming years on developing strategies to reach patrol officers as well through either in-person or Web-based training. And then in the middle there is a nice training we developed

for families. I have the YouTube link there. If you miss the YouTube link, you could just -- in the search window -- look up Massachusetts Silver Alert and see it. It's about six minutes long and it's pretty good. I guess that's all on that. Next slide, please.

So the thing we're right in the throws of right now is a pilot to encourage local police departments to develop a database where they register people with dementia who are at risk of wandering. Next slide, please.

The - we had a - we were lucky enough to have a champion on the Massachusetts Association of Chiefs of Police who is really passionate about this, and he sent an email blast out to all of the chiefs and twelve responded. So we have a really good group of twelve departments that are very proactively interested in this. Also taking part in the pilot are us, the Massachusetts Office of Elder Affairs, and the Alzheimer's Association. We have had - well, we've scheduled four kickoff meetings. We've had two and also taking part in the meetings are representatives from our aging service access points and our councils on aging. Next slide, please.

There's my contact info, but as far as the first two meetings have gone, we've been very up front about the fact that we want to encourage the local police departments to really do it their own way. We're not dictating how they have to do it. Melrose, which is where our champion is from -- he has a very good registration program which they're welcome to replicate, but if they already have a system in place they can use that. One of the towns we're working with has a very extensive registration form that includes the whole spectrum of mental and cognitive disorders.

And yes, we're - we've just started it now so we're not sure where it's going to go. Our goal would be to, in the coming years, have all 351 cities and towns

in Massachusetts taking part; but twelve, we thought, was a good number to start with and study. The one thing we very much noticed at the end of the two kickoff meetings we've had so far is we scheduled way more time than we needed. We scheduled about two hours and we were done with our presentation in just a little over an hour. But we scheduled two hours because we wanted the entities involved to have a chance to meet each other and talk. In many cases, they had already met each other many times.

So we noticed at the end of the meeting that the participants had broken off into groups with the Council on Aging and the Aging Service Access point and the police chief from the respective towns talking about what they were doing and how they were going to move forward. So we will be monitoring with them. We'll be checking in with them every month or so to see what strategies they're using to register people we've recommended - health fairs, community fairs, presentations at councils on aging and libraries with people signing up after.

In Melrose, I know they will - a detective will come to the person's home if they don't want to sign up in public because of the stigma or whatever. So far, all of the aging service access points and councils on aging and Alzheimer's Association representatives who've taken part have said they would be happy to include the registration form for the database as part of their arsenal of tools and interventions with working with a family with Alzheimer's and then pass the information on to the police chief.

So it's a good start. We're very optimistic about it, but as I say, it's - we don't know where it's going to go yet. Check in with me in a year, or even six months. That's it until the questions.

Amy Wiatr- Rodriguez: Wonderful, thank you so much Adam. And I just want to take this opportunity - this is Amy Wiatr-Rodriguez, moderator. I just want to thank all of our speakers -- Olivia, Raj, and Adam -- and I wanted to let all of you know too that we have a number of questions that are coming in on the chat line and in just a second I'll turn it over to the operator for her to give you instructions on how to line up to ask your questions and make your comments on the phone line.

But first I want to give a special thank you to Jennifer Throwe in our ACL Boston regional office who really helped to organize today's webinar. So thank you, Jennifer, and thank you again, all speakers. Don't go very far because you've got lots of questions coming for you. So could I turn it over to Mia to give the instructions on how to give the - how people can do the phone questions?

Coordinator: Thank you. If you'd like to ask a question, please press star and 1 on your touchtone phone. Be sure to unmute your phone and record your name clearly. Again, star and 1 with any questions. You can also withdraw your request by pressing star 2. One moment while we wait for the first question.

Amy Wiatr-Rodriguez: Great, and while we're waiting for that, I'm going to go through some of the questions we got on our chat feature. So the first question is for Olivia, and the question comes from Sally wondering if there was a link to the "After a Diagnosis" information.

(Olivia Mastry): Yes, there is. If you go to the Web site, which is www.actonalz, you'll see that there are some tabs along the horizontal border of the Web site. And if you go to the provider section, you'll click on "Provider tools" and all of the tools that have been developed are there, and after diagnosis is one. And you can

also access it through our “Caregiver” tab. There’s also the “After Diagnosis” tool there as well.

Amy Wiatr-Rodriguez: Great, thanks so much Olivia and I know I went and found it, so I may send that link out on the chat feature as well to everybody who’s on. I’ll do that right now.

Alright, we had another question that also came in from Nancy and this is for Adam. And the question was if you could clarify that the 12% statistic that you had was for 12% of the people being screened - if it was that they indicated the potential of dementia or potential for depression.

Adam Frank: Thanks for the question. Potential for dementia.

Amy Wiatr- Rodriguez: Great, thank you. Let me see with Mia. Are there any questions on the phone?

Coordinator: No questions from the phones currently. Again, if you’d like to ask a question, press star and 1 on your touchtone phone.

Amy Wiatr-Rodriguez: Great, we’ve got plenty on the chat side. Maybe people are more comfortable with that.

We have another question that came in and I think this is again for you, Adam, regarding the type of risk assessment tool that you use, perhaps after you do the initial screening.

Adam Frank: That’s a great question. I - beyond the general categories, I talked about home safety, wandering, and driving. I actually don’t know the answer, but I’d be

happy to - if the person left an email address, I'd be happy to look that up and follow up after the call.

Amy Wiatr-Rodriguez: Sure, absolutely. And if it is a tool that you are able to share, we can also include it in the listing of resources that we can also post to our Web site after the presentation.

Alright, wonderful. We have another question that came in from Michelle saying that they also use a letter to notify an individual's doctor. And again, this is for you, Adam - wondering if you would be willing to share your redesigned physician letter.

Adam Frank: I don't see a problem with that. I don't think it's proprietary to the Alzheimer's Association or anything. I think my guess is we'd be happy to share it and I'll just confirm that. If I can share it, should I pass it on to...

Amy Wiatr-Rodriguez: Yes, we can just follow up with you and, again, for everybody listening, we'll include that if it's available to be shared. We'll include it on the resources page that will also be posted with all the other materials from today's session. Great.

Another question from Deanna, and this one is for you, Olivia, wondering what types of funding support your ACT on Alzheimer's initiative?

Olivia Mastry: Yes. We have a variety of funders. So our direct funders -- we have twelve private philanthropic foundations that are funding our efforts. Some of them are actual foundations and some of them are large businesses in the area that have a foundation arm. We also have leveraged funds, so it's not direct funding into the initiative; but we've leveraged funds that have been federal grants to our state Department of Human Services and Board on Aging. And

so as a result of those funds, they've been able to lend us staff and expertise to help as well. So it is a mixture of foundation, philanthropic, private organizational, and leveraging some federal grant funds.

Then lastly, we do have some direct funds that we receive through our geriatric education center from the Health Resources and Services Administration or HRSA that have allowed us to develop some of our curriculum. So it is a real diversity of funding.

Amy Wiatr-Rodriguez: Wow. That's great. And while we have you, Olivia, another question came in. This one's from Hal wondering if you could explain what a memory café is.

Olivia Mastry: Sure. Memory cafes are being set up really all over the country and internationally as well. Essentially, they're existing businesses or people where people can congregate locally -- whether that could be a library, a restaurant, some kind of coffee shop organization -- and essentially there's a process by which you collaborate with those organizations and they set aside specific time that is available and specifically set aside for individuals with dementia and their family caregivers to come and know that they will be with others who may be working with the disease as well as understanding each other. It's support group-like but without formal support group mechanisms.

Most organizations who do set aside this time don't close themselves off to the public, but they do create this time as special, set-aside time. So you know when you're there, you'll be in an understanding environment with others who are also working with dementia and related issues. It just gives you an opportunity to be in community, to meaningfully engage but in a way that's safe and respectful.

Amy Wiatr-Rodriguez: Great, thank you. There's a question for Raj and this one comes from Deanna as well. She's wondering if your coalition developed the training for the DVD that you use with the aging network case managers, or if it was some type of existing training that you used, and if you could talk a little bit about the training itself as well as the response to the training that you've had.

Raj Shah: A very good question. Thanks for that question, Deanna. So this is a multistage process with working with case managers and caseworkers to help them to better engage and interact with older adults and people at risk for memory loss. The initial phase - how things started was to start by the thought of bringing the experts at the funded centers around the state and federally funded centers to provide expertise around how dementia is diagnosed, treated, and assessed. But as we started talking with the diverse group of caseworkers and case managers, what we ended up finding is when we surveyed them, one of their biggest struggles was how do you get in the door? How do you start the process of having a conversation with somebody and allowing that process to continue?

So in a very stakeholder-based method, what we decided to do is to think about it from the perspective of the caseworker that goes out into the field and has to make that first call and entry, and especially if that's a new caseworker - is how do you help them to learn from older, more experienced caseworkers in the state to tell their stories about how they handled scenarios?

So the initial DVD, then, became a DVD of description by caseworkers of scenarios that they had to undergo to deal with two situations -- one where there was a person that seemed to be having some troubles in maintaining their day-to-day lives and families and friends were calling for the aging network to come in and do a screening and evaluation of what was going on in a rural community. And the process of starting to figure out that there's more

things happening in this case by just doing that home visit and building a relationship than just the person not having resources and support - but they were actually having troubles with their memory and the struggles of trying to find resources to help them.

And then the second case was somebody that left the hospital with a diagnosis of dementia, was starting home and community-based services after getting services in the hospital, and how the case manager could initially assess and implement some ideas to help them through that initial evaluation. So we took the perspective of what the caseworkers are facing on a day-to-day basis, used the expertise of case managers to present the cases so there would be familiarity, and then using a panel of diverse experts ranging from physicians to nurse practitioners to social workers to talk about how they would maybe view the case or what the lessons learned were.

So that DVD has now been released and is being used. We haven't gotten any formal feedback. It just finished as of June 30, but now the next stage is - how do we move on and start developing a curriculum to help people to triage better once they recognize that somebody's having memory problems? And that - we don't want to reinvent the wheel, and so we're looking for other national resources.

I might have to reach out to Olivia in Minnesota about some of their training experiences so that we develop something that's evidence-based and really takes the issues from the perspective of a very busy aging and disability network service provider viewpoint; and then applying our expertise to help them to address that issue from that perspective rather than the other way around where it's more didactic.

I hope that helped. Thank you.

Amy Wiatr-Rodriguez: Great, thanks Raj. And we'll check in with Mia to see if there are any phone questions.

Coordinator: Yes, we do have a question from Reba. You may go ahead.

Reba: Good morning everybody. My name is Reba. I am an Aging and Disability Resource Connection Coordinator in Northern California at an independent living center. And my question is for Adam. I'd like to know if his pre-screening tool has anything built in to accommodate - for people going through the screening who already have pre-existing disabilities that might affect the outcome of the screening tool, such as cognitive or developmental disabilities or physical disabilities. That's my question.

Adam Frank: That's a really good question. The only one I know we specifically screen for is dementia and I'm just trying to think if I can find something more - not dementia, I'm sorry, depression. I'm trying to see if I can find something more specific than that. I don't think I'm going to be able to in the context of being able - the time restrictions right now, but I will look into that. I would guess that we would, but I'd rather offer something stronger than a guess.

Amy Wiatr-Rodriguez: Sure, that's absolutely something we can follow up on. And I don't know, too, Raj or Olivia if you have anything you wanted to add on that?

Okay. If not, that's - we'll definitely follow up on that. Thank you very much for that question.

Alright. Mia, are there any other questions on the phone line.

Coordinator: No further questions.

Amy Wiatr-Rodriguez: Okay. And we still have time and we still have lots of questions that are on the chat feature, so whatever - if people have additional questions, please feel free to send them in either way, via the phone or on the chat function.

So another question that was on the chat side was for Raj and this was from Nina. She's wondering if the different education and training including the DVD but some of the other presentations you had mentioned for the Public Health Association and the Illinois Academy of Family Practice -- are any of those different presentations or the DVD available anywhere? Or online access?

Raj Shah: Yes. So that's a good question and thank you for that. So right now, we're in the process of updating a more public Web site and we anticipate in the next few months to have the capabilities of the Illinois Cognitive Resources Network website to host some of that information as far as presentations or slides that have been developed over time.

Amy Wiatr-Rodriguez: Okay, great. A question for Olivia - actually two; one from Mary Martha regarding how were health systems involved for the collaboration and one from Charlotte regarding the number of staff members that ACT on Alzheimer's has.

Olivia Mastry: So in response to the health system involvement, we have representatives from health systems in each of those leadership groups that I mentioned, so populating many of the goal areas. So they were involved in helping to design and develop the tools that came out of our leadership groups and our goal areas.

And now we're also engaging them to help us work on how best to disseminate, implement, and assure adoption of the provider practice tools so that when people see their clinical or community-based providers, the health systems -- from a leadership standpoint -- are supporting the use and adoption of tools and practice, and people are receiving optimal dementia care. So that's the way the health systems are involved.

We really have a very small staff from ACT on Alzheimer's specifically in that we have - my role is a part-time executive lead. We have a part time project director and a part-time project manager -- so a total of about 1.5 people contracted with ACT on Alzheimer's to help what we call "support the backbone" or the glue that holds the collaboration together.

But we look at staff as well as all of the in-kind volunteer participants who lent their expertise and their time to develop the tools, who are out there training on and disseminating tools, helping to support communities. So we extend our staff with all of our volunteer participants as well as community liaisons that we have on contract, the area agencies on aging, and the Alzheimer's Association. So our staff is defined in multiple ways. We have the direct contract team which is very small, and then we have all of the players in the network who contribute in kind in some small way or with small contracts.

Amy Wiatr-Rodriguez: Great, thank you. The next question, I think, any of you who are panelists or any of our NIA colleagues who are also on the phone could answer this. The question is, "Is there an ideal cognitive screening tool in Spanish to be used in the community?"

Anybody aware of or have any cognitive screening tools in Spanish?

Raj Shah: So this is Raj. I just want to be clear I think this is a big area of work and trying to figure out what the right tools are. There are multiple tools that are out there that people have been using, whether it be the Mini mental state exam or other like the mini cog or the clock-drawing test.

But from a review point of view, I think it's important to realize the US Preventive Task Force Services did a recent review of what kind of screening tools could be available - short, five to ten minutes or less -- that are reliable and give appropriate and accurate results to move people - triage them into the high risk category of having a dementia versus not. And the results were really to point that there is not one particular screening instrument by itself that can be thought of as a standard. And so it is a little bit of a gap and a hole in our current system that is just continuously to work through.

That said, there are - the common tools that have been used and some of them have been translated into Spanish, including such things as the mini mental state exam. But I think this is still an area that needs a little bit more work as far as our capabilities on thinking about a good, short screening tool. And that's why even with the Medicare annual evaluation visit, it's been left open how people evaluate that, whether it's through just interviewing the person, looking over records, doing a screening test, doing some more formal testing. They've really left it open because this question hasn't been fully answered.

Olivia Mastry: This is Olivia. I'll just add on to Raj's comments that this isn't just a gap area for Spanish-speaking populations, but for many cultural communities. And so what we're doing within ACT on Alzheimer's - this is precisely the work of the health equity leadership group that I mentioned. We're taking all the tools that have been developed based on best evidence and we're testing those within the context of specific cultural perspectives to see which ones still hold

and which ones need revision so that they have meaning and actually accomplish their desired outcome in different cultural groups.

We're doing that over the next four to six months, so it's likely that some of our tools will be either revised or we will have companion tools for particular communities. So if you watch our website, I would say in about the next four to six month period you may see some changes based on this health equity filter that we're running all of our tools and processes through, including our website.

Adam Frank: This is Adam from Massachusetts. I would just add that our screening tool can be - it's the three word recall exercise and the clock can be administered in any language as long as you have a multilingual case manager or administering it in terms of whether it is optimal or standard. Echoing what Raj said, I couldn't make that opinion. I just - that's just the one that worked best for Massachusetts.

Amy Wiatr-Rodriguez: Great, thank you all. And just to note, I sent out something via the chat feature and we will also include this in our resources page. This is from Nina Silverberg at NIA who sent the information that NIA does have a searchable Web page listing cognitive screening tools, and that link is there on your chat feature. I know some others of you were writing in via the chat feature and mentioning things like the MOCA or MMSE and I encourage you to go to that website, look them up, and see what may be of interest in your local communities.

Olivia Mastry: And I would just add to Amy's comment -- because this is such an important issue -- that while there are, as I say, best-evidence tools out there to use, we're learning and hearing day after day that some of the concepts that are used to test and detect dementia don't have meaning in particular cultural

communities. And so that's that the work ahead of us is, is - are there tools that can be developed that are meaningful for all communities or can at least be refined so they have meaning across communities? So I think it's a really important question that's been raised, and we have work to do on that.

Amy Wiatr-Rodriguez: Great, thank you. Let me check with Mia. Do we have any questions or comments on the phone lines?

Coordinator: No questions from the phone.

Amy Wiatr-Rodriguez: Okay. And people still can go on the phone or also send your questions or comments via the chat feature. Let me go to another question for Adam, and my apologies if we've already discussed this one. Like I said, we've had lots and lots of questions coming in on the chat line - or chat feature today. So the question is, "What is the criteria for who gets screened using your screening tool?"

Adam Frank: Everybody gets screened except for consumers who already either have a diagnosis of dementia or who have already received the screening tool and scored two or below. So if you've received - if you've been screened but scored high, you would get the screen again a year later.

Amy Wiatr-Rodriguez: Okay, great. Another question has come in and, again, along the utilization of screening tools, but this is maybe a slightly different question regarding if anyone has any experience working with tribes in their community efforts.

Olivia Mastry: I can't answer that question with related to screening, but many of our local communities that are serving as action communities have multiple populations and we know of a few that not only have American Indian populations, Native

American populations, but that they're engaging them in their efforts. They're still pretty early on in their work right now so we don't know whether their shared goals will be around clinical screening or other community dementia-friendly efforts.

Amy Wiatr-Rodriguez: Great, thank you. Okay. Let me see if - I think there's one other question. I'm scrolling through.

Mia, are there any questions on the phone right now?

Coordinator: No questions.

Amy Wiatr-Rodriguez: Okay. I think - here we go. I just wanted to acknowledge we had a chat message from Elizabeth talking about something that the New York State Department of Health sent out to their medical providers, urging them to consider importance of early detection and diagnosis of cognitive impairment. So that may be something also that we can add to our resources page that is posted with the other materials within about a week or so. That's what we're anticipating.

We have a question from Debbie and this is, again, for any of our presenters. Is anyone doing any of the screenings in senior independent living apartments?

I'm not sure if maybe for Adam if I just - the answer that you provided just previously is similar.

Adam Frank: Depending on what is meant by senior independent living apartments - if it's like supportive housing where we would - which are served by our home care programs, then yes, absolutely.

Amy Wiatr-Rodriguez: Okay. Any other comments from Raj or Olivia?

Raj Shah: No, I don't think I have any particular comments, sorry.

Amy Wiatr-Rodriguez: Okay. Alright. And let's see. I'm going to move along to another couple of chat comments that we received in response to the question regarding working with tribes. We did have one participant saying that they are just getting started on their reservation. So that looks like work is getting underway there.

And then also, Nina Silverberg from NIA noted that the Arizona Alzheimer's Center is working with tribes and has a lot of information available. So that may be also something - if we could include a link to their website, perhaps that could be included on our resources page.

Alright. Well at this point, I will see if we can put out one last call if there are any further questions either on the phone or via chat. Mia, are there any questions?

Coordinator: No questions on the phones.

Amy Wiatr-Rodriguez: Okay, wonderful. Well at this point, if people do have any other questions that we didn't get to that I didn't - I missed when I was scrolling through all of them or that anything comes up after this, please do send your questions in. My email is amy.wiatr@acl.hhs.gov. I do want to thank again our wonderful speakers and thank you to Jennifer for setting this up. And thank you to everybody who attended and to everybody who asked such great questions. It was wonderful to have such a good dialogue and Q and A time today on our webinar.

Additionally, if you think of any feedback that you would be - that you're willing to share with us regarding whether this webinar was helpful or that there are any other topics that you'd like to hear about in future webinars, please let us know that via that same email. Everybody who registered for today's webinar will receive another email when the recorded materials from today are posted so that you can go back and reference the audio transcript or share this information with your other colleagues or people that you think would find this to be useful.

Again, thank you so much for you time and your attention on today's webinar and at this point, this concludes our webinar.

Coordinator: Thank you. That concludes today's meeting. You may now disconnect at this time. Thank you.

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