Transforming Dementia Care at Essentia

Stephen C. Waring, DVM, PhD, FACE
Senior Research Scientist
Essentia Institute of Rural Health
Gaps, Challenges, Needs

• Problem: Urgent need to standardize dementia diagnosis and management
  • enhance earlier detection of cognitive issues
  • better manage dementia and comorbid conditions
  • reduce burden, improve quality of life for patients, caregivers
  • measurable outcomes that align with expectations
  • sustainable
Gaps, Challenges, Needs

• Critical issues
  – need for standardized/centralized care
  – improved access to clinical and community support
  – Improved communications among all stakeholders
  – delivery of services on a timely basis

• Overcome barriers to making a diagnosis of dementia
  – value of diagnosis given limited treatment options
  – risk of misdiagnosis
  – lack of knowledge of support services
Gaps, Challenges, Needs

• Solution:
  - Integrate dementia care and management into Primary Care facilitated by decision support tool
  - Cognitive screening (MiniCog) within Annual Wellness Visit
  - Leverage Essentia’s commitment to accountable care that takes advantage of collaborations with community-based health care groups and Patient Advisory Councils
Patient Perspective

- Essentia Health Family Practice Patient Advisory Group:
  - Patient expectations of Essentia:
    - diagnosis dementia
    - determine if due to Alzheimer’s, non-AD dementia, etc
    - guidance on what to expect/planning
    - facilitate referrals for support
Essentia Memory Workgroup

- Advisory workgroup formed under leadership of Primary Care
  - Key stakeholders
    - primary care
      - providers, nurses, staff
    - specialty care
      - neurology, neuropsychology
    - community partners
      - Alzheimer’s Association, Arrowhead Area Agency on Aging, Northwood Partners, Family Memory Care Consultants, AgeWell
  - IS/IT/Informatics
  - Patient advisory group
Diagnostic Workup and Referral

**DIAGNOSIS**

- **MOCA**
  - MOCA Visit with PCP
  - Diagnostic workup
    - Labs
    - Imaging
    - Neuropsychology
    - Others as indicated
  - Diagnosis established
  - Care plan developed

**TREATMENT/MANAGEMENT**

- Diagnosis specific meds
- Referral to community support
  - Alzheimer’s Association
  - Senior Linkage Line®
- Maintain communication among all stakeholders (Patient/family caregiver, PCP, Care Coordination Team, Community support, Others)
Pilot Project

- Two sites: Essentia Health – Ely, Essentia Health – West Duluth
- Funding from MN DHS Grant
- Integration, implementation, evaluation
  - Early detection of dementia
    - Screening with Mini-Cog
      - incorporated into Annual Wellness Visits and other exams
    - Assessment (diagnostic work-up)
      - for individuals who fail screening or present outside of AWV
  - Care Coordination
    - Timely referrals
    - Dementia-relevant disease management plans that include input from community partners
Workflow Process Map

1. Patient identified by Health Care Coordinator at AHW or reg PC visit as suspected memory concerns

2. A referral for MOCA testing is ordered for patient by PCP

3. Patient comes in for MOCA

4. RN administers MOCA

5. RN scores MOCA with patient or advocate. May review with them or tell them provider will review with them. Provides list of patient instructions for brain health.

7A. Dementia diagnosis?

8. Diagnostic Specialist visit

11. Tell patient to see PCP in 3 weeks.

12. Patient makes 3 week appointment

10. Team Care RN Coordinator PCP Specialist

7B. FU as usual. Annual MinCog screening. END

7C. Further evaluation as needed (lab, imaging, referral).

Either PCP or Specialist gives order

8. Diagnostic Specialist visit

9. Dementia diagnosis?

13A. Refer to Community Services or additional services as needed. Use Epic letter “Community Partners Dementia Referral Form” Either PCP or Specialist gives order

Note A: RN bills AHW using appropriate code (regardless if MD visit follows on the same day)

Note B: If MD sees patient on the same day as AHW, MD must bill appropriate E&M + modifier

Note C: RN uses 96211 for MOCA unless patient sees MD same day. RN does not bill for time (including grant)

Note D: MD bills appropriate E/M code to include MOCA time if order same day appointment with RN

Essentia Health
Here with you
Workflow Process Map
Workflow Process Map

21. On-going Process and Evaluation

From Box 19 on Page 2

20 Incorporates feedback sent from Community Partner into Plan of Care

Essentia Health
Here with you
Referral to Community Partners

- Referral letter generated from within the EHR and sent by secure fax
- Allows community partners to communicate about patient care without requesting additional permission from patient/family
Program Evaluation: Results

- RN Effort: 1 day per week
- Most were at AWV
- 66 received new diagnosis (34%)
- Time to diagnosis: 14 days
- MOCA by RN followed by provider visit
- Referrals: Offered, not always accepted

Report by Wilder Research, 2016
Program Evaluation: Patient Perspectives

Family 1 – Caregiver of spouse with Alzheimer’s after delayed contact thinking they had no need for support:

You can feel all alone in your situation, and then you find out that you are not. People talk about their experiences and how they have dealt with them, which is helpful.

Family 2 – Caregiver of sibling with dementia after concerns about isolation:

I am grateful for the support we have received from the community support and the Essentia care coordinator. It has been essential to my well-being as a caregiver.
Program Evaluation: Conclusions

- Developed and implemented work flow protocols to guide work with adults aged 65 and older
- Successfully integrated new dementia protocols in clinics in West Duluth and Ely
- Screened older adults during routine wellness visits
- Completed additional diagnostic testing in a timely manner
- Engaged patients and families in care coordination efforts
- Referred patients to community partners for additional services and supports
Ongoing Evaluation Progress

- In addition to pilot sites, increased dementia screening by incorporating MiniCog into the Annual Wellness Visit (AWV) across Essentia
  - >13,000 completed from 1/1/2014 to 12/31/2015
  - 24% failure on Mini-Cog, consistent with other studies
- Increased provider buy-in due to decision support on next steps for screening failures, feedback, continued outreach
- Improved communications from community partners with provider/care team, services provided incorporated into care management plan
- Lessons learned informing further implementation across Essentia
Acknowledgements
Essentia Memory Workgroup

Essentia Health:

Neurology/Neuropsychology: Mike Sharland PhD, Gwen Cressman, Alyssa Eidson PhD, Sara McCumber CNP

Elder Care/Memory Clinic: Mark Boyce MD, Margaret Holberg CNP

Family Practice: Joe Bianco MD, Jane Rudd MD, Laurie Hall, Sandrea Kari RN, Paula Schultz RN, Julie Neuman RN, Nancy Dettle, Maribeth Horak RN

Information Services: Lisa Wilkinson

EIRH: Allise Taran, Jeanette Palcher, Paul Hitz

Process Excellence: Nancy Tario

Community Partners:

Alzheimer’s Association: Jenna Herbig, Deborah Richman

Arrowhead Area Agency on Aging: Cindy Conkins, Marjori Bottila

Family Memory Care Consultants: Kristine Dwyer

Northwoods Partners: Lisa Portham

Age Well Arrowhead: Marianne Bovee