Members Present

Richard Furlong,* MD, Virginia Mason Medical Center
Barak Gaster, MD, UW Medicine
Kelly Green, LCISW, Evergreen Health
Debbie Hunter,* Family Caregiver
Nancy Isenberg,* MD, MPH, FAAN, Virginia Mason Medical Center
Arlene Johnson,* Family Caregiver
Kerry Jurges,* MD, Confluence Health

Myriam Marquez,* Patient Advocate
Shirley Newell, MD, Aegis Living
Darrell Owens,* DNP, ARNP, UW Medicine NW
Kristoffer Rhoads, PhD (Chair), UW Medicine - Harborview
Tatiana Sadak,* PhD, ARNP, UW Medicine School of Nursing
Bruce Smith,* MD, Regence Blue Shield

* By phone/web conference

Staff/Guests

Diane Hickey, RN, Venteclife
Lynne Korte,* MPH, Department of Social and Health Services

Ginny Weir, MPH, Bree Collaborative
Emily Wittenhagen, Bree Collaborative

WELCOME AND INTRODUCTIONS
Kristoffer Rhoads, PhD, UW Medicine - Harborview reviewed the meeting schedule of the Dementia Action Collaborative. All those present introduced themselves.

Action Item: Approve 1/11/17 Minutes
Outcome: Passed with unanimous support

REVIEW SCOPE OF WORK AND REPORT FRAMEWORK
Ginny Weir, Program Director, Bree Collaborative reviewed the workgroup’s charter as presented and approved by the Bree Collaborative at their January meeting. The workgroup discussed:
- Advance care planning not advanced care planning.
- That supportive care and palliative care are synonymous and the goal of involving palliative care as early as possible.
  - Hospice care is a subset of palliative care and is appropriate for around 30% of patients.
- The group agreed that first focusing on case-finding or identification is important.

Action Items:
- Ms. Weir to reach out to Lynne Korte, MPH, Department of Social and Health Services to meet with the Dementia Action Collaborative.
- Ms. Weir to make changes to the charter.

DIAGNOSIS CLINICAL PATHWAYS AND TOOLS
Ms. Weir reviewed the first focus area on identification of cognitive impairment. The group discussed:
- Issues with screening a whole population (e.g., all those over 65) as part of a Medicare wellness visit.
Most clinicians who do screen are most likely using the mini-cog. The Montreal Cognitive Assessment (MoCA) is a more accurate tool, but takes longer (~14 minutes) and less pragmatic.

Opportunity to identify and target people with known risk factors.

Screening all adults over 65 is most likely the future state.

Universal screening will fall flat unless there is a referral pathway post positive screen. The United States US Preventive Services Task Force review of cognitive screening in older adults found insufficient evidence to support this as a population-level screen. However, robust studies have emerged since the 2014 review.

- Screening for risk of delirium post-surgery prior to the surgery.
- Biggest barrier is lack of early detection.
- The need to be able to have the recommendations speak to every primary care doctor in the state.
- We should focus on building the infrastructure to support providers, patients, and family members after a positive screening.
  - Many suburban and rural areas do not have access to specialty care.
- Our group will identify areas of most need – when cognitive impairment has been identified, how should the system move forward.
- Cognitive functioning assessment by direct observation is a required element of CMS for annual wellness visits, but is not universally implemented.
- The FINGER study – a multimodal intervention with positive cognitive stimulation, including nutrition counselling and cardiovascular fitness: A 2 year multidomain intervention of diet, exercise, cognitive training, and vascular risk monitoring versus control to prevent cognitive decline in at-risk elderly people (FINGER): a randomised controlled trial
- Multimodal interventions with nutrition counselling and cardiovascular fitness are proven to be effective.
- The MIND (Mediterranean-DASH Intervention for Neurodegenerative Delay) shows a 47% reduction in dementia risk over 5 years in subjects ages 50-80: MIND Diet Associated with Reduced Incidence of Alzheimer’s Disease
- There was a suggestion to narrow the number of recommendations in order to increase adoption possibility.
- Ms. Weir shared the framework put together by the Behavioral Health Integration group as a potential model.
- The importance of keeping evidence-based best practices in mind even when they may not be applicable.
- Ms. Weir also shared the framework put together by the Alzheimer’s Association, a universal approach to screening.
- Where recommendations for more screening for could be taken advantage of for early detection and diagnosis.
- More end-of-life conversations and cognitive screenings are being done now and could set a good precedent.
- The use of Medical Assistants available to perform cognitive screenings.
- Currently a large number of patients in the state, about 88%, aren’t getting annual wellness visits. One issue, in rural healthcare at least, is that patients who’ve traveled far for a visit find the screenings low priority in comparison to the other concerns they want addressed.
- Caution for the burden of trying to universally screen the entire population, including healthy people.
Concern for leaning too heavily on wellness visits as the main venue for screenings, and the idea of parsing it out amongst a team the way advance care planning is done with a facilitator and a separately billable code. So far, cognitive screening doesn’t have a separate billable code.

The idea of performing cognitive screening along with measuring diabetes as they are comorbidities, and considering intersections with other conditions.

The different tools a provider can use when a patient is worried about their memory:

- The MOCA test – most likely the go-to/most recommended test, although the instructions can be bulky and confusing.
- The Skinny/Mini MOCA – developed by Virginia Mason, still in review at the moment.
- GP Cog
- Mini Cog
- MIS

Developing a consistent care pathway with tools above and next steps for providers to utilize.

Considering what tools can be used by allied health and other alternative providers.

Other resources in development for PCPs:

- Position paper Dr. Rhoads is writing.
- The Caregiver Roadmap.
- Dementia Safety Kit – written for families and caregivers to maintain safety; focused on falls prevention, driving, wandering, emergency preparedness, etc.

There is a lot of interest from families and caregivers for tools they can use.

Leveraging ACHs and community care centers for implementation and awareness building and other improvements such as reducing preventable admissions.

There is a real need for the medical community to be at the table in this ongoing discussion – a gap that the Bree will be aiming to fill and address.

The importance of changing the conversation toward the conceptual framework and language used to speak to Alzheimer’s and dementia and moving it to incorporate scientifically validated “Constituents of Wellbeing,” resilience, positive regard, and generosity, etc, to intentionally shift the mindset toward hope – effectively bringing dementia out of the shadows.

**Action Items:**

- Tatiana will send a manuscript about dementia care guidelines.
- Ginny to disseminate:
  - The article: Alzheimer’s Association recommendations for operationalizing the detection of cognitive impairment during the Medicare Annual Wellness Visit in a primary care setting.
  - The Finnish Geriatric Intervention Study to Prevent Cognitive Impairment and Disability (FINGER) article: A 2 year multidomain intervention of diet, exercise, cognitive training, and vascular risk monitoring versus control to prevent cognitive decline in at-risk elderly people (FINGER): a randomised controlled trial (2015)
  - The MIND (Mediterranean-DASH Intervention for Neurodegenerative Delay): MIND Diet Associated with Reduced Incidence of Alzheimer’s Disease
  - The draft Behavioral Health Integration recommendations as a framework for the roadmap to implementation that this workgroup can develop.

**GOOD OF THE ORDER/OPPORTUNITY FOR PUBLIC COMMENT**

Ms. Weir thanked all for attending and asked for public comments and final comments. The meeting was adjourned.