

Logic Model (Driver Diagram) Example for **Addressing Dementia in Indian Country: Models of Care**

How to use this Logic Model / Driver Diagram:

1. The Driver Diagram is an action-oriented logic model that begins with an understanding of the Aim (i.e. goals) and identifies the Drivers (i.e., primary and secondary drivers) necessary to achieve that aim. The Strategies suggest the activities that will accomplish those Drivers.
2. We use measures linked to the Driver Diagram to help understand whether we are achieving our Aim in the work. We need measures that define the Aim and measures for each of the Primary Drivers (i.e., big ideas or areas of work) that tell us if we are making progress toward the Aim.
3. The Primary Drivers are outlined in the Notice of Funding Opportunities (NOFO) and Program Award Application. The Secondary Drivers and Strategies in this Logic Model are provided as examples. Each applicant will determine the Secondary Drivers (i.e., identify specifically what influences the Primary Drivers and how change ideas relate to the drivers) and Strategies that they believe will help them achieve their Aim. This process starts with questions: What can we do to increase Awareness and Recognition of Dementia? What can we do that will increase the likelihood of an Accurate and Timely Diagnosis? The answers to those questions are the Secondary Drivers. How they will do that work make up the Strategies.
4. The logic model provides an opportunity to envision a comprehensive approach to addressing dementia. The NOFO and Program Award Application asks that the Applicants provide a comprehensive approach to care and services for persons living with dementia and their caregivers and identify funding streams that will support service delivery. This is an example of how such an approach might be organized. The response to the NOFO should indicate the work to be undertaken in the two years of the project period; that work should be reflected in one or more of the Strategies of the Applicant's Driver Diagram / Logic Model.

AIM: Improve care, services, and outcomes for American Indians and Alaska Natives living with dementia and their caregivers

As Measured by: (How will this be measured? How will we know that changes are an improvement

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 individuals living with dementia and their caregivers.
4. Provide comprehensive, person-centered **Management and Referral** to meet needs
5. **Support Caregivers**

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

PRIMARY DRIVER What will be necessary to meet our aim?	SECONDARY DRIVERS <i>What are the steps or components necessary for this driver?</i>	STRATEGIES <i>Some examples of specific strategies related to this driver.</i>
Increase Awareness and Recognition of Dementia Example Measures: <ul style="list-style-type: none"> • Rates of dementia • # of referrals from community for assessment. • # of staff or Tribal orgs trained in early detection. 	Implement an Early Detection Strategy	Use a standard screening tools (e.g. Mini-Cog)
		Identify the triggers for screening in various settings.
		Train in screening in various clinical settings (for example: oral health, pharmacy, Public Health and Community Health Nursing, Community Health Representatives)
	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.
		Assess for cognitive impairment and delirium in the Emergency Department
	Educate in the Warning Signs for Dementia	Train front-line staff in warning signs and care pathways.
		Adapt the Warning Signs for Dementia and other dementia education materials to the Tribe's culture and language.
		Use Community or Tribal meetings, Health Fairs, and social media for education opportunities.
	Coordinate with community-based organizations touching the elderly	Senior Center / Elderly Services
		Financial institutions, local grocers and shops
		Law enforcement
		Post Office and Tribal Buildings

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

PRIMARY DRIVER What will be necessary to meet our aim?	SECONDARY DRIVERS <i>What are the steps or components necessary for this driver?</i>	STRATEGIES <i>Some examples of specific strategies related to this driver.</i>
<p>Make an Accurate and Timely Diagnosis</p> <p>Example Measures:</p> <ul style="list-style-type: none"> • Rates of dementia • % staff trained • Time to completed consultation • Self-reported confidence of Providers in assessing cognitive impairment. 	<p>Increase confidence and capacity for evaluation in primary care</p>	<p>Develop local dementia expertise in primary care</p> <p>Participate in case-based learning opportunities on dementia such as Project ECHO.</p> <p>Train providers in standardized approach to evaluation and diagnosis.</p>
	<p>Standardize the approach to evaluation and diagnosis of dementia.</p>	<p>Develop a standard diagnostic approach to cognitive impairment, adapted as needed for individual patients.</p> <p>Use EHR Templates for evaluation of cognitive impairment.</p> <p>Use the Medicare Cognitive Assessment and Planning Codes for diagnosis, assessment and care planning.</p>
	<p>Establish referral resources for difficult diagnoses</p>	<p>Establish relationships with Alzheimer’s Disease Research Centers (ADRCs) in the region.</p> <p>Develop telehealth resources for consultation.</p> <p>Identify referral pathways for geriatric, geropsychiatric, and neurology consultation.</p> <p>Establish resources for neuropsychiatric testing and evaluation.</p> <p>Participate in case-based Project ECHO Sessions</p>

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

PRIMARY DRIVER What will be necessary to meet our aim?	SECONDARY DRIVERS What are the steps or components necessary for this driver?	STRATEGIES Some examples of specific strategies related to this driver.
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: <ul style="list-style-type: none"> • % Assessment completed • % Care Plan completed • Needs identified • Medication changes 	Develop a standard approach to interdisciplinary assessment of persons with cognitive impairment.	Develop a standard approach to assessment that includes: Comprehensive patient history and exam, functional assessment, staging of dementia using standard instruments, medication review, 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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4. Provide comprehensive, person-centered **Management and Referral** to meet needs

PRIMARY DRIVER What will be necessary to meet our aim?	SECONDARY DRIVERS <i>What are the steps or components necessary for this driver?</i>	STRATEGIES <i>Some examples of specific strategies related to this driver.</i>
Provide comprehensive, person-centered Management and Referral to meet needs. Example Measures: <ul style="list-style-type: none"> • 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 navigation for persons living with dementia	Identify and train Dementia Care Specialists (providing specialty dementia care management). Use integrated care management and navigation services (non-specialty care management integrated into primary care).
	Formalize referral relationships with Tribal and Community-based organizations	Use a standardized referral for Tribal and Community-Based Services Ensure a closed loop on referrals for Tribal and Community-Based Services 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 and periodic care plan review and revision as needed.

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5. Support Caregivers

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Support Caregivers. Example Measures <ul style="list-style-type: none"> • Hours of respite provided • Hours of coaching provided • Placement outside the home • Confidence of Caregivers • Caregiver stress 	Identify caregivers and assess needs	Identify caregivers in the chart of the individual with dementia and identify the role of caregiving in the caregiver chart. Incorporate a caregiver needs assessment into the care of the individual living with dementia.
	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.