**DEMENTIA MODELS of CARE LOGIC MODEL SAMPLE**

**AIM: Improve the provision of culturally competent care, services, and outcomes for American Indian and Alaska Native people living with dementia and their caregivers**

**5 Primary Drivers: 1.)** Increase **Awareness and Recognition** of dementia; 2.) Make an **Accurate and Timely Diagnosis**; 3.) Provide an **Interdisciplinary Assessment** to identify need for services and an appropriate plan of care for people living with dementia and their caregivers; 4.) Provide comprehensive, person-centered **Management and Referral** to meet needs; and 5.) **Support Caregivers**.

1. Increase **Awareness and Recognition** of dementia

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| **PRIMARY DRIVER**  **What will be necessary to meet our aim?** | **SECONDARY DRIVERS - *EXAMPLES***  ***What are the steps or components necessary for this driver?*** | **STRATEGIES - *EXAMPLES***  ***Some examples of specific strategies related to this driver.*** |
|  | Select and implement an early detection strategy | Use a standard screening tools (e.g. Mini-Cog) |
| Increase **Awareness** | Identify the triggers for screening in various settings |
| **and Recognition** of | Train in screening in various clinical settings (for example: oral |
| Dementia | health, pharmacy, Public Health and Community Health Nursing,  Community Health Representatives) |
| Example Measures:   * Rates of | Create opportunities for detection of  cognitive impairment | Use a Well Elder Visit or the Medicare Annual Wellness Visit as an  opportunity to assess for cognitive impairment |
| dementia   * # of referrals |  | Assess for cognitive impairment and delirium in the Emergency  Department and make referral to PCP |
| from community | Educate in the 10 warning signs for | Train front-line staff in warning signs and care pathways |
| for assessment   * # of staff or | dementia | Adapt the warning signs for dementia and other dementia  education materials to the Tribe’s culture and language |
| Tribal orgs |  | Use Community or Tribal meetings, Health Fairs, or social media for |
| trained in early |  | education opportunities |
| detection | Coordinate with community-based | Collaborate with senior center / elder services |
|  | organizations touching the elderly | Financial institutions, local grocers and shops |
|  |  | Law enforcement |
| Post Office and Tribal buildings |

For 2023 applicants, the evaluation plan should, at a minimum, include performance measures about the number of persons newly diagnosed with dementia, the number of persons living with a pre-existing dementia diagnosis, screening measures, and case-finding efforts among their patient population.

1. Make an **Accurate and Timely Diagnosis**

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|  | Increase confidence and capacity for | Develop local dementia expertise in primary care |
| Make an **Accurate** | evaluation in primary care | Participate in case-based learning opportunities on dementia such |
| **and Timely** |  | as Project ECHO |
| **Diagnosis** |  | Train providers in standardized approach to evaluation and diagnosis |
| Example | Standardize the approach to | Develop a standard diagnostic approach to cognitive impairment, |
| Measures:   * # of new and   existing  diagnosed cases of dementia   * % staff trained * Time to completed consultation * Self-reported confidence of | evaluation and diagnosis of dementia | adapted as needed for individual patients |
| Use EHR Templates for evaluation of cognitive impairment |
| Use the Medicare Cognitive Assessment and Planning Codes for diagnosis, assessment and care planning |
| Establish referral resources for difficult diagnoses or complex cases | Establish relationships with Alzheimer’s Disease Research Centers  (ADRCs) in the region |
| Develop telehealth resources for consultation |
| Identify referral pathways for geriatric, geropsychiatric, or neurology consultation |
| Establish resources for neuropsychiatric testing and evaluation |
| Participate in case-based Project ECHO Sessions |

1. Provide an **Interdisciplinary Assessment** to identify need for services and an appropriate plan of care, for individuals living with dementia and their caregivers

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| Provide an  **Interdisciplinary**  **Assessment** to  identify need for  services and an  appropriate plan of  care, for individuals  living with  dementia and their  caregivers  Example Measures:   * % Assessment completed * % Care Plan   completed   * Needs   identified   * Medication   changes | Develop a standard approach | Develop a standard approach to assessment that includes: Comprehensive |
| to interdisciplinary  assessment of persons with  cognitive impairment | patient history and exam, functional assessment, staging of dementia |
| using standard instruments, medication review, hearing loss, assessment for |
| depression, anxiety, and challenging behaviors, safety assessment, and an |
| assessment of social supports and caregiving resources |
| Address Advance Care Planning based on the individuals values and |
| preferences |
| Develop a plan of care in collaboration with the patient and caregivers |
| Use the Medicare Cognitive Assessment and Care Plan Services Code (CPT  99483) to support assessment and care planning |
| Create EHR templates to support the process |
| Develop an Interdisciplinary Team for assessment and planning | Identify the members of an Interdisciplinary Team |
| Provide training to build capacity in the Team |
| Create workflows and EHR supports for Team process |
| Develop opportunities (huddles or team meetings) for Team process |
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1. Provide comprehensive, person-centered **Management and Referral** to meet needs

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| Provide  comprehensive,  person-centered  **Management and**  **Referral** to meet  needs  Example Measures:   * Care   management  hours provided   * Completed   referrals   * % of persons with   dementia with  current care plan   * Agreement with   statement: “my  needs are being  met” | Care Management and | Identify and train Dementia Care Specialists (providing specialty dementia |
| navigation for persons living | care management) |
| with dementia | Use integrated care management and navigation services (non-specialty care management integrated into primary care) |
| Develop and test telehealth and telebehavioral health services for ongoing care management |
| Formalize referral | Use a standardized referral for Tribal and Community-Based Services |
| relationships with Tribal and  Community-based | Ensure a closed loop on referrals for Tribal and Community-Based  Services |
| organizations | Develop or engage in a Tribal or community-wide process to identify  and meet gaps in available services for those living with dementia and |
|  | their caregivers |
| Perform regular review and revision of the Care Plan | Ensure regular follow-up, periodic care plan review and revision as needed, and annual evaluations |

1. **Support Caregivers**

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| **Support Caregivers**  Example Measures   * Hours of respite provided * Hours of coaching provided * Placement   outside the home   * Confidence of Caregivers * Caregiver stress | Identify caregivers and | Identify caregivers in the chart of the individual with dementia and |
| assess needs | identify the role of caregiving in the caregiver chart |
| Incorporate a caregiver needs assessment into the care of the individual living with dementia; consider assessments for depression, stress, etc. |
| Provide caregiver coaching | Develop evidence-based caregiver coaching that address problem-solving for challenging behavior, care navigation, and self-care for caregivers |
| Collaborate in the development of respite care | Collaborate with Tribal Programs or Community-Based Services in the development and allocation of respite care services |
| Identify and implement other caregiver systems and supports | Develop or partner with to offer caregiver support groups |
| Establish referral mechanisms to connect caregivers with paid and unpaid services within the Tribal health system and to community programs |