Cariños Model: Interdisciplinary Model of Outreach, Care, and Support in Southwest Texas

UT Health San Antonio
Biggs Institute for Alzheimer's & Neurodegenerative Diseases

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Financial Disclosures
None

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Cariños Model

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Objectives

Define the CARIÑOS Model

Describe how the CARIÑOS Model was developed

Describe lessons learned

Discuss future needs for the population we serve

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CARIÑOS

Compassionate (coordinated and comprehensive) care across clinical settings that meets the older adults' needs beyond the office walls.

Advocacy for patients and families with other clinicians and health care partners.

Respect for what matters most to older adults

Intentional redesign of processes and activities to meet older adults' needs

Nurtured relationships with families, social service agencies and community partners

Older adults are wise and know what they want, listen to what they say.

Supportive Care for better quality of life

*Cariño is Spanish for fondness, affection, tenderness, love

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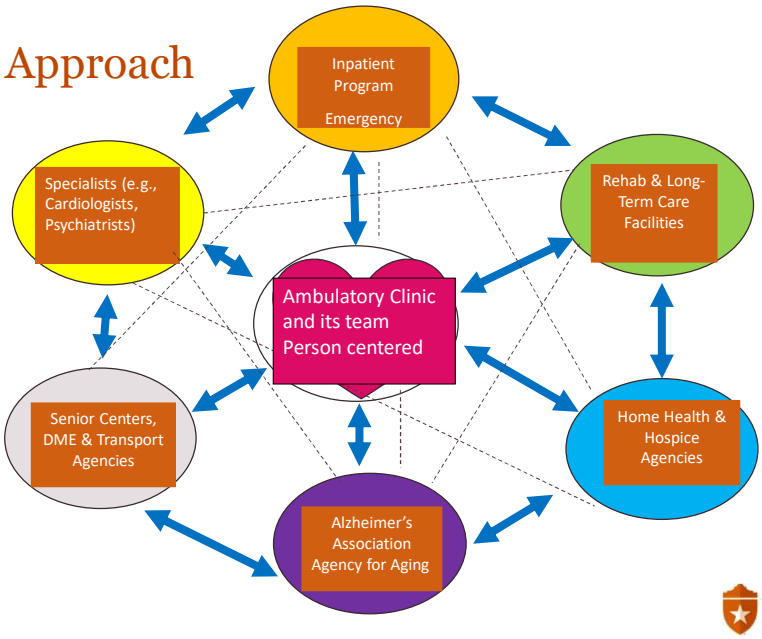
CARIÑO Approach



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Team members

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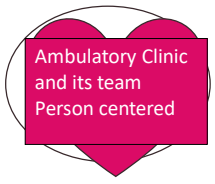
CARINOS Approach



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Steps in transformation

- Building a common mission and vision
- Process Improvement
- Time for reflection and course adjustment
- Accountability
- Safe work environment
- Electronic health record optimization
- Building a medical home neighborhood

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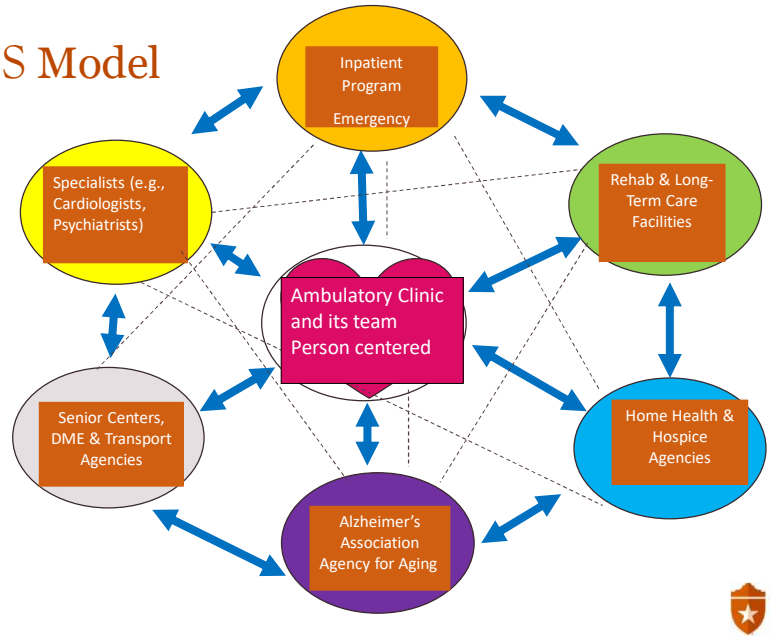
CARIÑOS Model



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Building the medical home neighborhood

- Consultants
- Home health agencies & Hospices
- DME companies
- Adult day centers & Senior Centers
- Alzheimer's association, Local Area Agency on Aging
- Adult Protective Services
- Local hospitals
- Local transportation
- Senior networking resources and groups

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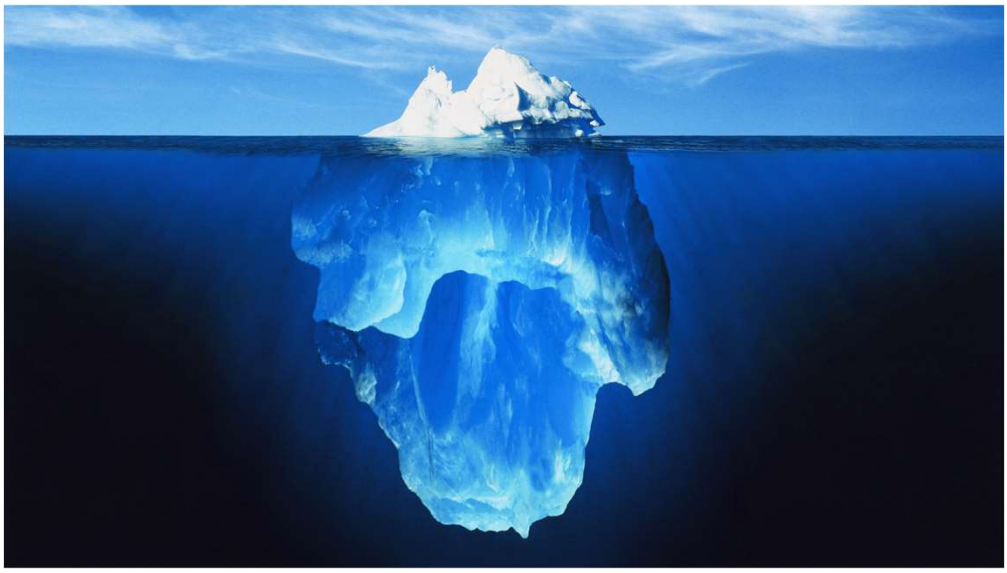

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Barriers to Care

- Poverty, inequality and segregation.
- Language and cultural barriers.
- Inability to navigate the healthcare and reimbursement systems.
- Lack of transportation and ability to visit specialty care providers.
- Multiple comorbidities, requiring consulting multiple providers.
- Dissatisfaction with healthcare system negatively impacts clinical outcomes.

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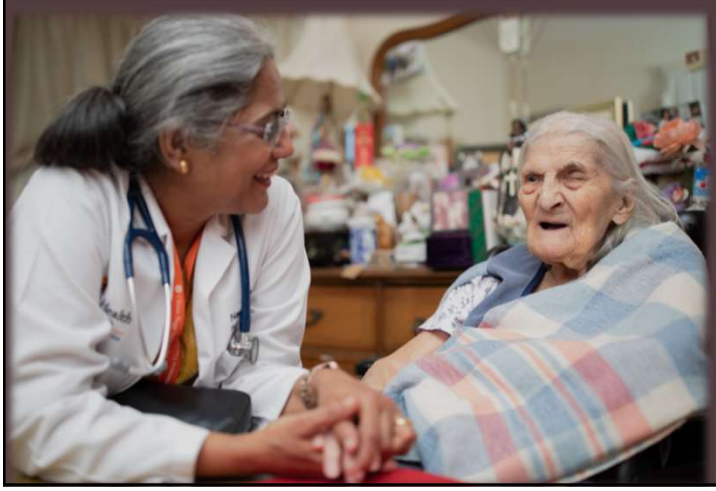
CARIÑOS En Su Casa – Care For You In Your Home

Serves vulnerable Hispanic Older adults in San Antonio who have limited access to health care services



Bexar County is home to nearly 2 million people.

64% are Hispanic

12% are older adults age 65+

11% of those 65+ live in poverty

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CARIÑOS En Su Casa

is in-home comprehensive, coordinated, compassionate care
that uses promoteres and trained community health workers to assist in breaking through barriers to healthcare.

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Cariños En Su Casa
Who We Serve?

- Current, registered patients at the UT Health SA Geriatric & Palliative Clinic
- Hispanic patients living in underserved areas of San Antonio
- Patients with stated incomes or resources below poverty levels
- Patients who have been assessed as "in need" of follow-up care
  - ✓ Missed multiple follow up appointments
  - ✓ Recently been seen in ED
  - ✓ Recently released from hospital care
- Patient caregivers - uncompensated family or friends providing health care to the patient.

UT Health San Antonio Geriatric & Supportive Clinic Patient Population

3,500 Unique patient visits in Clinic
2050 Unique patient visits at homes
Patients range in age from 50-104

92% of patients
cared for at the Clinic
meet underserved criteria.

In 2022
91% of patients were 65+

32% were 66-75
32% were 76-85
27% over 85
20 patients centenarians

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Lessons Learned: Integration of home visits

- Logistics:
  - Working with clinical operations
  - Electronic medical record
  - Scheduling challenges
- Financial challenges
  - Number of patients able to be seen in a half day and length of visits
- Interdisciplinary Support
  - UT Health is partnering with Dispatch Health for acute care needs
  - Needs for an extended team to provide support

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Over the next 10 years, how can we expand on this model to continue to serve our population?

- Extensive need in San Antonio and surrounding area but that's a small portion of South Texas
  - Need for clinicians (MD/DO/NP/PA)
  - Need for interdisciplinary team members: Ex social workers, community health workers, physical/occupational/speech therapy, pharmacists, nurse care managers
- Integration of resources that can expand outreach to patients
  - Currently seeing patients in Laredo

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GUIDE Model

Dementia Care Delivery Model for UT Health Geriatrics and Supportive Care Clinic and The Cariños Program

Juliandra Bryan, LVN
Clinic Care Coordinator and Care Team Navigator for The GUIDE's- Dementia Care Delivery Model for UT Health Geriatrics and Supportive Care Clinic and the Cariños Program

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Objectives

- Define the GUIDE Model- What is GUIDE?
- Describe how we are implementing GUIDE into our practice
- Outcomes and Lessons Learned

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What is GUIDE? *GU*iding an *I*mproved *D*ementia *E*xperience

Voluntary model of care for Medicare enrolled providers and practitioners that can implement the program within their practice

Comprehensive, coordinated, supportive care provided to the patient and their caregiver by an interdisciplinary team

Intentional comprehensive care provided to the caregiver

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Goals for GUIDE

Improve — Improve the quality of life for people living with Dementia

Provide — Provide support and resources for caregivers

Help — Help people with Dementia stay in their homes longer

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GUIDE Team

Comprehensive Supportive Care delivered by interdisciplinary team: Physician, Practitioner, Care Team Navigator, Community Health Worker and Social Worker

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Implementation of GUIDE

Identify Eligible Patients

- Current patients in practice or in entire ACO
- New patient referrals
- Scheduled patients
- Guidelines/Requirements

Introduce and get Consent

- During a scheduled visit by MD, NP, MA, LVN, CTN, CHW or MSW/LCSW
- When screening a new patient referral by staff
- While working a call or portal communication with a caregiver
- Using CMS provided information for consistency

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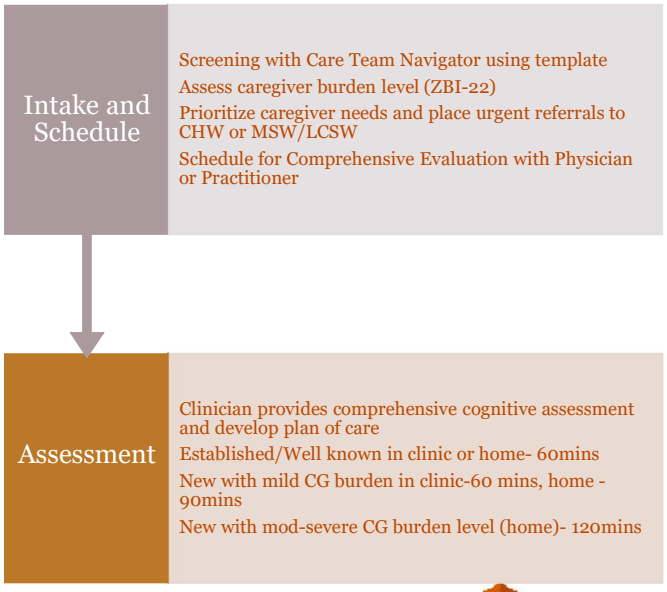
Implementation of GUIDE



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Outcomes

- Implemented November 2024
- Created template notes in EMR with IT dept for consistency and efficiency
- Met weekly with IT and team to review process and documentation
- Since November, we have submitted average of 25-30 eligible MCR enrolled PWD monthly
- Lost enrolled due to insurance and/or hospice care
- Half of our current enrolled have moderate-severe CG burden

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Lessons Learned

- In December and January, all enrollee's insurance needs to be checked for eligibility in program
- Verify insurance PRIOR to introduction
- Importance to check in with clinician during an appointment prior to introducing GUIDE- may not be a good idea
- Ask CG/family if they would like to hear about a new supportive program for Dementia PRIOR to introducing it (assess the room)
- If possible, determine what stage PWD is in prior to introduction-changes everything

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Lessons Learned

- Keeping a pristine spreadsheet for whoever is submitting to CMS monthly is critical (capitalization, no blanks, no abbreviations)
- Caregiver information required on the spreadsheet for submission can be obtained during intake and through conversation
- Importance of making time as a team to meet weekly
- Exposure of fragility in relationships between CG and PWD and desperate need of support

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Social Work and Supportive Services

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Social Work and Supportive Services

Role of Social Worker in a Dementia Clinic

Psychosocial Assessment	Counseling and Emotional Support	Advocacy	Resource Management and Case Management	Palliative and End of Life Care	Interdisciplinary Team Collaboration	Advocacy for Systemic Change
• Assesses a patient's social, emotional, environmental, financial, and support needs.	• Provide emotional support such as individual counseling, grief counseling, and crisis intervention to patient and families • Refer to other behavioral health professionals such as psychiatry, psychology, or counseling services.	• Advocates for patients and family members to other health care professionals and outside agencies.	• Navigate and access to healthcare resources • Social workers may also serve as case managers, coordinating patient care and ensuring that the patient's needs are met across various disciplines.	• Assisting families in making decisions about end-of-life care, including hospice services, advanced directives, and preparing for the patient's death.	• Medical social workers work as part of a healthcare team, collaborating with doctors, nurses, physical therapists, and others to develop comprehensive treatment plans that consider the patient's mental, emotional, and social well-being.	• Policy Development: In some settings, social workers may engage in advocacy on a broader level, working to influence healthcare policies, improve patient care standards, or address gaps in services for vulnerable populations.

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Biggs Institute Support Groups

Caring for a Parent with Dementia

Virtual support group for persons caring for a parent with a dementia diagnosis. Group is open to all adult children who have a parent with a dementia diagnosis.

Grief and Loss: During and After Caregiving

In-person support group for caregivers with a loved one in the later stages of dementia and those who have lost a loved one to the disease.

Living Together with Lewy Body Dementia

In-person dyad group for individuals diagnosed with Lewy Body Dementia and their care partners.

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Biggs Institute Counseling and Social Engagement

Counseling

Counseling services are currently provided by our licensed professional counselor and a counseling intern. Counseling is an opportunity to discuss and work through challenges and develop coping strategies.

We offer individual and family psychotherapy to families and patients of those seen in clinic using effective and tailored approaches such as Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, and Solution Focused Therapy.

Engagement Programing

Social engagement is important for those living with and caring for a dementia diagnosis. We aim to create dementia friendly events and activities for those living with a diagnosis and their family to connect with others and engage.

One such program is the ReCollections Art Program, a partnership with the local San Antonio Museum of Art, which provides a dementia friendly environment for reminiscing and conversation while viewing and creating art!

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Social Work and Supportive Services

Key Insights

- Support services offered by social workers and community health workers (CHW) play a crucial role in the healthcare setting.
- Caregiver support (emotional, logistical, and financial) is essential.
- Collaboration across disciplines helps minimize gaps in care and enhances patient outcomes.

Lessons Learned

- Services offered by social workers and CHW's are NOT reimbursed by Medicare, Medicaid, or private insurance.
- In-home care and respite care is a private pay expense that is not covered by most insurances.
- Support groups and social engagement events require funding, which is limited.

Opportunities for Improvement

- Enhancing family support system for caregivers
- Improving access to community resources
- Expanding social work, community health worker, and counseling program to serve more patients/families.

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Addressing the Ongoing Needs for the Population We Serve

Persons Living with Dementia

- Person-Centered Care
- Interdisciplinary collaboration with medical team
- Federal funding to assist with personal care needs

Care Partners and Families

- Access and funding for respite care options
- Training and education
- Mental health and emotional support
- Funding for in home care

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How Do We Expand Our Model of Care?

Policy and Advocacy

•**Funding and Resources:** Advocate for increased funding for dementia supportive services, caregiver support programs, and long-term care facilities. In many regions, dementia care is underfunded, and policy changes are crucial to expand services.

•**Legislation:** Push for policies that support individuals with dementia, such as better healthcare access, protections for caregivers (e.g., paid leave, workplace accommodations), and the establishment of dementia-friendly communities.

•**GUIDE Model:** Utilize the data obtained from the GUIDE participants to substantiate the need for increased funding for the aging population and persons diagnosed with dementia.

Family and Caregiver Involvement

•**Education and Training for Families:** Offer resources and training for families to help them understand dementia, manage challenging behaviors, and provide care at home.

•**Family-Centered Care:** Involve families in care planning and decision-making, while ensuring their well-being through respite services and emotional support.

•**Caregiver Recognition:** Advocate for policies that recognize and support family caregivers, including providing financial assistance, respite care, and access to professional support services.

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