Dementia Care Management Program

Report to

Chairman of the House Appropriations Committee
Chairwoman of the Senate Finance and
Appropriations Committee

Virginia Department for Aging
and Rehabilitative Services

Commonwealth of Virginia
Richmond
November 1, 2025

COMMONWEALTH OF VIRGINIA
DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

Kathryn A. Hayfield
Commissioner

8004 Franklin Farms Drive
Henrico, VA 23229

Office (804) 662-7000
Toll free (800) 552-5019
TTY Toll free (800) 464-9950
Fax (804) 662-9532

November 1, 2025

MEMORANDUM

TO: The Honorable L. Louise Lucas
Chair, Senate Finance and Appropriations Committee

The Honorable Luke E. Torian
Chair, House Appropriations Committee

FROM: Kathryn A. Hayfield KAH
Commissioner, Department for Aging and Rehabilitative Services

SUBJECT: Annual Report on Dementia Case Management Program

Pursuant to Items 315 J, 315 M, and 315 Q of the 2025 Appropriation Act, the Department for Aging and Rehabilitative Services (DARS) is pleased to submit the report on the status of the Dementia Care Management Programs delivered by the University of Virginia's (UVA) Memory and Aging Care Clinic in partnership with the Alzheimer's Association, by the Martha W. Goodson Center of Riverside Health Services in partnership with the Peninsula Agency on Aging, by The Span Center and by the Local Office on Aging (LOA). This document provides a brief description of the UVA and Riverside programs' history and information about their services through the year of funding from July 1, 2024, through June 30, 2025, and background about The Span Center and LOA's programs and expectations for their services going forward.

If you have any questions about the report, please do not hesitate to contact me.

KH/gw

Enclosure

Report on Dementia Case Management

A Report to the Virginia General Assembly *November 1, 2025*

EXECUTIVE SUMMARY

The Commonwealth of Virginia continues to strengthen its response to the growing needs of individuals living with dementia and their caregivers. Pursuant to Items 315 J, 315 M, and 315 Q of the 2025 Appropriation Act, the Department for Aging and Rehabilitative Services (DARS) provides an annual update on dementia case management programs funded through state appropriations. These programs deliver interdisciplinary care planning, caregiver support, and coordinated access to services in partnership with health systems, Area Agencies on Aging, and community organizations.

Since the initial pilot program launched in 2021, Virginia has expanded dementia case management through four key sites: the University of Virginia's Memory and Aging Care Clinic (MACC) in partnership with the Alzheimer's Association; the Riverside Martha W. Goodson Center in partnership with the Peninsula Agency on Aging; The Span Center (Capitol Area Agency on Aging) in Richmond in partnership with VCU Health; and the Local Office on Aging (LOA) in Roanoke in partnership with Carilion Clinic for Healthy Aging. Together, these programs are building the foundation for a statewide network of dementia care management.

Key accomplishments in SFY 2025 include:

- Enrollment of more than 200 individuals and caregivers at UVA MACC, with measurable improvements in caregiver burden, depression, and quality of life.
- The Riverside program's integration with community outreach through the Peninsula Agency on Aging, including expanded access to Spanish-speaking caregivers, home safety assessments, and personalized care planning.
- Establishment of new dementia case management capacity at The Span Center and LOA, with program guidelines developed, Memoranda of Agreement underway, and clinic partnerships secured.
- Work began on harmonized data collection tools in collaboration with the Virginia Memory Project to strengthen evaluation and demonstrate return on investment.
- Positive caregiver feedback, highlighting the value of consistent support, trusted guidance, and improved access to services.

The value of dementia case management can be seen through program outcomes. Results include reducing unnecessary emergency room visits and hospitalizations, providing families with tools to manage behavioral and safety challenges at home, and helping caregivers sustain their role while maintaining their own well-being. Equally important, they connect families to community resources and long-term care planning, promoting dignity and independence for people living with dementia.

Moving forward, DARS will continue to support program implementation at the new sites, ensure consistency in services across the Commonwealth, and partner with the Virginia Memory Project and the national State Alzheimer's Research Support (StARS) Center to measure outcomes and inform future initiatives.

REPORT MANDATE

Item 315 J. of the 2025 Appropriations Act: *Out of this appropriation, $262,500 the first year and $262,500 the second year from the general fund shall be provided for an interdisciplinary plan of care and dementia care management for 88 individuals diagnosed with dementia. This service shall be provided through a partnership between the Memory and Aging Care Clinic at the University of Virginia and the Alzheimer's Association. The Department for Aging and Rehabilitative Services shall report the status and provide an update on the results of the dementia case management program to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by November 1 of each year.*

Item 315 M of the 2025 Appropriations Act: *Out of this appropriation, $200,000 the first year and $200,000 the second year from the general shall be provided for an interdisciplinary plan of care and dementia case management for 100 individuals diagnosed with dementia. This service shall be provided through a partnership between the Martha W. Goodson Center of Riverside Health Services and the Peninsula Agency on Aging. The Department for Aging and Rehabilitative Services shall report the status and provide an update on the results of the dementia case management program to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by November 1 of each year.*

Item 315 Q of the 2025 Appropriations Act: *Q. Out of this appropriation, $400,000 from the general fund the second year shall be provided to the Capitol Area Agency on Aging and Local Office on Aging, Inc. for an interdisciplinary plan of care and dementia case management for 200 individuals diagnosed with dementia. Funding shall be allocated evenly between the two Area Agencies on Aging. The Department for Aging and Rehabilitative Services shall report the status of the program and provide an update on the results of the dementia case management program to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by November 1 of each year.*

DARS AND DEMENTIA

DARS' mission is to improve the employment, quality of life, security, and independence of older Virginians, Virginians with disabilities, and their families.

Under the Code of Virginia § 51.5-152, DARS has several powers and duties with respect to Alzheimer's disease and related disorders (ADRD). These include evaluating the needs of individuals with ADRD and their caregivers, and identifying the services, resources, and policies that may be needed to address such needs for individuals and their caregivers, and recommending policies, legislation and funding necessary to implement the state plan for meeting the needs of individuals with ADRD and their caregivers.

The most recent plan, the *Virginia Dementia State Plan 2024-2027: Building a Dementia-Capable Virginia*, was developed by the Alzheimer's Disease and Related Disorders Commission in consultation with stakeholders and citizens and includes six main goals, including a new goal highlighting brain health and dementia risk reduction. Goal Four is to provide access to quality coordinated care for individuals living with dementia in the most integrated setting.

The Dementia Services Director, housed within the Division for Community Living at DARS, supports the Alzheimer's Disease and Related Disorders Commission, disseminates information on systems, services and related activities, and coordinates services and activities of state and local agencies, service providers, advocacy groups, first responders and law enforcement, as well as other entities throughout the state that engage with people with ADRD and their caregivers, specifically the Alzheimer's Association, Area Agencies on Aging and Adult Protective Services.

I. UNIVERSITY OF VIRGINIA MEMORY AND AGING CARE CLINIC in partnership with the ALZHEIMER'S ASSOCIATION

BRIEF HISTORY

Dementia Case Management began at UVA MACC in 2016 with support from a federal grant awarded to DARS. UVA MACC collaborated with the Jefferson Area Board for Aging (JABA), the Area Agency on Aging serving the Charlottesville region, to deliver services to a total of 220 people living with dementia and their caregivers over the three-year grant period.

The project reported several measurable outcomes that highlighted the benefits of care management. Among both people living with dementia and caregivers, these included: decreased depression; improved quality of life; reduced problematic behavioral symptoms and lower severity of dementia symptoms; and reduced health care utilization. In addition, caregivers reported a reduction in caregiver burden. Overwhelmingly, both people living with dementia and their caregivers felt the program was beneficial, helping prepare them for the future, improving clinical care and treatment, improving access to community resources, and reducing stress.

These results help explain why dementia case management has maintained a high profile in Virginia's Dementia State Plan since the first plan in 2011. The Alzheimer's Disease and Related Disorders Commission has consistently advocated for state funding to support dementia case management with the goal of having these services available across the Commonwealth. Since the DARS-supported grant projects ended in 2018, dementia care management services have been maintained using a mix of grant funding and, since 2021, state general funds.

DESCRIPTION

The *Innovative Supportive Care Model for Dementia* aims to fill a gap in care through implementation of a non-pharmacological dementia care coordination program for caregivers of community-dwelling persons living with dementia. The program is delivered both in person and via a novel telehealth technology approach. The project examines the program's efficacy in 1) reducing caregiver burden, 2) reducing symptoms of depression, 3) improving caregivers' ability to cope effectively with the behavioral symptoms of dementia, and 4) improving the quality of life in caregivers of persons living with dementia.

IMPLEMENTATION

Partnership with the Alzheimer's Association

As directed in the budget language, UVA MACC continues to partner with the Alzheimer's Association to carry out the project. This is accomplished under a Memorandum of Agreement (MOA) that covers the Association's Dementia Care Manager's (DCM's) time and effort.

Additionally, the Association offices and staff are available to provide resources to assist clinic patients and their caregivers. The DCM maintains relationships with personnel at the Association and communicates regularly with them regarding initiatives and services available.

How the program works

Several new modifications have been made to the program in the past year. Members of the clinic team developed a tailored database in REDCap, a survey distribution tool, loosely based on the Benjamin Rose Institute's evidence-informed program. This tool is streamlined to more closely reflect the actions and activities of the DCM with the added benefits of being more cost and time efficient, and more reflective of the needs of the caregivers and the actions of the DCM.

Additional benefits arise from integrating the DCM's database into the caregiver's questionnaire database, enabling DCMs quick and efficient access to needed data. An additional modification includes that the caregiver questionnaires are integrated into the new REDCap database. A subset of questionnaires are now sent out quarterly in addition to the questionnaires sent out annually.

The content of the questionnaire battery has also been changed based on caregiver feedback and to increase efficiency. Some of the changes include removing the Resource Utilization in Dementia scale after caregiver reports of burden related to filling out the questionnaire. Geriatric versions of questionnaires have been replaced with versions appropriate for the general population to more accurately reflect the caregiving population. The General Self-Efficacy Scale was replaced with a caregiver specific version, and the dementia knowledge test was replaced with a more up to date and relevant scale. A brief caregiver loneliness questionnaire has been added as loneliness has been identified as a potential intervention target. A full description of the new battery can be found in the next section.

Persons living with Alzheimer's disease or related dementias (ADRD) and their families are approached in the MACC at UVA by members of their health care team (neurologist, neuropsychologist, or nurse practitioner) or program personnel. A brief description of the care provision program is provided and if the families are interested, their contact information is shared with the program coordinator. The program coordinator calls the families to discuss the program in detail and identify a primary caregiver to meet regularly with their assigned DCM.

Once an appropriate caregiver is identified and the person living with dementia is willing to participate, a comprehensive set of questionnaires are sent to the caregiver from the REDCap platform. The questionnaires provide DCMs essential information on how to provide the most effective care, and include measures assessing depression, anxiety, quality of life, dementia-related behaviors and caregiver reactions, and others. Caregivers are additionally asked to complete measures of caregiver stress and burden, dementia knowledge and preparedness for caregiving.

After questionnaires are completed, the program coordinator contacts the caregiver with an introduction to their DCM and further details regarding the program and telehealth platform used. DCMs have ongoing contact with caregivers and the patient once a month at minimum by phone, email, videoconferencing, and/or in person. The job and care provided by DCMs are multifaceted, emphasizing a person-centered approach for both people living with dementia and caregivers, while examining their needs through the lens of their emotional, physical, and spiritual wellbeing.

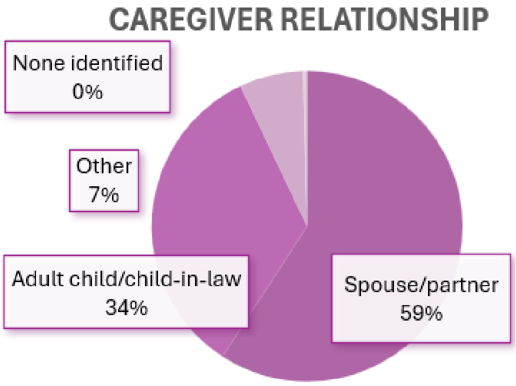
How the DCM helps

One of the primary goals of the DCM program involves coordinating care regarding the dementia diagnosis, with an emphasis on providing person focused support, education and guidance as individuals navigate the healthcare and community systems that are available to them. An equally important but less often discussed piece of DCMs' impact involves providing validation and emotional support at a time in life where things can be particularly overwhelming. DCMs validate the persons with dementia (PWDs) and care partners' emotional experience, while also providing disease-specific education and helping them to identify supports and strategies that would be beneficial for their unique needs. DCMs have the flexibility to meet the PWD and caregiver where they are both physically and emotionally, allowing for rapport, safety, and trust established early on in the relationship.

Most of the DCM program's interventions can be organized into seven main categories: 1) care coordination, 2) education on diagnosis and dementia progression, 3) guidance and education on community resources, 4)

Table 1: UVA Participant Demographics 6/30/2025

	Individual Living with Dementia	Primary Caregiver
Female	48%	67%
Black/African-American	7%	10%
Hispanic/Latino	3%	3%
Veterans	12%	11%
Age Range		
Under 60	5%	29%
60+	92%	67%
Lives alone	8%	n/a
Rural	50%	48%



guidance and education on financial resources, 5) guidance and support for long term care planning, 6) emotional support, and 7) behavioral symptom management and safety strategies (see Table 5 in Appendix A for examples of each).

While the goals and anticipated outcomes of care are unique for each individual living with dementia and the primary caregiver, DCMs can broadly anticipate preparing individuals for the challenges associated with living with dementia, reducing the need for unplanned medical treatment, decreasing the emotional and physical burden of living with dementia, as well as improving emotional outcomes for both the person living with dementia and the caregiver.

At each 3-month quarter, caregivers complete caregiver burden, preparedness for caregiving, and self-efficacy questionnaires. At the end of each 12-month period, they complete the full battery of questionnaires with the program satisfaction survey. DCMs review the caregiver participation at the end of the 12-month period. If the caregiver has participated monthly and utilized the services provided by the program, the caregiver is invited to remain in the program for another year. This process of evaluation is repeated annually.

DCMs use a variety of means to maintain contact with the participants including phone, email, videoconferencing and in-person visits. Typically, DCMS will also accompany participants while they are in the MACC for follow-up care visits, providing another set of ears in often emotional and sometimes overwhelming appointments. Clinic visits usually entail meeting with several members of the care team that can include neurologists, neuropsychologists, nurse practitioners, social workers, and others.

Program enrollment

As of June 30, 2025, 216 individuals and their caregivers were enrolled in the program, of which 93 were new enrollments in the past year. Demographic information about the participants is in Table 1. Caregivers are often younger than the person living with dementia and generally female. By relationship, 59% of caregivers were the spouse or partner of the person living with dementia, followed by 33% who were adult children, typically daughters.

Services provided

Care coordination is provided in a variety of settings, including during participants' visits to the clinic and DCM visits to the participants' homes, and through phone calls, emails and telehealth visits. Home visits are an important component of the program as they typically provide a wealth of information to help the DCM support the participant more effectively, as well as providing an important opportunity to develop rapport.

Table 2. UVA SFY 2025 DCM Outputs	
Total Service Hours	2,897
Direct	1,525
Indirect	1,372
Total Contacts (#)	4,267

At a minimum, DCMs contact each participant once a month, with an average of four contacts per month. DCMs record the time spent assisting participants as direct hours and indirect hours (see Table 2). Direct hours are actual time spent with the participants including at clinic visits, in-person home visits, phone calls, telehealth visits, and emails. Indirect hours are time spent working on tasks for the participants such as leaving or answering voicemails, time spent locating resources, time spent communicating with providers about specific patient needs, travel to and from visits, and time spent documenting interactions with participants.

Program Outcomes

In supporting people living with dementia, clinic staff have noticed that several caregivers experience cognitive changes of their own, and several have transitioned from being the assigned caregiver in the program to being a care receiver after receiving a diagnosis of dementia. Typically, when that happens, a family member or friend will step in as the assigned caregiver. This person is frequently considered to be part of the "sandwich generation" and is often still working while trying to manage care needs. In recognition of the acute levels of stress these families are experiencing, DCMs assist in expediting necessary diagnostic appointments to ensure that access to appropriate care is maintained.

Once two family members have both received a diagnosis of cognitive impairment, DCMs work to ensure they can be seen in consecutive or otherwise convenient appointments to help minimize caregiver burden. This person-centered care is essential in helping to promote a high quality of life and overall wellbeing for participants.

Additionally, many of the caregivers who received support through the Department of Defense-funded iteration of the Care Coordination Program found significant value in the program and have requested to rejoin the current state-funded service. This re-enrollment demonstrates the ongoing success of the program.

To help increase efficiency and ensure availability to patients and caregivers in the MACC, there is now a designated "on-call" care coordinator present in the clinic. The interdisciplinary team is made aware of who is on-call so that questions, concerns and referrals can be handled appropriately. This has also allowed the care coordination program to broaden its reach by providing targeted and brief support to patients who may otherwise not have had access to this specialized level of support and understanding. The on-call program has had 196 contacts since its start on May 22, 2024. DCMs have logged 80.03 direct and 63.25 indirect hours assisting caregivers and individuals living with dementia.

The clinic also offers the FAMILIES program, a telehealth-based, evidence-supported intervention that helps caregivers streamline their support systems and reduce burnout. Its virtual delivery makes it scalable, allowing clinic staff to extend support more broadly. The FAMILIES program, an adaptation of the evidence-based New York University Caregiver Intervention, was developed with the same DARS grant that launched dementia care management in Virginia in 2016.

The clinic's DCMs have taken on the management of support groups being offered by MACC. The ongoing Younger Caregiver Support Group was previously peer-led, but the participants reported a need for increased clinical presence. As a result, the group was re-created into a joint endeavor with the Alzheimer's Association and the MACC, both of whom provide support and facilitation.

An essential tenet of the DCMs' work is to ensure caregivers and people living with dementia are aware of and thus can access available community resources and programs. These resources range from adult day programs for respite care, financial grants or tax breaks, and other assorted community programs and benefits that may be specific to the community in which they live. As an advisory board member of Blue Ridge Respite, DCM Elizabeth Boyd helped to establish a thriving social respite program in Nelson County and is now advocating for an expansion of these services to two other rural satellite locations. Her advocacy is helping to increase access to support for caregivers and their loved ones living with dementia in rural communities that historically would have more difficulty accessing these vital supports.

Elsewhere, in response to the rapidly changing expectations for federal employees, DCMs needed to quickly support caregivers needing to implement changes in the day-to-day care of their loved ones. Many caregivers who were previously able to work from home were required to return to the office full time, which necessitated devising care plans for their loved ones who could not safely remain at home alone. DCMs ensured that the affected caregivers knew which agencies or programs they could contact to initiate services and provided emotional support and validation throughout the adjustment.

Program dissemination

The program is being actively researched to expand knowledge about the effectiveness of dementia care management services. Significant progress has been made in disseminating the findings from the allied research project: Individualized coordination and empowerment for Care Partners of Persons with Dementia (ICECap). The study rationale and protocol paper were published in *Contemporary Clinical Trials* as was the feasibility and acceptability paper. The Primary Mental Health and Burden Outcomes manuscript was published in medRxiv, a preprint server for Health Sciences to ensure timely dissemination of the findings. The Impact on Preparedness for Caregiving manuscript was published in *Aging Clinical and Experimental Research*. Additionally, the study team has presented abstracts at national conferences, further extending the reach and impact of the program.

Lessons from the fourth year

Clinic staff noted that families were sometimes confused about who to designate as a 'primary' caregiver, so the language around this was modified for easier understanding.

In response to caregiver feedback, the initial and annual assessments disseminated by the program were adjusted to help increase efficiency and minimize caregiver burden. Additionally, the clinic began to send out abbreviated quarterly assessments to ensure caregivers have ample opportunity to provide feedback and ensure that the support being offered by the program matches the current needs of the caregivers.

Program reception

Reception of the Dementia Care Management program has been overwhelmingly positive in the MACC clinic and with associated partners. The team has found that the great majority of caregivers receiving clinical care are interested in care management services. As such, the team has had to be strategic in how the program is advertised to prevent the waitlist from being overwhelmed. Demand for services has consistently far outstripped the availability of DCMs. Clinic staff continue to find appropriate ways to prioritize families with the highest need. Having a designated "on-call coordinator" in clinic as described above is a strategy to provide help to more families, with the hope that all families will be able to receive dementia care management in the future.

Dementia care management is a highly desired service in the MACC clinic. The limiting factor in providing this service to all interested patients and families is the insufficient number of DCMs available.

II. RIVERSIDE MARTHA W. GOODSON CENTER in partnership with PENINSULA AGENCY ON AGING

BRIEF HISTORY

Dementia Case Management began at Riverside in 2018, through the former Center for Excellence in Aging and Geriatric Health, now the Riverside Martha W. Goodson Center (MWGC) and the Riverside Neurology Memory Care Clinic. The development of this program, referred to initially as dementia care coordination, was funded in part by a grant awarded to Riverside by the federal Administration for Community Living under the Alzheimer's Disease Program Initiative. One full-time and one part-time dementia care coordinator were hired to support this project through the fall of 2021. These dementia care coordinators served 117 patients living with dementia and their families during the grant period utilizing the Benjamin Rose Institute on Aging Care Consultation (BRICC) program.

Measurable outcomes among these families included a substantial drop in emergency room visits (from 35% to 29% of enrolled participants) at program completion. Hospitalization rates remained the same at 18.4%. Overall quality of life for participants living with dementia was largely maintained, dipping from 1.56 to 1.50. Caregivers reported an increased ability to manage day-to-day caregiving and handle new problems. Negative indicators, such as being angry or feeling overwhelmed, also improved. Both persons living with dementia and their families consistently reported satisfaction with the program and highlighted benefits such as having things explained in an understandable way, listening to what the caregiver has to say, including both the person living with dementia and their caregiver in planning, and helping to connect with resources and services.

In the spring of 2021, Riverside received a donation that facilitated the continuation of this program after the federal funding ended, with the program renamed as Memory Care Navigation. The first Memory Care Navigator (MCN) was hired by the MWGC in the fall of 2021, and since then, three additional MCNs have been hired. This team of MCNs utilizes a care coordination protocol, and they serve a caseload of more than 325 families. As part of the program offering, the clinic tracks both extensive services (e.g., at least 6 months of case management) and limited services (e.g., generally 1-2 touchpoints). In reporting extensive services, MWGC served 112 families in 2022, 276 in 2023, 500 in 2024, and 270 to date in 2025. This team of MCNs is also supported by a Geriatric Care Specialist and a Community Health Care Navigator. The MWGC remains in contact with the UVA Memory Care Clinic to learn about their approach and workflow in offering dementia case management.

Program Description

Known at MWGC as the Dementia Care Coordination (DCC) Program, DCC provides support to persons living with dementia and/or their family caregiver or care partner. Engagement in the program includes a home visit; a personalized care plan; regular check-ins through monthly touchpoints over six months; and medication management. The program is delivered both in-person and via telephone, email, and a virtual video platform (e.g., Microsoft Teams) with overarching goals of improving health and coordinated care that is person-centered and tailored to the needs of the person living with dementia and their caregiver. DCC efficacy is measured through 1) reducing caregiver burden; 2) improving caregivers' ability to cope with the symptoms (e.g., physical, emotional, and social) of dementia; and 3) improving the caregiver's quality of life through providing valuable information and access to community resources.

IMPLEMENTATION

Partnership with Peninsula Agency on Aging (PAA)

As directed in the budget language, the MWGC has subcontracted with the Peninsula Agency on Aging (PAA) to facilitate referrals and community education about the value of DCC. The partnership is outlined in a Memorandum of Understanding that went into effect on August 14, 2024, ending on June 30, 2026. Several orientations about DCC were held with PAA staff to both familiarize them with the program and to gather their input about how they can build program awareness and facilitate referrals. The organizations jointly developed a referral workflow that has seen 38 referrals during the reporting period. Additional referrals have come through self-referrals made by people living with dementia and/or their caregiver after learning about DCC through engagement in a PAA program.

Members of the MWGC and PAA met monthly as DCC was launched in the Fall of 2024 and transitioned to meet bi-monthly starting in March 2025. These meetings are used to strategize program promotion, support for those who are enrolled, and address any challenges or barriers to delivering the program. Additionally, all referrals made by PAA are tracked and status reports (e.g., enrolled in DCC, unable to contact, eligible for another program) are provided to PAA each month.

Spanish-language services

PAA has a robust community health program (CHP) that provides broad outreach to the Hispanic community. Staffed by two native Spanish Speakers and a Korean Speaker, the CHP offers a variety of programs, such as the Active Aging POP-UP Center, Caregiver Support Group (offered in Spanish) and health presentations throughout the area. This allowed PAA to increase the reach of the DCC program to Spanish speaking individuals. PAA also advocated for the DCC outreach flyer to be translated to Spanish so that it could serve as a tool for educating Spanish speaking individuals about the opportunity to participate. Even with targeted outreach, the team has found that it can take several meetings to build trust and rapport before potential enrollees agree to participate in the DCC.

Building Program Infrastructure

MWGC is utilizing its team of MCNs to build up to a caseload of 100 families per year, and one MCN has been designated to offer DCC as her primary focus. Since being hired in late August 2024, this MCN has engaged in extensive orientation and onboarding with both Riverside Health and with the MWGC, including 75 hours of online and in-person training and professional development. Training content included: overview of case management; dementia-related assessments; advanced care planning; safety in the home; supporting family/friend caregivers' well-being; shadowing members of the interdisciplinary care team; exploring community resources; and managing and tracking patients and assessments in Epic (electronic health record).

Outreach efforts included developing promotional materials such as a program flyer (also available in Spanish since January 2025). Between September and December 2024, MCNs visited community partners including Olde Towne Medical Center, James City County CONECT, Riverside Brentwood Family Medicine, Riverside Charlie and Golden Bethune Hill Clinic, and Riverside Neurology.

How DCC works

People living with Alzheimer's disease or related dementias (ADRD) and their families are identified through a variety of sources. In addition to referrals received from PAA, referrals are also received from: patients being served by the MWGC MCNs; the Geriatric Assessment Clinic; Driving Evaluation Program; and Riverside primary and specialty care practices including Brentwood Family

Medicine and Riverside Charlie and Golden Bethune Hill Clinic. Referrals also come from Riverside hospital case managers, and from community partners and service providers (e.g., Sentara Healthcare, TPMG, James City County CONECT, York County Adult Services).

Once a willing and eligible caregiver or care partner and PLWD are identified, the caregiver is invited to complete the Zarit Burden Inventory (ZBI -22) and then they are officially enrolled in DCC and are sent a welcome letter. An episode is created in Epic and all encounters are documented by the MCNs and are linked to the initial episode. A home visit (or meeting at the MWGC office or a neutral site) is scheduled within a few weeks of enrollment.

During this initial visit, the *Dementia Health and Wellness Welcome Booklet* is presented and reviewed. This booklet is designed for families who are new to the program and the services offered. It provides information to guide participants through the care process and helps them navigate the resources available. Having the *Welcome Booklet* facilitates a smooth transition into DCC and gives the family and individual living with dementia their MCN's contact information as well as key information about the care coordination process, wellness and self-care strategies, educational resources, and notes for tracking monthly sessions. The booklet serves as a participation guide and a pledge for how DCC can offer support, education and enhanced quality of life for both the person living with dementia and the caregiver or care partner.

A tailored Care Plan is then developed and documented in Epic. This Care Plan identifies the key issues or needs to be addressed at the monthly sessions. Once the 6th session has been completed, the caregiver is invited to complete the ZBI-22 at follow-up as well as a program satisfaction survey. The satisfaction survey can be completed via email or by scheduling a brief telephone call. Caregivers and people living with dementia who need ongoing support can receive intermittent support from the MCN program.

How DCC helps

The DCC Program provides comprehensive support to individuals living with dementia, as well as their care partners, families, and friends. The program is committed to enhancing quality of life through personalized outreach, individualized care planning, education, supportive services, and connection to community resources. DCC is designed to reduce caregiver burden by offering consistent engagement, access to helpful tools and services, and regular educational support. Monthly touchpoints allow MCNs to ensure progress, provide reassurance, and adjust the Care Plan as needed. This ongoing relationship adopts a coordinated approach to dementia care that increases care partner's confidence and supports their ability to manage dementia-related symptoms at home. Through continuous guidance and timely interventions, DCC ensures that care partners do not face the journey alone—particularly during the many changes and losses that come with a dementia diagnosis.

Program Enrollment

Between September 2024 and June 2025, 168 individuals were screened for enrollment. Of these, 52 caregivers or care partners and people living with dementia have been enrolled in DCC (see Table 3). MWGC launched DCC in late August 2024 when the MCN was hired. It has taken several months to build the program infrastructure and workflow. Epic reports have been designed and are in the process of being built. These reports were not available in time for preparing this report.

Services Provided

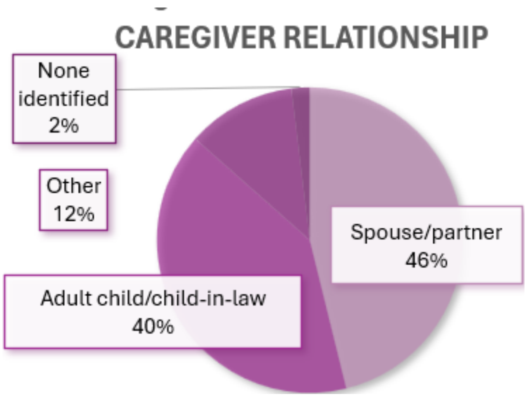
Personalized Care Plan

Each Care Plan is developed based on the specific needs, goals, and priorities of the care partner and the person living with dementia. Through a combination of in-person visits, virtual communication, and structured follow-

Table 3: MWGC Participant Demographics 6/30/25*

	Individual Living with Dementia	Primary Caregiver
Female	65%	80%
Black/African-American	29%	43%
Hispanic/Latino	4%	12%
Age Range		
Under 60	6%	25%
60+	83%	45%
Lives alone	56%	n/a
Rural	0%	n/a

*Percentages may not sum to 1 due to missing values



up, MCNs assess not only the logistical needs of the household but also the educational background, caregiving experience, and emotional readiness of the care partner. MCNs tailor their education and communication strategies to match the care partner's level of understanding, cultural context, and ability to absorb information. They offer targeted education on disease progression, communication strategies, behavioral responses, and safety concerns—always aligned with what the care partner can meaningfully engage with and apply in real time.

Home Safety Assessment and Checklist
During the initial home visit, the MCN conducts a comprehensive home safety assessment to identify potential concerns such as fall risks, wandering behaviors, improper medication storage, and limited access to emergency support. The MCN collaborates with the caregiver to implement practical safety improvements and may recommend modifications or assistive devices when appropriate.

Educational Materials and Welcome Booklet
In addition to the *Dementia Health & Wellness Welcome Booklet* described above, participants receive additional handouts and condition-specific materials based on the stage of dementia and the family's expressed needs.

Regular Check-ins
Monthly check-ins take place by phone, video, or in person depending on the family's preference. These sessions focus on reviewing and updating the Care Plan, discussing challenges, offering emotional support, and problem-solving. They serve as a reliable, ongoing point of contact for both encouragement and crisis response.

Resource Coordination
MCNs connect families to a wide range of local services including adult day programs; respite care; Meals on Wheels; personal care supplies; social engagement programs; legal assistance; durable medical equipment; transportation services; caregiver education; and memory assessment clinics. To address common barriers to accessing services, MCNs provide guidance on eligibility criteria and hands-on support with applying for state and federal assistance programs.

Emotional Well-Being
Recognizing the emotional toll of caregiving, MCNs provide compassionate support through regular conversations, active listening, and empathy. When needed, families are referred to counseling services, caregiver support groups, mindfulness practices, or other mental health resources to address stress, grief, and burnout.

Team-Based Interdisciplinary Review
Weekly Interdisciplinary Team meetings support complex or high-need cases by bringing together staff from nursing, social work, pharmacy (see Appendix C), and program leadership. Additional disciplines such as occupational therapy, physical therapy,

speech therapy, and home health are consulted as needed. This collaborative model ensures that families receive well-rounded, expert-driven recommendations.

At a minimum, MCNs contact each participant once per month, with an average of 12 contacts during the participant's time in the program, see Table 4. Service hours are tracked as direct and indirect. Direct hours are actual time spent with the participants including in-person and home visits, phone calls, and emails. Indirect hours include time spent working on tasks for the participants such as responding to or leaving voice messages, time spent identifying and securing community resources, time spent making additional referrals or communicating with other providers on the care team, travel to and from visits, and time spent documenting all encounters and tasks with and for participants.

Table 4. MWGC MCN Outputs SFY 2025	
Total Service Hours	1,055
Direct	468
Indirect	587
Total Contacts (#)	624

Program Outcomes

With respect to caregiver stress as measured by the ZBI, baseline scores ranged from 9 (no to mild burden) to 70 (severe burden) with an average ZBI of 39.7 (mild to moderate burden) across all caregivers.

Enrolled participants are currently in process with their 6th-month participation period. Four participants have been invited to complete the program satisfaction scale, indicating their official completion in DCC. Two participants have submitted the program satisfaction survey.

Interestingly, clinic staff have not identified any person living with dementia enrolled in DCC who has been treated in the emergency department or hospital during their time enrolled.

Lessons from Year 1

Outreach efforts prior to enrollment

The MWGC team has recognized that it is taking on average 2-3 contacts, and sometimes more, before a person living with dementia and/or their caregiver are officially enrolled in DCC. This is due to several factors including: 1) difficulty reaching the caregiver; 2) challenges identifying time to complete enrollment paperwork; and 3) caregiver not feeling ready to commit to the program or requesting more time to consider participation.

Enrolling Spanish-speaking participants

Implementing the program revealed several barriers that prevent members of the Hispanic community from enrolling in dementia-related services:

- **Fear and Stigma Around Diagnosis**: Many participants were reluctant to seek a dementia diagnosis due to fear of stigma or denial about the condition.
- **Distrust in the Health System**: Some families expressed hesitation engaging with healthcare providers due to a lack of trust, often tied to previous negative experiences or cultural perceptions.
- **Limited Health Literacy**: Navigating healthcare options was challenging for individuals with limited understanding of medical terminology or system processes.
- **Strong Informal Support Networks**: Many families rely on tight-knit support systems and often believe their needs are already being met, making them less likely to seek formal help until they are in crisis.
- **Overwhelmed Caregivers**: Caregivers are often stretched thin and hesitant to take on something that feels like "another task," even if it could help them in the long term.
- **Logistical Barriers**: Issues like lack of time, transportation, or the caregiver's work schedule further delayed access to diagnosis and program services.
- **Expectations vs. Program Timeline**: Families often seek immediate solutions, such as respite care, and can become discouraged when services are part of a longer-term process.

Despite these challenges, early outreach and engagement through community events (Cafecito, POP-Ups) helped build relationships. While not all caregivers were ready to enroll immediately, many were open to staying connected and accepted referrals to other support services. Trust-building is key, and enrollment often requires time and ongoing contact. As PAA support groups continue to grow, greater participation in the DCC is expected.

Program Reception

The reception of DCC, within Riverside Health, PAA, and the larger communities served, has been positive. The MWGC has a variety of programs available to support people living with dementia and their caregivers or care partners. The team has worked diligently to explain these options and help patients and families identify program eligibility, opportunities for enrollment, commitment once enrolled, and benefits of program participation.

III. THE SPAN CENTER and the LOCAL OFFICE ON AGING

BRIEF HISTORY

The General Assembly appropriated funding for two new programs of Dementia Care Management in 2025. These will be housed at The Span Center, the Area Agency on Aging (AAA) serving Richmond and surrounding counties, and at the Local Office on Aging (LOA), the AAA serving Roanoke and surrounding counties. This level of clinical service has not been delivered previously by AAAs in Virginia, and to provide comparable services to the existing programs that are both housed in clinical settings, DARS suggested that both partner with a clinic serving in their area. The Span Center will be partnering with VCU Health, and LOA with the Carilion Clinic for Healthy Aging.

IMPLEMENTATION

DARS began consulting with the two host organizations early in the process and worked to develop a Program Guideline document that would help put together Program Implementation Plans, which are a required element of the MOA. As of June 30, 2025, the respective MOAs were yet to be executed. The goal is to have those executed during the first quarter of the fiscal year with the hiring of the Dementia Care Managers and services commencing shortly thereafter.

The general program description for the two new programs will be in line with the existing programs to ensure that a similar level of service is available to people enrolled in any of the state-supported dementia care management programs. However, the execution details are expected to vary given the non-clinical nature of the host organization.

DARS is currently consulting with all four programs on best practices for data collection and analysis, and harmonization of assessment instruments and questionnaires to ensure comparable data is available. The goal of this effort is to improve the quality of dementia care coordination data available in Virginia, and to help quantify the return on investment of the appropriated funds.

DARS is currently a partner on a national grant project called the State Alzheimer’s Research Support (StARS) Center. The goal of this project is to better evaluate existing and new programs of dementia care management and coordination. Having the Virginia Memory Project, the state’s Alzheimer’s disease and related disorders registry, involved in this project will allow for rigorous evaluation and understanding of the benefits of dementia care management for the participants and the state in future years.

APPENDIX A

Table 5. Action types and examples of DCM interventions

Action Step Types	***Examples***
Behavioral management strategies	E.g., for sundowning, hallucinations; using dry erase boards for scheduling; dementia clocks.
Safety strategies	E.g., grab bars in the shower, removing rugs from the home; reviewing how to call 911 in the event of an emergency; reviewing personal safety equipment (e.g., medical alert device); contacting Adult Protective Services about concerns of abuse or neglect.
Strategies for both behavior management AND safety	Discussing strategies for managing/reducing the likelihood of wandering (e.g., alarms on doors); camera systems for in-home safety and monitoring; strategies for discouraging persons with dementia from driving.
Strategies for activities of daily living	Discussing automatic pillboxes/pillboxes with alarms; educating about incontinence care; putting water bottles on the counter as a visual reminder to hydrate throughout the day.
Administration/case management	Initial chart review; scheduling visits; consulting with other providers (e.g., on the team) with whom the individual is already established; completing paperwork.
Referrals to other providers	E.g., to speech therapy, physical therapy, psychotherapy, palliative care, hospice.
Providing education about navigating diagnosis and disease progression	Reviewing the diagnosis of Alzheimer's disease and what might be expected for Mild Cognitive Impairment or the relevant stage of dementia; educating about the difference between depression and apathy, or about anosognosia.
Guidance and education on community resources	Discussing Silver Sneakers program, directing a care partner to the local area agency on aging; connecting them with Meals on Wheels or another specific community resource; sharing information about the Alzheimer's Association 24/7 Hotline.
Guidance and education on financial resources or benefits	Discussing Medicare/Medicaid benefits, long-term care insurance, VA benefits, or FMLA benefits; making the care partner aware of grants; assisting with affordable housing vouchers or respite care vouchers.
Guidance and support for long-term care planning	Discussing options for assisted living versus in-home help; providing guidance about questions to ask home health agencies or facilities.

(table continued on next page)

Action Step Types	***Examples***
Providing emotional support	"Above and beyond" active listening and typical counseling skills, such as validating and discussing anticipatory grief, ambiguous loss, or guilt about transitioning the individual to an assisted living facility.
Guidance and education about	Providing information about local research

research/clinical trials	opportunities/clinical trials; helping to coordinate brain donation/autopsy for research purposes.
Guidance and education about legal resources	Discussing the importance of updating wills and advance directives, designating an agent under power of attorney; connecting the participants with an elder law attorney.
Rapport-building	Initial establishment of rapport; could also occur after an issue or conflict between the DCM and the participants (either the individual living with dementia or the caregiver), for example if the care partner is frustrated with the DCM about a conversation or resource. On-going maintenance of rapport and provision of empathic care.
Lifestyle, quality of life, and enrichment/engagement resources	Memory scrapbooking for the purpose of enrichment and reflection on the individual’s life; encouraging increased use of respite to improve quality of life; discussing the benefits of a specific enrichment activity (e.g., arts/crafts).

APPENDIX B

Testimonials provided to program staff directly or through the satisfaction surveys.

> *Thanks for your consistency in outreach to me, and to the others that you're supporting. It means so much to me, and indirectly to [participant], too. We know how much you care, and reading your emails always brings me some quiet comfort. I don't know how you do it!!*
>
> *You guys were very important to us personally and professionally. Thank you so much for being there.*
>
> *I know this is a surprise but wanted to reach out after all this time. It's been 4 months since dear [participant] passed away. I think I'm doing well. I have my moments, of course. They sometimes come out of nowhere and tears start but I know it is part of my grieving process. I will always miss him. Thank you for all you did for us. Your patience was infinite even during our most difficult times. You are truly special.*
>
> *I must tell you...it's such a relief to have someone to reach out to when I come up against a wall. You are a blessing and I appreciate you so much! Even if you don't have any financial resources for this situation, you are such an amazing person and I am so grateful just to have you to reach out to. I wouldn't wish this illness on my worst enemy! Bless you and thank you!*
>
> *I feel like I am a bad person because I am frustrated and get short with my husband. I'm turning into a person I don't like and don't want to be. It's so nice to speak with someone who actually understands what I am talking about. Thank you.*
>
> *Thank you for reaching out to me, I appreciate all your help. You are the best advocate.*
>
> *When we meet with my husband's doctor, he doesn't answer my questions or listen to me, and he doesn't even look at my husband. Thank you so much for listening to me.*

APPENDIX C

Importance of Pharmacy Review: Patient Story

Notes follow on a comprehensive medication review conducted by the pharmacist at MWGC where the impact was substantial and contributed to enhanced well-being for the person living with dementia and their family. A pharmacist-led comprehensive medication assessment offers significant benefits for older adults with dementia by ensuring safe, effective, and individualized medication use. Pharmacists are uniquely trained to identify potentially inappropriate medications, drug interactions, and duplications that may worsen cognitive impairment, increase fall risk, or contribute to other adverse outcomes. Through detailed chart review, caregiver interviews, and collaboration with the healthcare team, pharmacists can recommend deprescribing or optimizing regimens to align with the patient's current goals of care. This proactive approach not only enhances medication safety but also supports quality of life by reducing unnecessary medication burden and simplifying complex regimens for patients and caregivers.

The pharmacist conducted a visit with NR and her spouse. At that time, patient was noted to be on several high-risk medications, including Tylenol PM, two antiplatelets, 3 diabetes medications, and an anti-inflammatory drug. Pharmacist provided education on avoiding the use of Tylenol PM, which can cause memory loss and cognitive issues. Patient knew to avoid diphenhydramine (Benadryl) but was unaware that Tylenol PM contained diphenhydramine. Patient was also unaware of increased bleeding risk with antiplatelets and anti-inflammatory drug. She agreed to try to stop anti-inflammatory medication while pharmacist works with PCP to address these medications. Pharmacist is also working with PCP to stop one diabetes medication that causes low blood sugar and is not recommended for use in older adults