Improving Outcomes: Systemic Approaches to Dementia Detection, Diagnosis & Care

March 24, 2017
Objectives

• Discuss the rationale/case for strategic optimization of dementia management in health care systems
• Review best practices in detection, diagnosis, care and management of patients with Alzheimer’s and related dementias
• Highlight evidence- and consensus-based tools to simplify workflows
• Share systematic approaches to dementia care that have been implemented in multiple health systems
Drivers of Quality Dementia Care

- Aging Population with Increased Dementia
- Best Practice Tools Available
- Patient/Family Demand
- Increasing Cost of Inaction
- Urgent Need to Address Disparities
- Strong Minnesota Infrastructure & Innovation History
- Changing Payment & Care Delivery Models
- Emerging Research Supporting Detection, Diagnosis & Care
Aging Population with Increased Dementia

Projected number of people 65+ years old in the U.S. with Alzheimer’s disease (2010-2050)

- **65+**
  - One in nine people age 65+ has Alzheimer’s.

- **85+**
  - One-third of people age 85+ have Alzheimer’s.

Aging Population with Increased Dementia

A Population with Complex Care Needs

- 2.5 chronic conditions (average)
- 5+ medications (average)
- 3 times more likely to be hospitalized

*Indisputable correlation between chronic conditions and costs

Many admissions from preventable conditions, with higher per person costs

Urgent Need to Address Disparities

African Americans
2xs more likely than Caucasians

Hispanics/Latinos
1.5xs more likely than Caucasians

Women
2xs more likely than Men
Urgent Need to Address Disparities

Percent of Seniors Diagnosed with Condition, or Their Caregivers, Who Have Had Their Diagnosis Shared With Them

- Alzheimer's Disease: 45%
- Four Most Common Cancers*: 93%
- Cardiovascular Disease: 90%
- High Blood Pressure: 83%

*Breast, Lung, Prostate, and Colorectal

Alzheimer’s Association Facts and Figures 2014; Alzheimer’s Association HOPE for Alzheimer’s ACT Fact Sheet
Patient & Family Demand

Respondents who would prefer to know if they had AD (%)

- Blendon, et al, 2012 (n=639): 89%
- Turnbull, et al, 2003 (n=182): 92%
- Holroyd, et al, 1996 (n=124): 79.5%

“It took nearly 4 years for us to get a diagnosis. The doctor told us it was Alzheimer’s, that there was nothing he could do, and to come back in a year. We were first devastated, then angry. I also have diabetes, and I got medication, education and care management for that. Now I have a fatal brain disease, and I got ‘diagnose and adios’.

We have to do better.”

Julie,
Living with Early Alzheimer’s
Emerging Research

Aging Brain Care in the USA

- Any Cognitive Impairment: 25% - 40%
- Unrecognized cases: 60% to 80%
- Drugs with Adverse Cognitive Effects: 22% to 26%
- ER visit per year: 49% (pts) / 21% (Caregivers)
- Hospitalization per year: 26% (pts) / 11% (Caregivers)
- Length of Hospital Stay: 5.9 to 9.2 days

Emerging Research

The Collaborative Aging Brain Care Model (ABC)

ABC Package

- Caregiver Intervention
- Medical Management
- Home Environment Modification and Self Management

Delivery

- ABC Team
  - ABC Coordinator
  - Adult Day Care or Home Health
  - Local Area Agency on Aging
  - PCP
  - MCP

ABC: Aging Brain Care
PCP: Primary Care Provider
MCP: Memory Care Provider
AA: Alzheimer Association

Boustani et al, Aging & Mental Health 2011
Emerging Research

ABC Impact (Health Outcomes)

- 7 NPI point improvement
- Each 1 point decline in NPI = $250-$400 in health care expenses
- Potential saving $1,750-$2,800 per patient
- Improvement in family stress

NPI: Neuropsychiatric Inventory; CG: Caregiver

Callahan, Boustani et al, JAMA 2006
# ABC Impact (Care Quality)

<table>
<thead>
<tr>
<th>Domain</th>
<th>ABC</th>
<th>PCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>% patients with at least one ER visit</td>
<td>28%</td>
<td>49%</td>
</tr>
<tr>
<td>% patients with at least one hospitalization</td>
<td>13%</td>
<td>26%</td>
</tr>
<tr>
<td>% patients re-hospitalized within 30 days of discharge</td>
<td>11%</td>
<td>20%</td>
</tr>
<tr>
<td>% patients with HbA1c &lt; 8</td>
<td>78%</td>
<td>51%</td>
</tr>
<tr>
<td>% of patients with LDL &lt; 130</td>
<td>45%</td>
<td>23%</td>
</tr>
</tbody>
</table>

ABC; Aging Brain Care patients; PCC: primary care center patients

Boustani et al, Aging & Mental Health 2011
Emerging Research

ABC Impact (Cost)

<table>
<thead>
<tr>
<th>Total Cost Savings Per Patient</th>
<th>Low</th>
<th>Mid</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2,885</td>
<td>$3,474</td>
<td>$4,227</td>
</tr>
</tbody>
</table>

French et al, Health Affairs (In Press)
Increasing Cost of Inaction

<table>
<thead>
<tr>
<th></th>
<th>Recognition +</th>
<th>Recognition -</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Duration (Day)</td>
<td>6.7</td>
<td>7.5</td>
</tr>
<tr>
<td>30 day Post Hospital Mortality</td>
<td>4.8%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Discharged Home</td>
<td>31.5%</td>
<td>45.2%</td>
</tr>
<tr>
<td>Driving</td>
<td>11.6%</td>
<td>22.1% *</td>
</tr>
<tr>
<td>Managing Medications</td>
<td>14.9%</td>
<td>40.4% *</td>
</tr>
<tr>
<td>Managing Finances</td>
<td>7.3%</td>
<td>20.1% *</td>
</tr>
<tr>
<td>Preparing Hot meals</td>
<td>10.8%</td>
<td>34.1% *</td>
</tr>
</tbody>
</table>

* Adjusted P value < 0.05

Boustani et al, J Hospital Med 2010; Amjad H et al, JAGS 2016
Cognitive Impairment Predicts Readmissions

Mini-Cog Performance Novel Marker of Post Discharge Risk Among Patients Hospitalized for Heart Failure (Patel, 2015; Cleveland Clinic)

- **Method**: 720 patients screened with MiniCog during hospitalization for HF
- **Results**: 23% failed screen (M age 78, 49% men)
  - MiniCog **best predictor** of readmission over 6 mos. among 55 variables
    - Stronger than length of stay, cause of HF, and even comorbidity status
    - Readmission rate 2 times higher among screen fails
    - Fails discharged to facility (vs. home) had lower readmission rates within first 30 days
Changing Payment Models

FFS Existing Reimbursement Pathways:

- Medicare Annual Wellness Visit
- Diagnostic Work-Up
- Chronic Care Management
- Advance Directives
- Disease Management (G0505)
Best Practice Tools Available

- Evidence and consensus-based practice standards for providers of Alzheimer’s care

ACTonALZ.org
Best Practice Tools Available

Systematic approach:

✓ Multidisciplinary planning team, champions
✓ Workflow development
✓ EMR decision support
✓ Education
  • Provider, Patient/Family
✓ Incentives
  • Financial, Quality, Performance
✓ Measurement
Case Example: HealthPartners

Terry Barclay, PhD
Director of Neuropsychology
HealthPartners
Case Example: HealthPartners

• Minneapolis/St. Paul Minnesota
• Integrated health care system
  – Healthcare delivery
  – Health insurance plans
• Largest consumer-governed non-profit healthcare organization in the nation
  – > 1.5 million members
  – > 3000 medical providers (750 PC physicians)
  – > 50 primary care clinics, 7 hospitals
Design / Planning Phase

• Effort initiated by champions in neurology
• Meetings with key leaders in PC, neurology, geriatrics, ambulatory care, quality improvement, research institute
  – Made the case
    • No systematic approach
    • Patients not receiving diagnosis, care, support
    • Poor outcomes in neurology/hospital
    • Tools and resources available but grossly under utilized
Design / Planning Phase

• Pain points
  – What is the value of diagnosis?
  – Limited time
  – Dementia detection not a quality indicator
  – How do we handle complex issues such as:
    • Driving / safety?
    • Behaviors?
  – What is value of using detection tools?
    • Cognitive impairment is obvious
Design / Planning Phase

• Decided to pilot in 3 areas:
  – AWV: 3 primary care clinics (65+, no diagnosis)
  – Neurology (65+, no diagnosis)

• Simple approach
  – Use objective detection tool to identify who needs work-up
    • Leverage nursing/rooming staff
  – Offer options for follow-up
  – Embed ACT on Alzheimer’s tools
    • Create EMR decision support (EPIC “smart sets”)
Detection Tool Selection

- Can be administered in less than 3 minutes
- Widely available, free of charge
- Developed to assess age-related cognitive impairment
- Assesses at least memory + one other cognitive domain
- Validated in primary care
- Easily administered by non-MD medical staff
- Relatively free from educational, language and/or cultural bias
Mini-Cog

Instructions for Administration & Scoring

ID: __________ Date: ________________

**Step 1: Three Word Registration**

Look directly at person and say, “Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now.” If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies. For repeated administrations, use of an alternative word list is recommended.

- **Version 1**
  - Banana
  - Sunrise
  - Chair

- **Version 2**
  - Leader
  - Session
  - Table

- **Version 3**
  - Village
  - Kitchen
  - Baby

- **Version 4**
  - River
  - Nation
  - Finger

- **Version 5**
  - Captain
  - Garden
  - Picture

- **Version 6**
  - Daughter
  - Heaven
  - Mountain

**Step 2: Clock Drawing**

Say: “Next, I want you to draw a clock for me. First, put in all of the numbers where they go.” When that is completed, say: “Now, set the hands to 10 past 11.”

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

**Step 3: Three Word Recall**

Ask the person to recall the three words you stated in Step 1. Say: “What were the three words I asked you to remember?” Record the word list version number and the person’s answers below.

Word List Version: ___ Person’s Answers: ____________  ____________  ____________

**Scoring**

<table>
<thead>
<tr>
<th>Scoring</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Word Recall</strong></td>
<td>(0-3 points)</td>
</tr>
<tr>
<td><strong>Clock Draw</strong></td>
<td>(0 or 2 points)</td>
</tr>
<tr>
<td><strong>Total Score</strong></td>
<td>(0-5 points)</td>
</tr>
</tbody>
</table>

**Contents:**
- ✓ Delayed recall for 3 words
- ✓ Clock drawing (10 past 11)

**Scoring:**
- 0-2 = cognitive impairment
- 3 = possible impairment
- 4-5 = no impairment

**Sensitivity/Dementia:** 76%
**Specificity/Dementia:** 89%
Staff Training

• 1:1 clinic training with RNs, LPNs, APPs and MDs
  – Rationale for timely detection
  – Administration and scoring of tools
  – EMR decision support
  – What to do if patient screens positive

• Scripting
  – Introducing Mini-Cog to patients
    • New standard of care (vital sign for the brain)
    • “Check up from the neck up”
Staff Training: Video Tutorials

http://youtu.be/CRQEighdb0w
Free Online Video Tutorials

Communicating Cognitive Assessment Results - Download Template Letters: client/family and health care provider (letter format or checkbox format)

Webinar: Communicating Cognitive Assessment Results
(17:13 minutes)

Mini-Cog Administration and Scoring - Download the Mini-Cog

Demonstration Video with Patient: Mini-Cog: Colleen
(3:19 minutes)

Demonstration Video with Patient: Mini-Cog: Sam
(4:06 minutes)

Webinar: Administration and Scoring of the Mini-Cog
(15:17 minutes)
Embedded ACT Tools

**CLINICAL PROVIDER PRACTICE TOOL**

**COGNITIVE IMPAIRMENT IDENTIFICATION**

- **Annual Exam**
  - Mini Screen
  - **Normal**
    - Follow up in 1 year
  - **IF**
    - Mini-Cog < 4 or 8PODG < 9
    - Family Questionnaire > 2

- **Cognitive Assessment**
  - (norma1 cognition or new alert)
  - **Normal**
    - Follow up in 1 year
  - **IF**
    - Score falls outside of normal range
    - SLUWS = 27-30 (HS education)
    - MoCA = 26-30 (HS education)
    - K-BAT = 25-30
    - MMSE/MMS = 27-30

- **Option 1**
  - Do complete dementia workup (see provider directed)

- **Option 2**
  - Refer to: Cogstate in your practice, neurologist, neuroimaging***

*Note: a cutoff of ≤3 on the Mini-Cog has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cutoff point of ≤4 is recommended as it may indicate a need for further evaluation of cognitive status.

***Neuropsychological evaluation is typically most helpful for differential diagnosis, determining nature and severity of cognitive functioning, and the development of an appropriate treatment plan. Using it typically maximally beneficial in the following scores ranges:

- SLUWS: ≤18-27
- MoCA: ≤14-21
- K-BAT: ≤15-30
- MMSE/MMS: ≤18-26

For diverse populations see ACT website:
www.ACTonALZ.org/Screening/diverse-populations
## Orders

- **Labs** - All of the following studies should be obtained in any memory loss evaluation based on American Academy of Neurology (AAN) recommendations. Repeat labs unnecessary if prior results obtained following onset of presenting memory loss.

  - BASIC METABOLIC PANEL
    - Routine, Qty-1
  - CBC (HEMOGRAM/PLTS)
    - Routine, Qty-1
  - LIVER PANEL (HEPATIC FUNCTION PANEL)
    - Routine, Qty-1
  - B12 ONLY
    - Routine, Qty-1
  - TSH, SENSITIVE
    - Routine, Qty-1
  - RPR (SYPHILIS SCREEN)/RPR (SYPHILIS SCREEN) - the American Academy of Neurology (AAN) does not recommend routine screening for syphilis in dementia except in specific populations where the disease may be suspected
    - Routine, Qty-1

- **Imaging** - According to the American Academy of Neurology (AAN), either the Head CT or Brain MRI are considered appropriate imaging tools in evaluating memory loss. Repeat imaging unnecessary if prior head CT or brain MRI obtained following onset of presenting memory loss. Consider MRI in cases where patient has focal neurological findings, rapidly progressive dementia, atypical presentation for Alzheimer's Disease, and early onset dementia at age < 65.

  - CT HEAD WITHOUT CONTRAST
  - MR BRAIN / STEM WITH/WITHOUT CONTRAST

- **Neurology Consult** - Indication: Diagnostic Uncertainty, Early onset dementia, Atypical Dementia, Dementia Medication Management, Management of Moderate-Severe Dementia with Psychosocial Factors, or Management of Behavioral Symptoms in the Setting of Dementia

## Patient Instructions (Initial Evaluation)

- **Patient Instructions**
  - Patient Instructions for Coping with Memory Loss [edit]
# EMR Decision Support

## Consults, Referrals, Education, & Support

<table>
<thead>
<tr>
<th>Indication</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Uncertainty, Early onset dementia, Atypical Dementia, Dementia Medication Management, Management of Moderate-Severe Dementia with Psychosocial Factors, or Management of Behavioral Symptoms in the Setting of Dementia</td>
<td>0 of 1 selected</td>
</tr>
<tr>
<td>Driving</td>
<td>0 of 1 selected</td>
</tr>
<tr>
<td>Cognitive and Functional Assessment</td>
<td>0 of 1 selected</td>
</tr>
<tr>
<td>Polypharmacy Contributing to Cognitive Disorder</td>
<td>0 of 1 selected</td>
</tr>
<tr>
<td>Counseling, Education, and Support Systems</td>
<td>0 of 2 selected</td>
</tr>
<tr>
<td>Cognitive Stimulation, Rehabilitation, and Healthy Lifestyle</td>
<td>0 of 1 selected</td>
</tr>
<tr>
<td>Newly diagnosed Dementia Resulting in Difficulty Coping with Diagnosis for both patient and caregivers</td>
<td>0 of 1 selected</td>
</tr>
<tr>
<td>Behavioral Interventions</td>
<td></td>
</tr>
</tbody>
</table>

## Pharmacological Treatment

Patients with mild cognitive impairment or dementia should be followed every 1-3 months in the setting of newly initiated medications. Patients with stable symptoms and medication dosing may be followed at 6 month to 1 year intervals at which time, cognitive, behavioral, and functional status should be reassessed.

**Contraindicated Medications:**
The use of anticholinergics (e.g., diphenhydramine, oxybutynin, Tylenol PM), benzodiazepines (e.g., lorazepam, alprazolam, zolpidem), mood stabilizers (e.g., valproic acid), and narcotics (e.g., oxycontin, methadone, morphine) should be avoided in dementia.

## Pharmacological Treatment Orders

<table>
<thead>
<tr>
<th>Indication</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild-Moderate Alzheimer’s Disease</td>
<td>0 of 5 selected</td>
</tr>
<tr>
<td>Moderate-Severe Alzheimer’s Disease</td>
<td>0 of 1 selected</td>
</tr>
<tr>
<td>Depression/Anxiety</td>
<td>0 of 3 selected</td>
</tr>
<tr>
<td>Insomnia</td>
<td>0 of 1 selected</td>
</tr>
<tr>
<td>Agitation</td>
<td>0 of 3 selected</td>
</tr>
<tr>
<td>Stroke prevention in vascular dementia</td>
<td>0 of 1 selected</td>
</tr>
</tbody>
</table>
Workflow

• AWV
  – Mini-Cog one of many standardized tools
• Neurology
  – Rooming nurse conducts Mini-Cog during vital signs
• Name of tool and score entered into EMR
• Provider discusses test result and next steps
  – If screen positive, orders placed for work-up at subsequent visit (e.g., labs, imaging)
  – Work-up in primary care or neurology
Results

• N = 1,124  (459 PC, 665 neurology)
• Average age 77  (75 PC, 78 neurology)
• Male 42%  (41% PC, 42% neurology)
• Mini-Cog score <3 = 17%
  – PC / AWV = 13%
  – Neurology = 19%
• Follow-up after screen failure
  – 28.15% took one or more actions toward work-up
Results

• In 18 months leading up to detection visit, unrecognized cognitive impairment associated with significantly more:
  – Ambulatory visits
  – ER visits
  – Hospitalizations
  – Phone encounters
  – Cancelled appointments
Lessons Learned

• Mini-Cog well tolerated/accepted by patients
  – Positive feedback re: comprehensive care
• Mini-Cog easy to administer
  – Clock drawing requires specific training to score reliably
• Rapid assessment did not disrupt RN/provider workflow
Lessons Learned

• EMR tools easy to use (creates unified standards of care)
• Assessment works
  – Quickly identifies those with cognitive impairment who need a work-up
  – Increases capture rate of dementia dx
• Some providers did not trust Mini-Cog scores
  – Need to emphasize common disconnect between subjective impressions and objective data on validated, reliable tool
Mini-Cog Improves Provider Recognition

**CDR Stage**

- 0.5 MCI
- 1 Mild
- 2 Mod
- 3 Sev

**% Correct**

- Mini-Cog
- Patient’s own physician

*** p < .001

Lessons Learned

• Universal challenge to increase percentage of patients who receive work-up
  – Need more scripting to ensure next steps strongly encouraged (show PCP believes in value, degree of urgency) and presented as standard of care

• Systematic approach feasible
  – Working to identify best approach to roll out more broadly across the system
Case Example: Allina Health

Ellie Madison, MHA
Program and Operations Manager, Neuroscience Clinical Service Line
A Glance at Dementia in Allina Health

Over 500,000 unique patients were seen at Allina Health primary care clinics in the last year
- 130,000 were patients over the age of 65
- 9.5% of patients over the age of 65 have some form of a dementia diagnosis
- Incidence increases dramatically with age

Source: EDW – Face to Face Encounters
Allina Patients – At least 2 encounters in past 2 years; 1 encounter in past year
Dementia Diagnosis = ICD codes 331.XX and 294.1X and 290.XX and 797.XX and 780.93
# Annual Wellness Visits (AWVs)* at Allina Health: 2011 - 2014

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Number of AWVs</th>
<th>Allina's Medicare Eligible Population</th>
<th>Eligible Pts who had AWV (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td></td>
<td>63,448</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>15,720</td>
<td>70,884</td>
<td>22.2%</td>
</tr>
<tr>
<td>2012</td>
<td>22,726</td>
<td>76,966</td>
<td>29.5%</td>
</tr>
<tr>
<td>2013</td>
<td>26,115</td>
<td>84,656</td>
<td>30.9%</td>
</tr>
<tr>
<td>2014</td>
<td>28,912</td>
<td>92,905</td>
<td>31.1%</td>
</tr>
</tbody>
</table>

*Data shown for Allina Health Clinic patients, age 65+, eligible for a Medicare AWV for at least 6 months in calendar year.
Dementia Services Continuum of Care: Current State

Digital/TeleHealth
- E-consults
  - Geriatric psychiatry, primarily with SeniorCare Transitions

Primary Care
- Allina SeniorCare Transitions Assisted Living Program
- Medicare Wellness Programs
  - Screening (mini-cog, functional assessment)

Community-Based Care and Partnerships
Wellness
- Aging Well Program, Penny George Institute for Health and Healing

Allina Health Group Clinics and Independent Partners
- Geriatric psychiatry, United
- Courage Kenny Rehabilitation Institute
  - Physical Medicine & Rehabilitation outpatient clinics — multiple sites
- Neuro-psychology, Courage Kenny Rehabilitation Institute
- Various independent neurology partners
- Allina Health Laboratories and Pathology Services

Community Partnerships and Resources
- Act on Alzheimer’s
- Isanti County dementia grant
  - Allina Health Clinic — Cambridge
- LifeCourse:
  - Late stage dementia care
  - Care guides
  - Screening (mini-cog, functional assessment)

Home/Self

Emergency Department

Hospital
- Geriatric Psychiatry Program — United, Unity, Regina
- Acute Care for the Elderly unit, Unity
- Inpatient neuro-psychology consults, Abbott Northwestern and United
- Grace Unit, Regina
  - Senior Behavioral Health

Post-Acute Care
Outpatient Courage Kenny Rehabilitation Institute Services
- Neuro-psychology evaluations
- Rehabilitation evaluation and treatment
- Driver assessment and training services
- Physical therapy, occupational therapy, speech therapy

Inpatient Rehab
- United, Abbott Northwestern

Skilled Nursing
- SeniorCare Transitions Transitional Care Units

Home Care
- Allina Health Home Health

Palliative Care
- Palliative consults

Hospice
- Interdisciplinary team-based Dementia Champion Training Program

February 2016

ACUITY
Dementia Consensus Conference - Feb. 2016
Conference Outcomes: Current State (Jan, 2016)

- Patients who have dementia or other cognitive disorders are under diagnosed
- The existing care plans for patients and caregivers are segmented and incomplete
- There is a stigma around dementia that may yield denial, noncompliance, and/or a lack of understanding in both patients and caregivers
- Patients and caregivers do not have a clear understanding of who to turn to for what issues
- Allina Health has silos which yields gaps in the care pathways for patients and caregivers
Conference Outcomes: Future State

- Standardize screening and documentation processes
- Implement diagnostic and medical management best practices
- Improve communications between providers and patients
- Enhance diagnostic and post-diagnostic provider visits
- Improve patient educational materials
- Implement EMR tools to facilitate changes in care model
- Simplify connections to community resources
- Develop business case for care coordination resources
Allina Health’s Cognition and Memory Program (CAMP) Committee
Cognition and Memory Program Committee

Committee Members
- Dr. Richard Golden, Medical Director of CAMP
- Neuroscience Service Line leaders
- Committee members:
  - Primary care, neurology, neuropsychology, neurosurgery, neuropathology, mental health, rehab, senior care transitions, home care, social work, geriatrics, geri-psychiatry, voice of the caregiver, research, data analyst

Clinical Responsibilities
- Develop evidence-based clinical standards and guidelines
- Measure quality performance
- Enable and guide process improvement
- Evaluate performance
- Facilitate communication across the system

Operations Responsibilities
- Coordinate services from across the system
- Develop relationships with community organizations and partners
- Pilot standard processes
- Implement medical and diagnostic best practices
- Market clinical capabilities, brand promise and value proposition to community
Cognition and Memory Program: Vision for the Future

Establish an infrastructure for consistent, best-practice clinical approaches for screening, diagnosis and management of dementia

Define care pathways for patients, with primary care as the hub

Ensure that patients and their care circle feel connected and supported after diagnosis

Engage patients and their care circle with clinicians in a cohesive health care team
CAMP Work Groups

• Dementia Work Group
  – Develop a dementia algorithm for screening, detection, diagnosis and management of dementia for primary care physicians, including a referral guide, based on ACT on Alzheimer’s Clinical Practice Tools
  – Develop pilot and implementation plan for dementia algorithm, referral guide and EMR tools

• Delirium Work Group
  – Develop evidenced based guideline for prevention, screening and detection, diagnosis and management of delirium in the inpatient setting
Dementia Algorithm for Primary Care

ACT on Alzheimer’s Clinical Provider Practice Tool

CAMP’s Dementia Care Algorithm

DRAFT 2/16/2017
Minnesota Board on Aging: Isanti County Dementia Grant
January 2016 – June 2017
Cambridge, MN
One of MN’s Dementia-Friendly Communities
Goals of the MN Board on Aging Grant

• Educate local businesses, community members, and health professionals regarding dementia
• Improve the diagnosis and follow through process for individuals with dementia and their caregivers
• Offer seniors health screenings and evidence-based programming to help manage chronic disease
• Facilitate social connectedness for elderly people in Isanti County
ACT on Alzheimer’s: EMR Decision Support Tools

We adapted the guidelines to fit Allina Health’s EMR and work flows with the help of our physician champions.
LifeCourse Care Guides
LifeCourse: Key Components

- Whole Person Care
- Care Guide
- Family-Oriented Approach
- What Matters Most
## Research Outcomes

<table>
<thead>
<tr>
<th>Measure</th>
<th>Early Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PATIENT &amp; FAMILY OUTCOMES</strong></td>
<td></td>
</tr>
<tr>
<td>Quality of Life</td>
<td>+</td>
</tr>
<tr>
<td>Experience</td>
<td>+</td>
</tr>
<tr>
<td><strong>SYSTEM OUTCOMES</strong></td>
<td></td>
</tr>
<tr>
<td>Palliative Care Utilization</td>
<td>↑</td>
</tr>
<tr>
<td>ED Visits</td>
<td>↓</td>
</tr>
<tr>
<td>Inpatient Days</td>
<td>↓</td>
</tr>
<tr>
<td>Advance Directives</td>
<td>↑</td>
</tr>
<tr>
<td>Hospice Enrollment</td>
<td>↑</td>
</tr>
</tbody>
</table>
LifeCourse Spread – 2016

Primary Care Clinics

Specialty Clinics

Community
CAMP 2017 Goals

- Finalize dementia care model for screening, detection, diagnosis and management of dementia in primary care
- Finalize referral guide for primary care providers to refer to other clinicians and community resources
- Develop implementation plan for EMR Tools, dementia care model and provider education
- Continue to make connections with dementia friendly communities where Allina Health has clinics
- Design pilot for dementia-trained care guides
Discussion