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NDCC National Dementia Care Collaborative

The John A. Hartford Foundation

National Dementia Care Collaborative 2024 Autumn Summit

Strategies for Implementing Comprehensive Dementia Care: Resources for CMS GUIDE Participants and Other Dementia Care Providers

November 19, 2024

Welcome and Introductions

Rani Snyder, The John A. Hartford Foundation

Rebecca Stoeckle, EDC.org

The National Dementia Care Collaborative 2024 Autumn Summit

Gary Epstein-Lubow, MD

Kristin Lees Haggerty, PhD

Mission Moment: A Conversation about Best Practices for Dementia Care

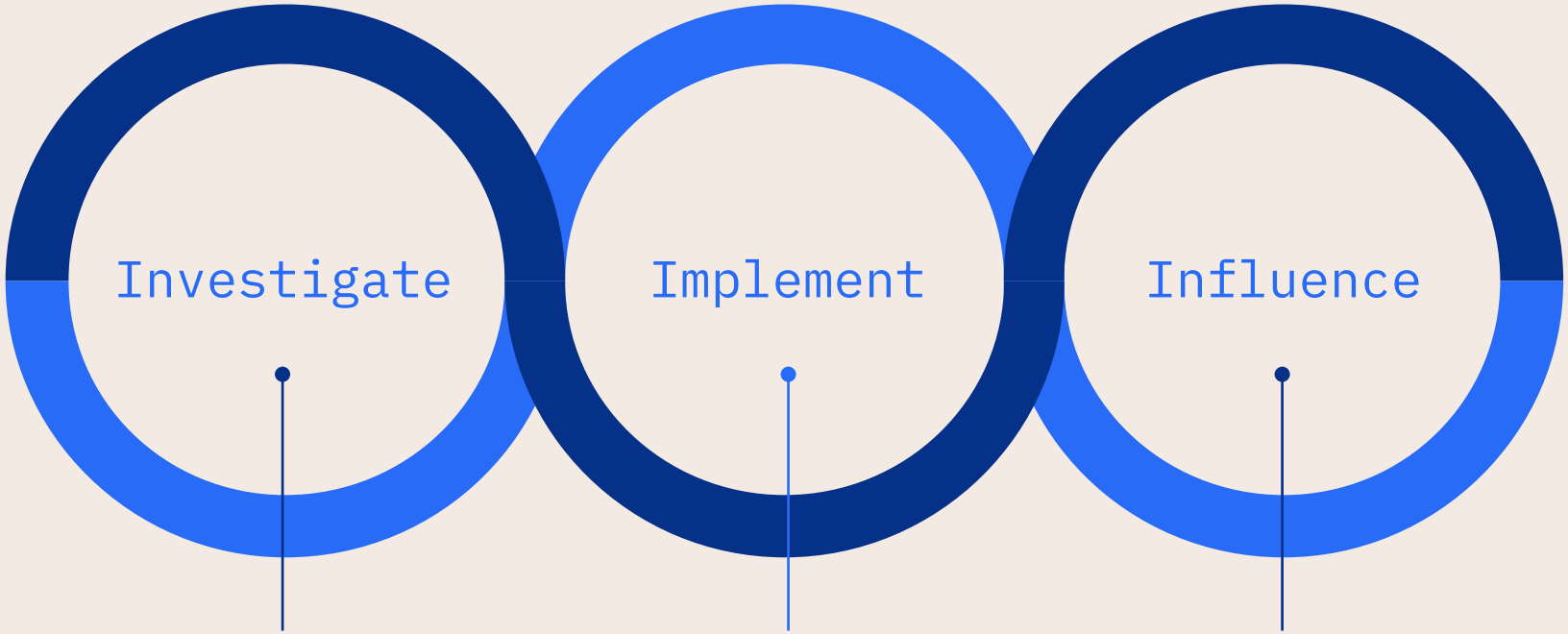
Bart Brammer, Advisor to NDCC and living with dementia

Roberta Cruz, Advisor to NDCC as a family caregiver

Miriam Owens, Advisor to NDCC and living with dementia

Lauren Sullivan, Care Navigator, Healthy Aging Brain Center, Eskenazi Health

Approach



- Understand complex problems
- Design and adapt interventions
- Assess trends in policy change

- Implement programs in diverse settings
- Improve health system-community collaboration
- Convene diverse partners
- Build local capacity

- Disseminate evidence-informed interventions
- Advance the field
- Move policy
- Sustain Successes

Autumn Summit Goals

1. Connect health systems and community-based organizations with resources to improve dementia care
2. Encourage adoption of evidence-based approaches wherever dementia care improvement is taking place
3. Promote engagement in collaborative learning opportunities

Recommendations to Improve Payment Policies for Comprehensive Dementia Care

The John A. Hartford Foundation

One-day convening October 2019 in Washington, DC

Over 50 national experts in dementia care from diverse perspectives

Recommendations

- Payments for services to family caregivers
- Education for consumers, providers and policymakers
- Advance a population health model approach

Lees Haggerty, Epstein-Lubow et al; J Am Geriatr Soc; 25 Sept 2020

National Dementia Care Collaborative

NDCC
National Dementia Care Collaborative

Aims

- Improve access to evidence-based comprehensive dementia care.
- Provide a common platform for health systems and other provider organizations implementing or interested in implementing a proven model of comprehensive dementia care.

Unsplash/Dario Valenzuela

Comprehensive Dementia Care Models

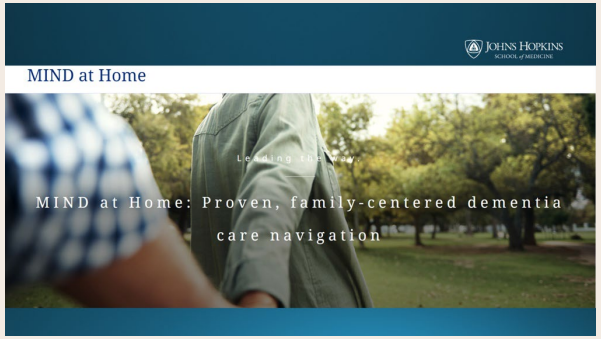
EDC.ORG

Convener

The John A. Hartford Foundation

Funder

National Dementia Care Collaborative



See links to all pograms at: https://www.ndcc.edc.org/six-models-of-ndcc

Elements of Comprehensive Dementia Care

Continuous Monitoring and Assessment

Ongoing Care Plans

Psychological Interventions

Self-Management

Caregiver Support

Medication Management

Treatment of Related Conditions

Coordination of Care

Recommendations to Inform and Support the GUIDE Model

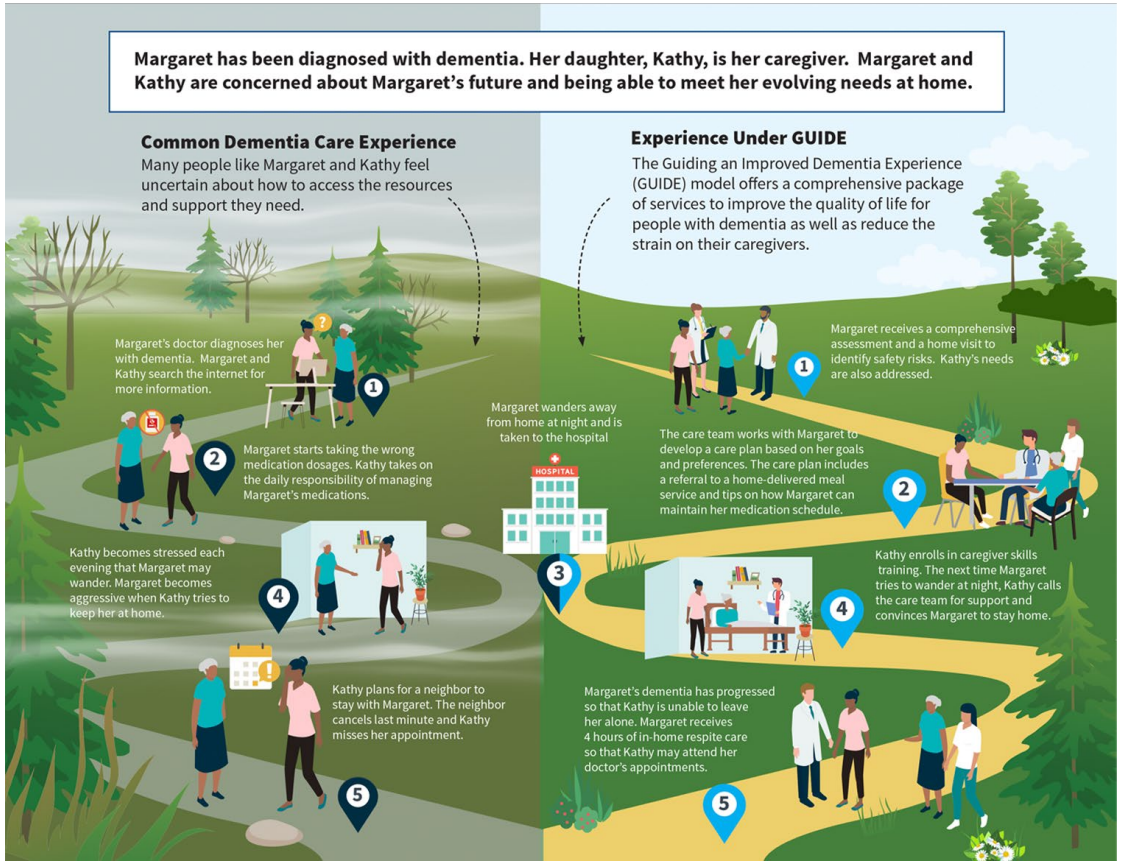
Payment For Comprehensive Dementia Care: Five Key Recommendations

Nora Super, Gary Epstein-Lubow, David B. Reuben, Rani E. Snyder, Jane Carmody, Abby Maglich

FEBRUARY 7, 2023

Super, N., Epstein-Lubow, G., Reuben, D. B., Snyder, R. E., Carmody, J., & Maglich, A. (2023, February 7). Payment for comprehensive dementia care: Five key recommendations. Health Affairs. https://www.healthaffairs.org/content/forefront/payment-comprehensive-dementia-care-five-key-recommendations?ftag=MSF0951a18

Guiding an Improved Dementia Experience (GUIDE) Model



Centers for Medicare & Medicaid Services. (n.d.) *Guiding an improved dementia experience (GUIDE) model)*. CMS.gov. https://www.cms.gov/priorities/innovation/innovation-models/guide

The CMS Guiding an Improved Dementia Experience (GUIDE) Model Learning Systems

Tonya Saffer, CMMI

Abiodun Salako, CMMI

Guiding an Improved Dementia Experience (GUIDE) Learning System

Center for Medicare and Medicaid Innovation (CMMI)
Nov 19, 2024

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

CMMI's Goals for Success

Partner with participants in Implementation and Learning

Provide key resources and assistance to accelerate implementation

Ongoing support to help participants achieve their goals

CMMI Participant Support

Technical Assistance

Goal:

Support Participants in successfully fulfilling model requirements

Active CMS Program and Policy assistance:

Webinars, Office Hours, Helpdesk

Reference Materials:

User manuals, policy methodology papers, fact sheets, tip sheets, checklists and FAQs

Learning System

Goal:

Facilitate Participants' integration of strategies and tactics to effectively meet model goals

Peer-to-Peer & Expert-led support:

Webinars, case studies, affinity groups, participant spotlights, SME consultation, toolkits and tip sheets

Connect Site:

Virtual platform for peer sharing, collaboration and coordination to support learning and continuous improvement

CMMI's Approach to Learning in GUIDE

During participation in the model, the learning system will:

Connect participants with each other to share strategies and ideas on model implementation

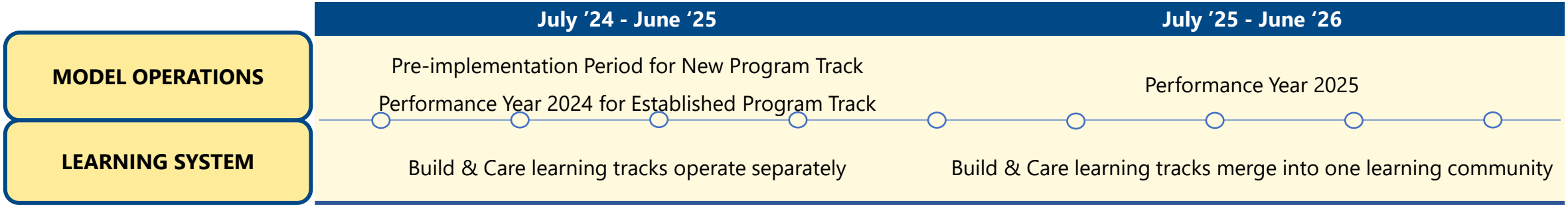
Disseminate best practices and tools on the delivery of comprehensive dementia care

Capture and share participant strategies and tactics associated with better outcomes

Design

Two learning tracks designed to meet the learning needs of the model's participants:

	Build Track	Care Track
Target population	New Program Track participants	Established Program Track participants
Key features	Regular, virtual SME consultation sessions: • Brief didactic SME presentation followed by case-based learning and peer-to-peer sharing during breakout sessions and Q&A with the SME	• Webinars featuring a didactic presentation on a topic followed by a Q&A session • Peer-to-peer sharing using affinity groups (participants with similar goals learning over time) and/or topic-focused huddles



Learning System Topics in Year One

Some of the topics that may be covered include:

Developing your Interdisciplinary Care Team and Provider Network

Patient Outreach, Recruitment, and Referrals

Preparing to Implement the Comprehensive Assessment

Conducting Home Visits

Engaging in GUIDE Respite Services

Looking Beyond Year One

Our approach will evolve as the model matures

Refine learning system design and activities based on participant learning needs and feedback

Identify strategies and tactics associated with high performance in the model

Disseminate tactics associated with high performance through the learning system

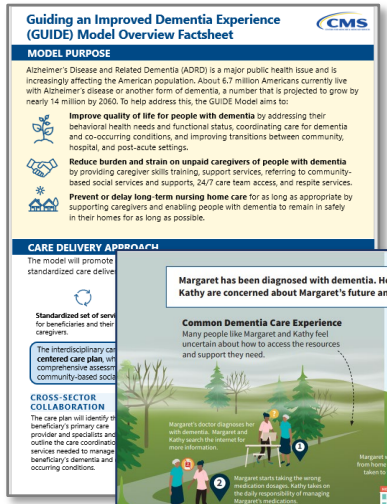
Model Resources Publicly Available

The GUIDE Model team has a host of resources to support interested organizations. To see the latest resources, visit the Model's website at https://innovation.cms.gov/innovation-models/guide.

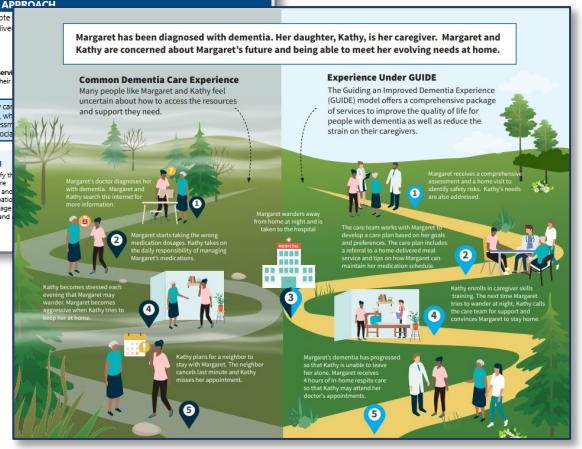
Frequently Asked Questions
Please reference the list of FAQs on the Model's website for answers to common questions.

Model Factsheets
Model Overview Factsheet, Dementia Pathways Infographic, Strength in Partnerships Factsheet, and Participant Incentives Factsheet may be found on the Model's website.

Find Participants
Visit the Model's web site to identify participating dementia care programs



Model Overview Factsheet



Dementia Pathways Infographic

Thank You for Listening

We appreciate your time and interest!

Do you have questions? Email the GUIDE Model Helpdesk (GUIDEModelTeam@cms.hhs.gov)

NDCC Resources to Support Implementation of Evidence-Based Comprehensive Dementia Care

Kristin Lees Haggerty, EDC.org

Gary Epstein-Lubow, EDC.org

Alignment: Evidence-Based Programs with GUIDE Model Components

GUIDE Care Delivery Requirements	ABC	ADC Program	BRI CC	Care Ecosystem	IMC	MIND at Home
1. Comprehensive Assessment Initial comprehensive assessment and reassessments each year.	✓	✓	✓	✓	✓	✓
2. Care Plan Beneficiaries receive care plan	✓	✓	✓	✓		
3. 24/7 Access Member of care team or third-party representative	✓	✓	Online Portal Only			
4. Ongoing Monitoring and Support Provide long-term help to CG and beneficiaries to revisit goals and needs	✓	✓	✓	✓		
5. Care Coordination and Transitional Care Management Coordinate with PCP, coordinate with specialists, support transitions between personal home and care settings	✓	✓	✓	✓		
6. Referral and Coordination of Services and Supports Care navigator connects beneficiary and CG to community-based services	✓	✓	✓	✓		

GUIDE Care Delivery *Requirements (cont'd)*			ABC	ADC Program	BRI CC	Care Ecosystem	IMC	MIND at Home
7. Caregiver Support	Education provided	Caregiver Skills Training	✓	✓	✓	✓	✓	✓
		Dementia Dx Information	✓	✓	✓	✓	✓	✓
		Support group services	✓	✓	Through Referral	Through Referral	✓	Through Referral
		Ad-hoc 1:1 Support Calls	✓	✓	✓	✓	✓	✓
8. Medication Management	Clinician reviews and reconciles medication		✓	✓		✓	✓	Site Dependent
	Care Navigator provides tips to maintain schedule		✓	✓	✓	✓	✓	✓
9. Respite Services	Beneficiary receives respite (required in-home), can be outside agency		✓	Through contracts	Through Referral			

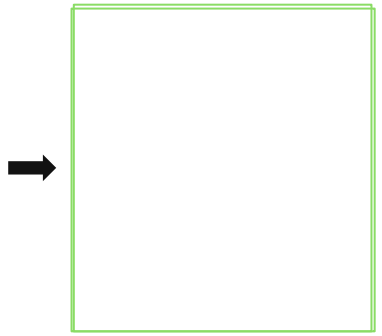
Haggerty K, Epstein-Lubow G, Stoeckle RJ, Carmody J, Maglich A, Johnson M, Super N, Spragens L, Lee DR, Snyder RE (2023, November 22).

Applying an Evidence-Based Approach to Comprehensive Dementia Care Under the New GUIDE Model Health Affairs.

https://www.healthaffairs.org/content/forefront/applying-evidence-based-approach-comprehensive-dementia-care-under-new-guide-model

NATIONAL DEMENTIA CARE COLLABORATIVE (NDCC)

User Journey and Resource Map



Health system or community-based organization interested in improving dementia care

National Dementia Care Collaborative

Dementia Care Improvement Instrument

- Established Track GUIDE
- New Track GUIDE
- Non-GUIDE Health Systems

Current dementia care approach

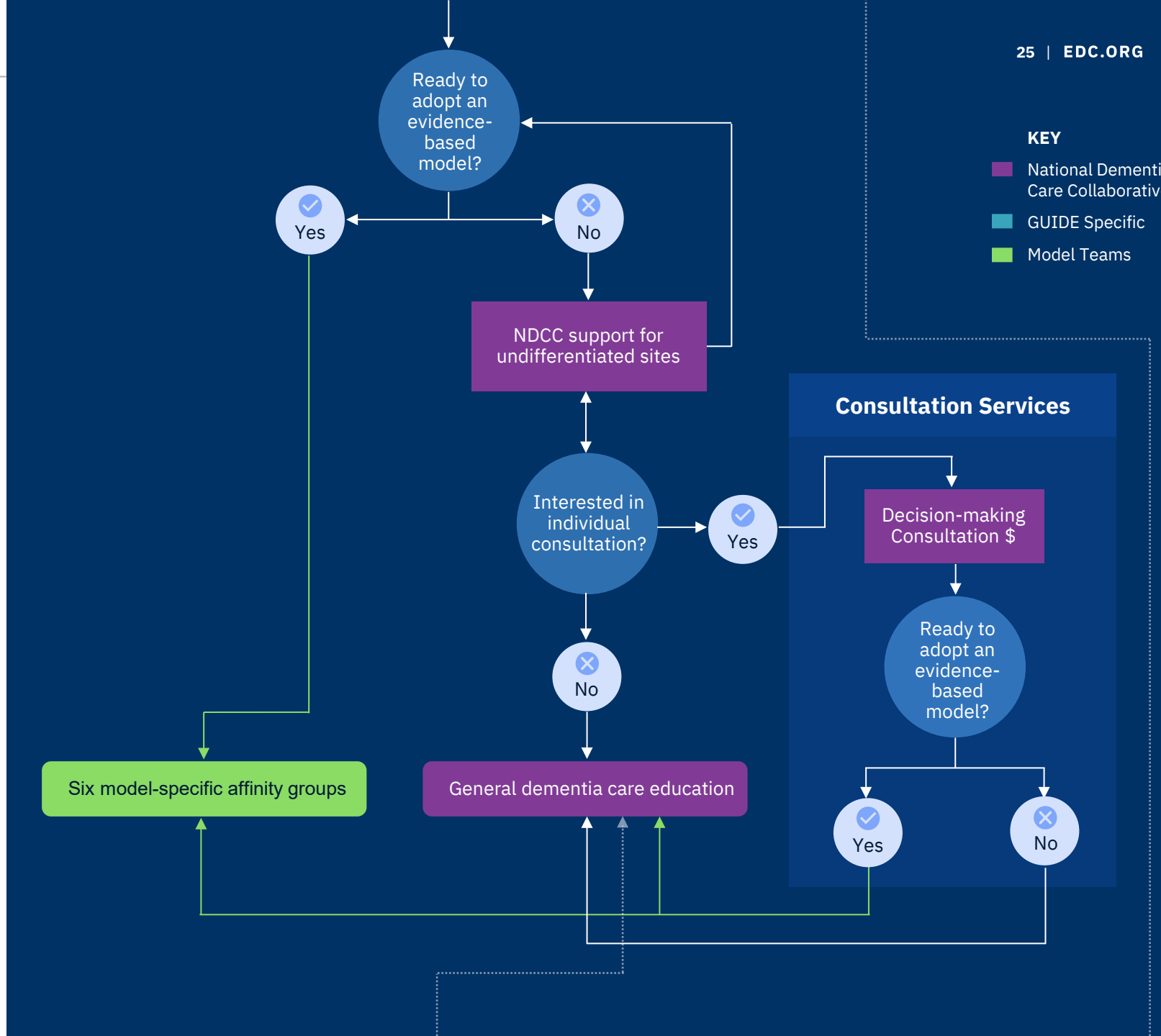
- Using or already selected an Evidence-based model
- Undecided
- Using non-model care

KEY

- National Dementia Care Collaborative
- GUIDE Specific
- Model Teams

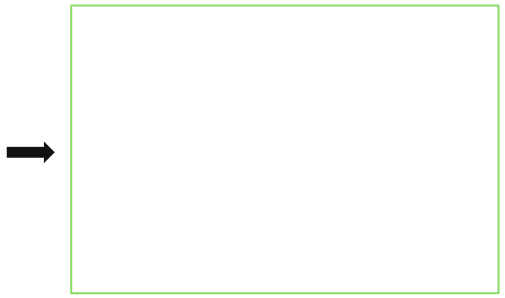
NATIONAL DEMENTIA CARE COLLABORATIVE (NDCC)

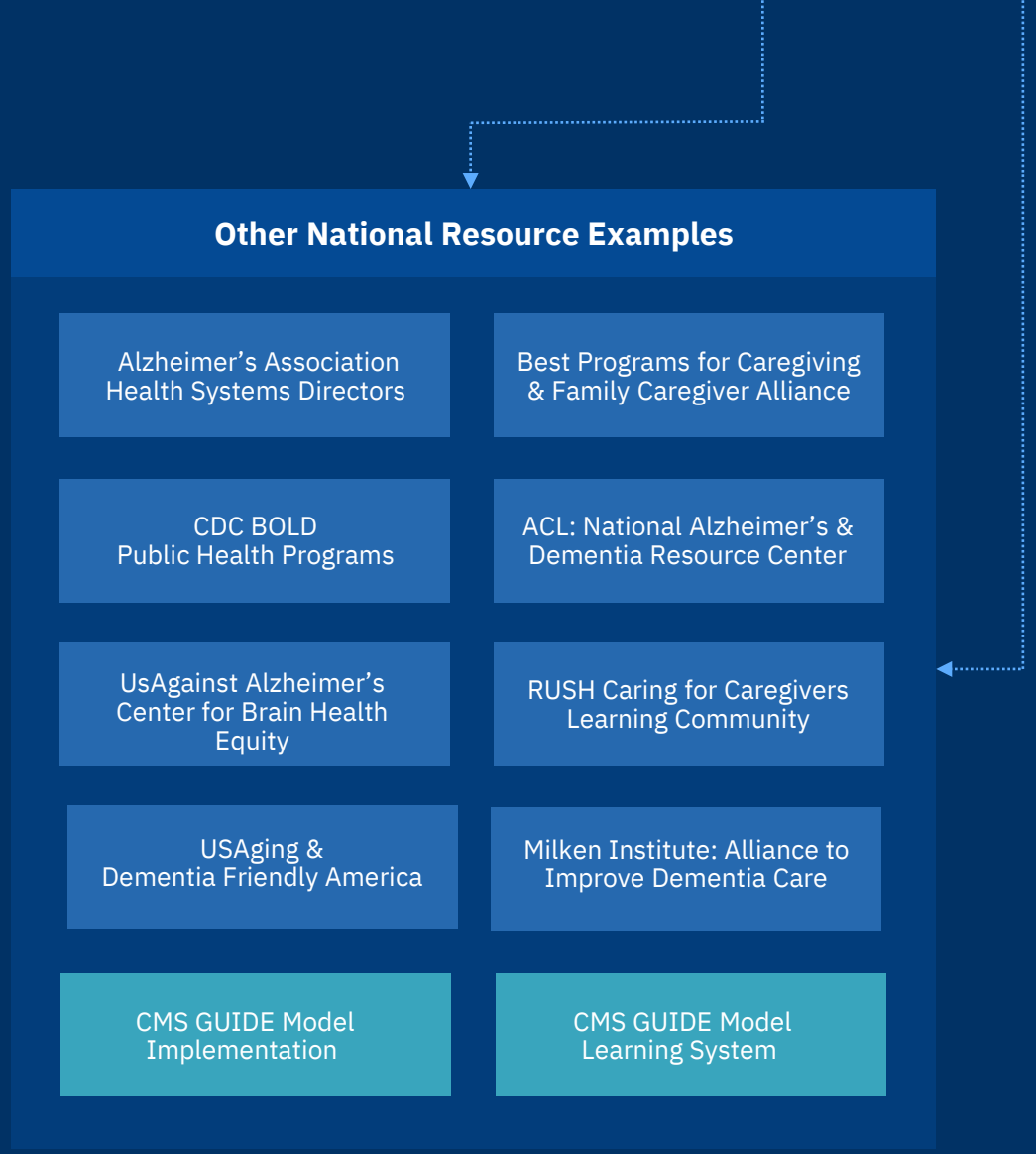
User Journey and Resource Map



NATIONAL DEMENTIA CARE COLLABORATIVE (NDCC)

User Journey and Resource Map





KEY

- National Dementia Care Collaborative
- GUIDE Specific
- Model Teams

Caring for Caregivers Learning Communities

Goals of C4C Learning Community

- At the RUSH Center for Excellence in Aging
- Explore caregiver support strategies
- Including information about billing and utilization of the new CMS Caregiver Training Services codes
- All Age-Friendly Health Systems, Area Agencies on Aging, GUIDE Model participants, and other interested parties are invited
- Meetings November 2024 – June 2025

National Alzheimer's and Dementia Resource Center (NADRC)
Resources for Implementing Dementia Focused Interventions

Resource	Brief description
Choosing an Evidence-Based or Evidence-Informed Intervention: Considerations to Inform Decision-Making	This resource provides a series of questions and considerations to assist in the selection and implementation of dementia-specific interventions.
Seizing the Opportunity to Develop Dementia Programs: Successful program funding, planning, and delivery	This webinar includes information on the planning process for ACL funded dementia projects with an emphasis on developing programs that are tailored to the needs of the community.
Translating Evidence-Based Dementia Interventions to the Community	This report analyzes the experiences of some past ACL's dementia grant programs to understand issues they encountered, and strategies used to address them.
Tips and Tools for Writing Contracts and Other Agreements	This guide summarized practical guidance on developing contracts and agreements with partners who can support service delivery.

NADRC Website- https://nadrc.acl.gov

NADRC
National Alzheimer's and Dementia Resource Center

Building Systems for Comprehensive Dementia Care:

Opportunities for Public Health to Support Implementation of the CMS GUIDE Model

December 9, 2024 | 10am-11am CT | Zoom

- Webinar designed for local and state public health agencies.
- Discover the Guiding an Improved Dementia Experience (GUIDE) Model and its potential for family caregiver support and education.
- Explore partnerships with health systems in the GUIDE pilot.
- Find resources and ideas to support dementia care in underresourced communities.
- Ask YOUR questions!

Speakers join us from CMS, Tennessee and Rhode Island.

Register & **submit your questions** for the panel:
https://bit.ly/CMS_GUIDE

BOLD PUBLIC HEALTH CENTER OF EXCELLENCE ON DEMENTIA CAREGIVING

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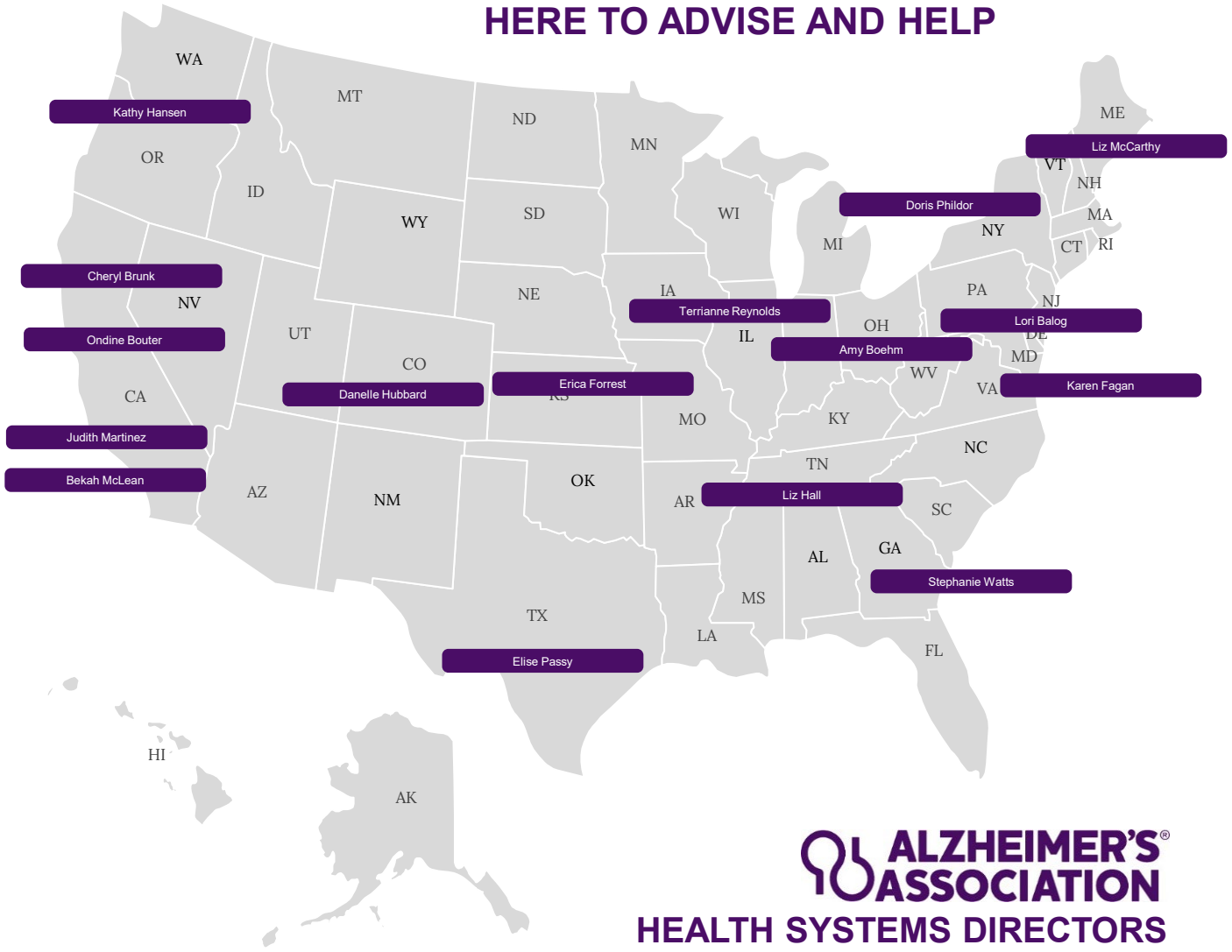
Karen Fagan kafagan@alz.org: DC

Stephanie Watts stwatts@alz.org: FL, GA, NC, SC

HERE TO ADVISE AND HELP



ALZHEIMER'S ASSOCIATION®

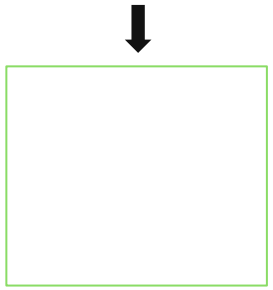
HEALTH SYSTEMS DIRECTORS

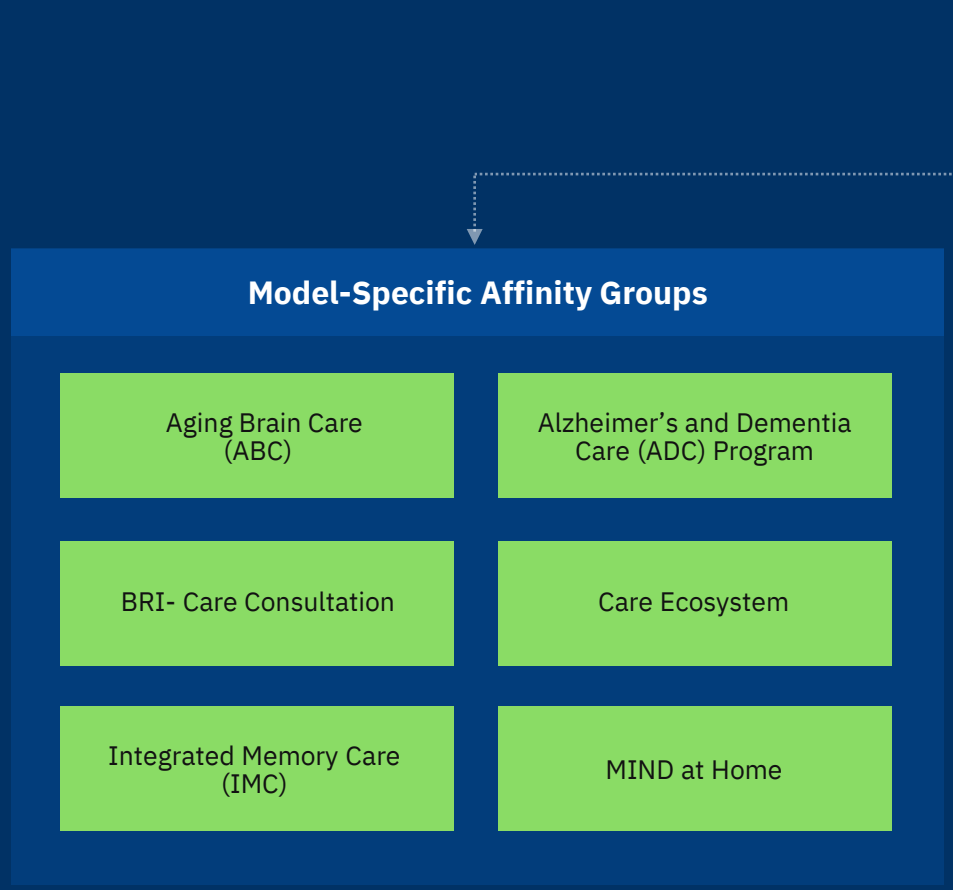
Regional and Local Resources

- Local Alzheimer’s Association Chapter
- Area Agencies on Aging
- Local community-based organizations
- Faith-based Organizations
- Dementia-Friendly America
- Local health systems

NATIONAL DEMENTIA CARE COLLABORATIVE (NDCC)

User Journey and Resource Map





KEY

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- GUIDE Specific
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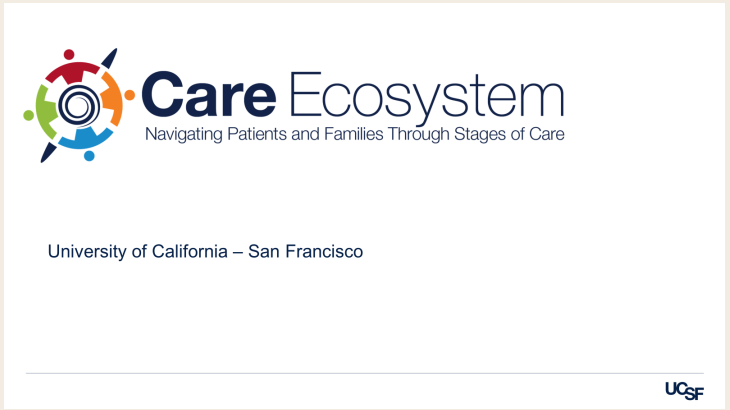
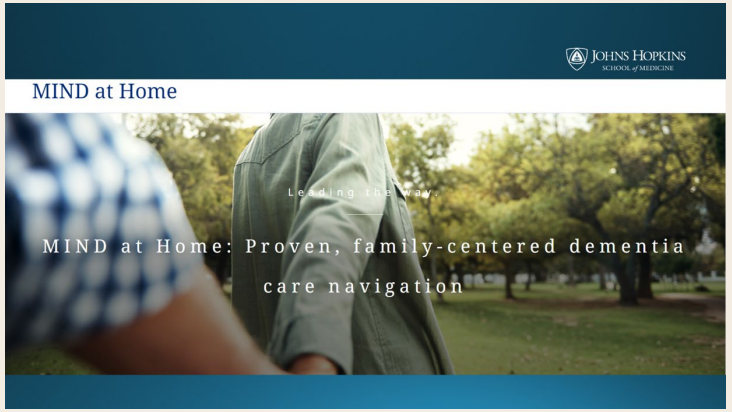
Collaborative Learning with Engaged National Leaders

See links to all programs at: https://www.ndcc.edc.org/six-models-of-ndcc





Session 3: Getting Comprehensive Dementia Care Right: What We're Hearing, Learning, and Doing

Ian Kremmer, Moderator, LEAD Coalition (Leaders Engaged on Alzheimer's Disease)

Malaz Boustani, Aging Brain Care (ABC)

David Reuben, Alzheimer's and Dementia Care (ADC) Program

David Bass, Benjamin Rose Institute Care Consultation (BRI-CC)

Sarah Dulaney, Care Ecosystem

Amy Imes, Integrated Memory Care (IMC)

Quincy Samus, Maximizing Independence (MIND) at Home

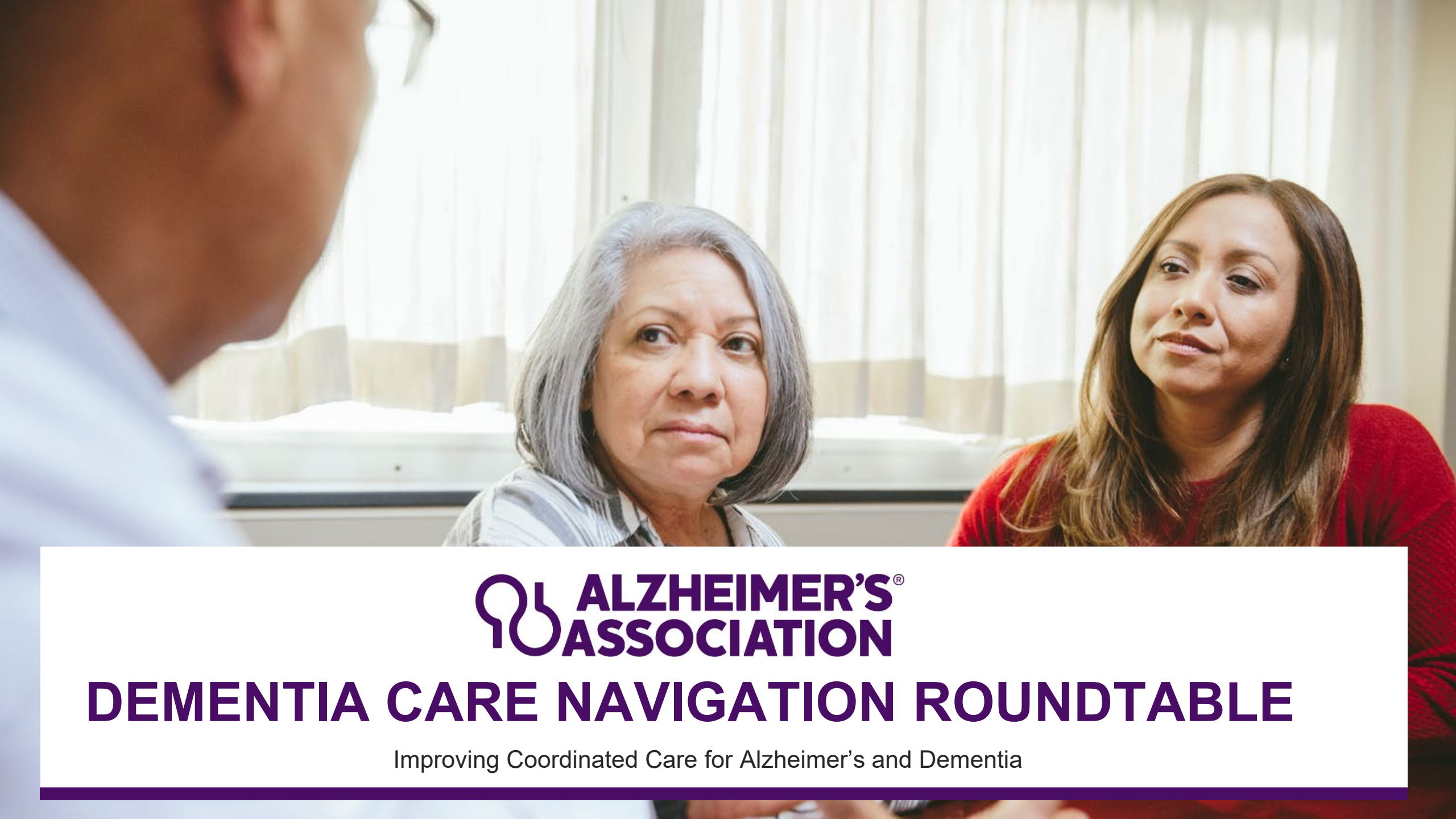
Session 4: Care Navigation: Essentials for Success

Morgan Daven, Alzheimer's Association

David Reuben, UCLA

Leslie Evertson, UCLA

Joan Weiss, HRSA



ALZHEIMER'S® ASSOCIATION

DEMENTIA CARE NAVIGATION ROUNDTABLE

Improving Coordinated Care for Alzheimer's and Dementia

DEMENTIA CARE NAVIGATION **GUIDING PRINCIPLES**

01 Be person and family centered

02 Be culturally responsive and address disparities

03 Include well-defined roles and responsibilities for all members of the care team

04 Address barriers relating to medical, legal, financial, emotional and other domains

05 Provide solution- focused coaching, education, and coordination

06 Focus on the family unit as defined by the person living with dementia

07 Ensure processes and protocols are evidence-based

Kallmyer, B. A., Bass, D., Baumgart, M., Callahan, C. M., Dulaney, S., Evertson, L. C., Fazio, S., Judge, K. S., & Samus, Q. (2023). Dementia care navigation: Building toward a common definition, key principles, and outcomes. *Alzheimer's & dementia (New York, N. Y.)*, *9*(3), e12408. https://doi.org/10.1002/trc2.12408

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DEMENTIA CARE NAVIGATION ROUNDTABLE

LEADERSHIP

David Reuben, MD
Professor of Medicine, Geriatrics
UCLA Health

David Bass, PhD
Senior Vice President & Senior Scientist
Benjamin Rose Institute on Aging

ALZHEIMER'S ASSOCIATION

DEMENTIA CARE NAVIGATION ROUNDTABLE

PURPOSE

- A premier source of strategic guidance for advancing quality, person-centered dementia care navigation.
- Promotes the integration of care navigation across healthcare systems and communities, ensuring equitable access to dementia care.
- Provides leadership and guidance to shape the growth and evolution of dementia care navigation as the field continues to advance.

ALZHEIMER'S ASSOCIATION

DEMENTIA CARE NAVIGATION ROUNDTABLE **GOALS**

01 Build consensus around the **components of a quality navigation program** and **promote shared understanding** of the principles of dementia care navigation.

02 Develop and disseminate **training and resources** to support implementation of a quality, evidence- based navigation program based on established programs.

03 Develop **business models** for implementing and sustaining care navigation.

04 Identify **program evaluation measures** that support the delivery of high-quality dementia care navigation.

05 **Foster collaboration** and knowledge exchange among roundtable members.

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DEMENTIA CARE NAVIGATION ROUNDTABLE

Examples of planned outputs

01 Papers outlining **policy changes** needed to support reimbursement for dementia care navigation services

02 Research summaries highlighting the latest **evidence and innovations** in care navigation

03 **Metrics** for measuring the effectiveness of dementia care navigation services

04 **Webinars** for healthcare professionals and healthcare leaders

05 Dementia care **navigation information** on the Roundtable page on alz.org

ALZHEIMER'S ASSOCIATION

Workgroup: Care Navigation

Chair

Leslie Evertson

Purpose

Using a health equity lens, members will:

- determine what components of dementia care navigation must be included for quality dementia care
- how these components may be met by licensed and non-licensed staff

Work in Progress

- Definition of roles & responsibilities of Dementia Care Navigators based on background & licensure against key GUIDE elements
- Summary of areas for further discussion & development

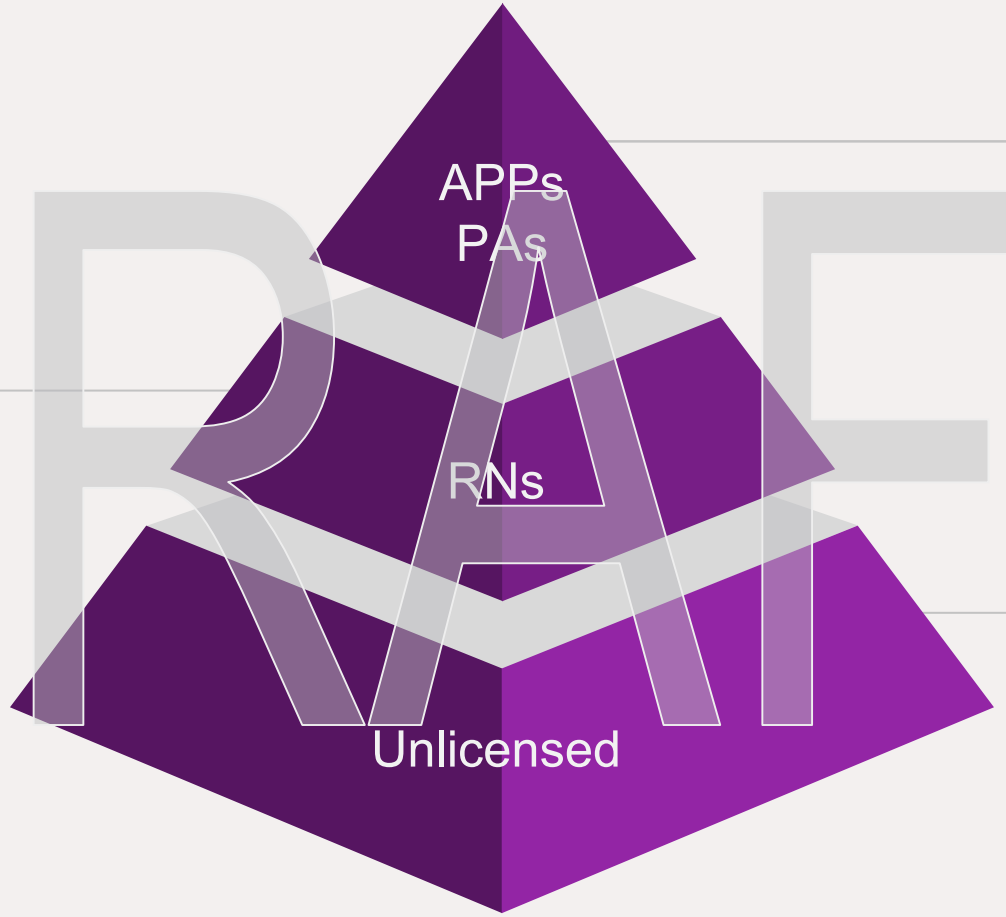
Roles & responsibilities

☆ Communication with the GUIDE Team. Caregiver Agency/ Home Health – Behavior Log/ Transitions of Care
❍ List medications/ tips sheets ok. Med Mgmt/ Reconciliation = APP/MD/PharmD only

		Comprehensive Assessment	Care Plan	24/7 Access to a team member	Ongoing monitoring and support	Care Coordinati-on and Traditional Care Mgmt	Referral and Coordination of Services and Supports	Medication Management and Reconciliation	Caregiver Education and Support	Respite	Home Visit
Part of the GUIDE Interdisciplinary Care Team	Non-licensed* DCN	+ (w/team)	+ (w/team)	+	+	+ (w/team)	+	❍	+	- Can refer to services	+
	RN DCN	+	+	+	+	+	+	❍	+	- Can refer to services	+
	SW DCN	+	+	+	+	+	+	❍	+	- Can refer to services	+
	APP DCN	+	+	+	+	+	+	+	+	- Can refer to services	+
	Dementia Proficient Clinician	+	+	+	+	+	+	+	+	- Can refer to services	+
Contracted Services	Caregiver Agency (Respite)	–	–	–	–	–	–	–	☆	+	+
	ALF/SNF/ADHC (Respite)	–	–	–	☆	☆	–	–	☆	+	–
	Home Health Agency RN/OT/PT	–	–	–	☆	☆	–	–	☆	+	+

Further Development & Discussion

Registered Nurses
Medication reconciliation, including correcting discrepancies



APPs & PAs

1. Medication reconciliation & medication management, including prescribing

Unlicensed Staff/Social Workers

3. Medication reconciliation with support from management for discrepancies

Workgroup: Training Standards, Credentialing, and Fidelity for Dementia Care Navigation

Chair

Joan Weiss

Purpose

Using a health equity lens, members will define:

- the knowledge and skills required for dementia care navigators
- standards of training for navigation, and what a framework for credentialing may encompass

Members will also identify or create:

- measures that indicate high quality dementia care navigation has been implemented
- recommendations for all elements of credentialing to include licensing requirements, levels of education, and professional disciplines.

Work in Progress

- Content of Training Standards
- Didactic & Clinical DCN Training Requirements
- Credentialing
- Outcome Measures

Work in Progress

Content of DCN Training Standards

- Flexibility of the training model
- Alignment with existing structure & processes
- Capacity for in-house vs. contracted training
- Electronic Medical Records (EMRs) capability
- Integration with existing protocols and guidelines

Didactic & Clinical DCN Training Requirements

- **Topics focusing on key dementia care management functions**,i.e. Comprehensive Assessment
- **Topics addressing health equity and providing high quality, culturally competent dementia care,** i.e. Diversity in Dementia
- **Other topics identified by geriatrics educators**, i.e.: Co-management of Dementia
- **Specific trainings for nurses**, i.e. Cognitive Health and Function

Work in Progress

Credentialing

- The Workgroup **recommends the use of certificates of completion** rather than credentialing.
- A dementia care certificate indicates education, knowledge and skills in Dementia that can be applied immediately.
- Certificates provide flexibility when factoring in time and financial constraints, & changing career goals and job requirements.

Further Development & Discussion

Outcome Measures

- There is currently no evidence-based information on the topic of health outcomes of dementia care navigation education and training.
- Quality measures related to processes of care and utilization of services may be used as a key indicator of impact

Workgroup: Value Proposition

Chair

R. John Sawyer

Purpose

Members will:

- Help programs make a viable business case for dementia care management and navigation
- will thereby help strengthen program development, sustainability, and future growth to better support patients and caregivers.

Work in Progress

- Definition of scope of workgroup
- Key considerations of business case development
- Prioritization of next-phase work products/deliverables

Scope & Themes

Definition of Scope:

- Financial metrics
- Outcomes beyond just financial but related to value
- Clinical workflows and efficiency metrics are out of scope
- People scope: Dementia criteria (dx or not) people with and without caregiver (different calculation)

Key Considerations:

- An effective business case must align with existing/other key metrics ((Patient experience, Quality, STAR ratings, social ROI, reputational ROI)
- Value-based care models present a large opportunity for dementia care programs

Key Considerations (continued):

- Health systems budget based on expected revenue not expected savings
- Very hard to track and attribute cost savings to specific programs in large organizations
- Multi-year cost Savings analysis from Year 1 and beyond

Further Development & Discussion

Next-Phase Product/Deliverable Development

- Support for the business case of care navigation:
  - Billing/financial modeling templates
  - Education
- Payer recruitment to the workgroup for metrics & utilization considerations

Session 5: Addressing Health Equity when Implementing Comprehensive Dementia Care

Kaleigh Ligus, CMMI

James Noble, Columbia University

Guiding an Improved Dementia Experience (GUIDE) Model: Health Equity

Center for Medicare and Medicaid Innovation

November 19, 2024

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

CMMI Strategic Objectives: Advance Health Equity

Aim: *Embed health equity in every aspect of CMS Innovation Center models and increase focus on underserved populations.*

Health Equity Plan

The Health Equity Plan will allow each GUIDE participant to identify disparities in outcomes in their patient populations and implement initiatives to measure and reduce these disparities over the course of the model.

Initial Health Equity Plan

FOCUS	**Beneficiary Outreach and Engagement**
GOAL	Encouraged Participants to develop and implement health equity recruitment strategies from model start

- Encouraged GUIDE participants to reach historically underserved eligible beneficiaries
- Questions focused on identification of health disparities within the participant's beneficiary population using reliable data sources and consideration of outreach strategies

Annual Health Equity Plan

FOCUS	**Reducing Disparities in Dementia Care**
GOAL	Encourage Participants to implement initiatives to measure and reduce disparities

- Identify and select evidence-based interventions for addressing health disparities and achieving equitable outcomes
- Set goals and report progress on Health Equity Plans as an element of the model's annual care delivery reporting

Health Equity Adjustment

The Model's core payment methodology is a per beneficiary per month care management payment, called the Dementia Care Management Payment (DCMP), that is adjusted for health equity and performance on a set of quality metrics.

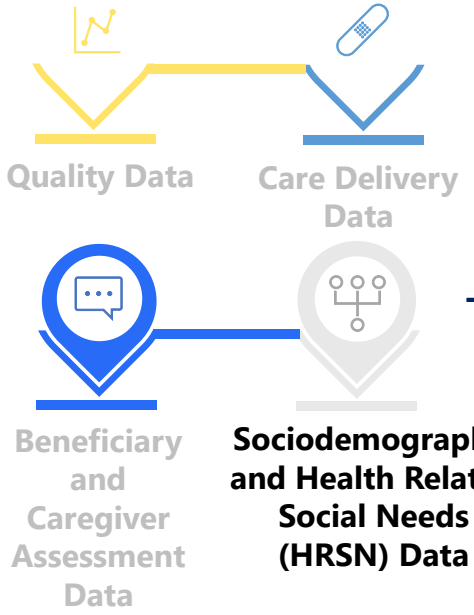
The Health Equity Adjustment (HEA) is applied to the DCMP based on beneficiary-level health equity scores and is designed to decrease the resource gaps in serving historically underserved communities.

HEA will be based on the following social risk factors:

- National Area Deprivation Index (ADI)
- State Area Deprivation Index (ADI)
- Low-Income Subsidy Status (LIS)
- Dual Eligibility Status (DE)

Expanded Data Collection Efforts

All Innovation Center model participants are required to collect and report data deemed necessary to monitor and evaluate the model. GUIDE participants will report the following:



Socio-demographic Data

Participants will be required to report a **core set of sociodemographic measures** for their aligned beneficiaries annually.

The core measures are:

- Race
- Ethnicity
- Sex assigned at birth
- Disability status
- Primary language

Health-Related Social Needs (HRSN) Data

HRSN collection and referrals will be part of the model's broader care delivery requirements for comprehensive assessment and referral for services and supports.

At minimum, GUIDE participants must screen for HRSNs and report results, in aggregate, in the following domains: **food insecurity, housing instability, transportation needs, social isolation, and safety.**

Thank you for your time

We appreciate your time and interest!

Do you have questions? Email your comments and feedback to GUIDEModelTeam@cms.hhs.gov

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National Dementia Care Collaborative 2024 Autumn Summit

Main session closure and transition to affinity groups

BREAKOUT SESSIONS

Affinity Groups for Six Evidence-Based Comprehensive Dementia Care Models

1. Aging Brain Care (ABC) Program
2. Alzheimer's and Dementia Care (ADC) Program
3. Benjamin Rose Institute (BRI) Care Consultation
4. Care Ecosystem
5. Integrated Memory Care (IMC)
6. Maximizing Independence (MIND) at Home

Affinity Group Meetings

Summit Breakout Group	Model	Post-Summit Affinity Group Meeting	Time	Contact
1	Aging Brain Care (ABC) Program	December 10	2:00 pm ET	seffler@iupui.edu
2	Alzheimer's and Dementia Care (ADC) Program	January 6	1:00 pm ET	dementiaPM@mednet.ucla.edu
3	Benjamin Rose Institute (BRI) Care Consultation	January 29	12:00 pm ET	mminyo@benrose.org
4	Care Ecosystem	November 21	1:00 pm ET	sarah.dulaney@ucsf.edu
5	Integrated Memory Care (IMC)	December 9	7:00 pm ET	amy.imes@emoryhealthcare.org
6	Maximizing Independence (MIND) at Home	December 10	3:00 pm ET	mreulan1@jhmi.edu

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Thank you!

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