Performance Improvement Project
Annual Report Format Guideline

Reference: EQR Protocol 3, Version 2.0
Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for
External Quality Reviewers (EQR)

Organization:	Community Care, Inc.	Report Prepared by:	Theresa Baker, MS	
Project Title:	Increasing Screening through Dementia Simulation			
Date Project Initiated:	03/31/2017	Date of DHS Approval:	03/30/2017	Date Report Submitted: 12/28/2017
Project Team:	**Name**		**Title/Department**	
	Theresa Baker, MS		Quality Improvement Coordinator	
	Mary Gavinski, MD		Chief Medical Officer	
	Holly Onsager		Director of Behavioral Health	
	Cindy Cowie		Director of Medical Informatics	
	Kelly Covelens		Data Specialist	
	Erin Robinson		Learning and Development Specialist	
	Kathleen Kaniewski		Healthcare Engineer	

1. Study Topic

Describe the process used to prioritize and select this topic from among others as an area identified for improvement. Include information about:
- The relevance of this topic to the organization's membership;
  - Identify how it relates to the health and/or functional status of members, and why it is important to members.
- How the topic was initially identified as an opportunity for improvement;
  - Document the needs assessment that helped identify baseline performance, including any data.
- Any member input obtained in considering this as an opportunity for improvement; and
- The size of the applicable population when selecting a study topic.

To align Community Care, Inc.'s (CCI) business plan with the Department of Long Term Care (DLTC) and the Department of Human Services (DHS) priorities, CCI focused its 2017 Performance Improvement Plan (PIP) on dementia screening. In response to the 2014 DHS statewide initiative to remodel Dementia care in Wisconsin, Community Care has responded in many ways. One of which was to examine dementia screens within the organization. At the beginning of 2016 CCI's Chief Medical Officer began examining the frequency for which dementia screens were conducted by care teams to get an accurate picture of our dementia competency from the most critical beginning stage. With proper and prompt attention to early diagnosis, members and their caregivers will be able to work with Care Teams to form vital care planning around the member's current and anticipated needs. Current research shows that seven out of ten people with dementia live at home where family and friends provide 78% of the care, (Second Wind Dreams, 2017). This highlights the reality that a member's ability to remain independent longer and

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maintain successful community living with the assistance of informal supports depends on the support system knowing and understanding resources available to them. In addition to the challenges for informal support systems, Health Care costs for those with dementia now are more than three times higher than among older Americans not living with Dementia, (Second Wind Dreams, 2017). According to the Alzheimer's association, "Medicare and Medicaid were expected to pay $154 billion in 2015 for health care, long-term care and hospice for people with Dementia. And the need is not diminishing with Alzheimer's Disease being diagnosed every 68 seconds in the U.S. alone", (Alzheimer's Association, 2016)

From the current research, one can understand that there is a need for early and continuing intervention. Before those services can be provided, however, a proper diagnosis is essential. Illustrating this need is the statistic from the 2014 Alzheimer's Disease Facts and Figures, "1-in-9 Americans over age 65 has Alzheimer's disease but only 1-in-4 people with the disease have been diagnosed", (Alzheimer's Association, 2014). Applying that information to our local population we knew in December 2016, CCI's Family Care Program had 9969 members, 3653 of which were age 65 and older and 1686 met criteria for cognitive screening. CCI's system in Family Care of identifying those at risk for dementia is to conduct the following dementia screening tools: Mini Mental State Exam (Mini- cog) evaluation/Animal Naming starting at age 65 or as deemed necessary. CCI's Family Care Registered Nurse Care Managers (RNCM) currently are responsible for conducting cognitive screenings.

In August of 2016 Care Teams were given a formal training which highlighted the importance of completing annual screens. At the close of 2016 data was again pulled to check the effectiveness of that August training. At that time our baseline data showed no change in the compliance of administering dementia screens to the eligible membership. The 2016 average of dementia screening was 26% for CCI's Family Care Program. The intervention to address dementia screening performance was determined to necessitate a different and more innovative approach.

2016 Family Care Cognitive Screening Baseline Data

Dementia Screening - All FC Teams	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Year End Averages
# Total Screens Completed (rolling year)	327	354	393	416	426	441	464	475	472	481	464	491	433.66
Total # of Eligible Members	1593	1526	1618	1616	1628	1553	1635	1638	1653	1659	1731	1686	1628
% of Eligible Members who had a Screen	20.53%	23.20%	24.29%	25.74%	26.17%	28.40%	28.38%	29.00%	28.55%	28.99%	26.81%	29.12%	26.60%

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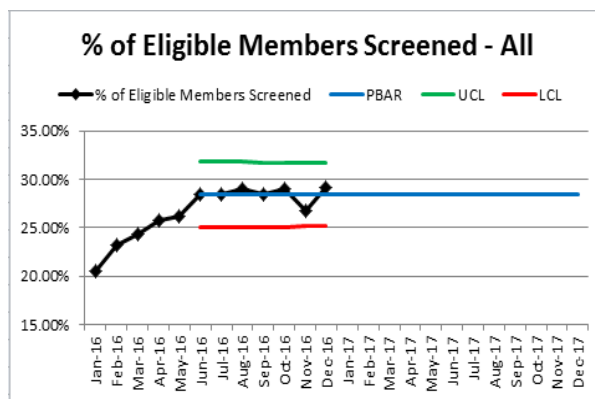External Quality Reviewers (EQR)

Chart Key: PBAR: Average Proportion
UCL: Upper control limit
LCL: Lower control limit

Our urgency to increase compliance with early dementia screening and diagnosis was not only to increase dementia screens, it also created the opportunity to prioritize proper care planning for those who receive a dementia diagnosis. Our efforts for the 2017 PIP augmented the areas of improvement identified by the DHS initiative for which CCI is involved, and created a foundation of sensitivity training within our managed care organization which attached a higher level of understanding and urgency to carry out these essential tasks for the betterment of the communities we serve.

CCI values and appreciates all member input. The CCI website has a link for members to submit any project feedback directly to the QM department. The PIP proposal was presented at several member advisory committees for input. The members had expressed support for and understanding of the project, and gave some suggestions for expanding the initiative in the future such as including caregivers or providers who care for members who have a diagnosis of dementia.

2. Study Questions/Project Aims

State the study question(s) or aim(s) as clear, simple, answerable question(s), including the numerical goal and target date.
- Identify the rate of desired improvement (from what to what) in the study question

Study Question/Numeric Target: Can the Virtual Dementia Tour increase the average completion rate of dementia screening within the test group 6% from 26% to 32% by December 1, 2017?

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(Study population = Family Care members assigned to the Washington, Sheboygan, Fond Du Lac, Manitowoc, Ozaukee, Waukesha, Calumet, Outagamie, Waupaca, Winnebago, Kenosha regions. See section 4 of this report for more details related to inclusion and exclusion criteria)

Dementia Screening - TEST Group	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Baseline Averages
# Total Screens Completed (rolling year)	205	216	243	260	266	273	286	296	300	304	294	322	272.08
Total # of Eligible Members	1031	987	1042	1040	1048	999	1046	1047	1058	1050	1099	1072	1043.25
% of Eligible Members who had a Screen	19.88%	21.88%	23.32%	25.00%	25.38%	27.33%	27.34%	28.27%	28.36%	28.95%	26.75%	30.04%	26.04%

% of Eligible Members Screened - Test Group
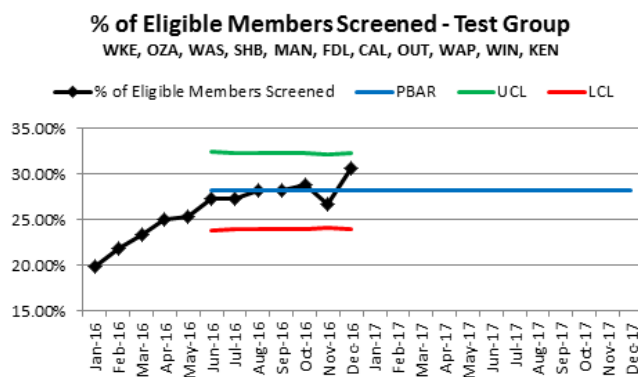WKE, OZA, WAS, SHB, MAN, FDL, CAL, OUT, WAP, WIN, KEN

Chart Key: PBAR: Average Proportion
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Control Group:
To evaluate the effectiveness of the added intervention strategy, outcome results will be compared to Family Care members in the Walworth, Racine, Milwaukee regions meeting the same inclusion criteria.

Dementia Screening - Control Group	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Baseline Averages
# Total Screens Completed (rolling year)	122	138	150	156	160	168	178	179	172	177	170	169	161.58
Total # of Eligible Members	562	539	576	576	580	554	589	591	595	609	632	614	587.75
% of Eligible Members who had a Screen	21.71%	25.60%	26.04%	27.08%	27.59%	30.32%	30.22%	30.29%	28.91%	29.06%	26.90%	27.52%	27.60%

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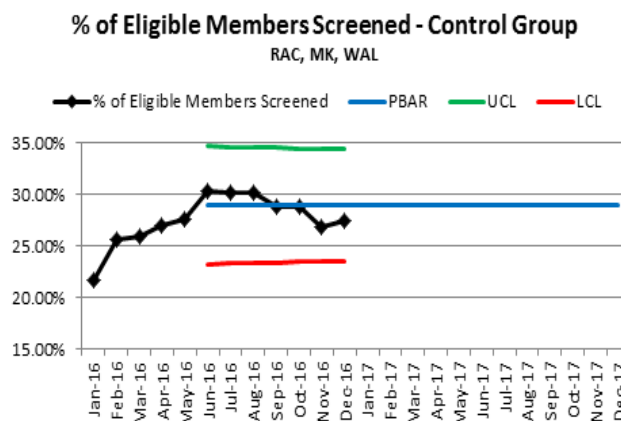External Quality Reviewers (EQR)

Chart Key: PBAR: Average Proportion
UCL: Upper control limit
LCL: Lower control limit

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3. Study Indicators

List all study measures/indicators.
- Define measurable indicators and ensure they adequately answer the study questions.
- Clearly define all numerators and denominators.
- If Healthcare Effectiveness Data and Information Set (HEDIS®)[1] measures are used, include the relevant specifications.

PROCESS indicators

Measure #1 – Percentage of ongoing Family Care RN Case Managers (RNCMs) having completed the Virtual Dementia Tour (VDT)

Rationale – The dementia screening is housed within the RNCM assessment thus making it imperative that the RNCM staff complete the training. The dementia screening that CCI utilizes within the Family Care program is the mini cog and animal naming.

Denominator: Total number of ongoing RNCM staff within the test regions.

Numerator: Total number of ongoing RNCM staff who completed the VDT

Data Source: Training sign in sheets transferred into Community Care's internal learning system Usucceed

Measure #2 - Percentage of Family Care Case Managers (CMs), Family Care Supervisors, and Managers having completed the Virtual Dementia Tour (VDT)

Rationale – RNCMs and CMs comprise the primary Interdisciplinary Team (IDT) making it important for CMs to gain the same understanding of the importance of dementia screening so that they can

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[1] "HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)."

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support and encourage RNCM compliance with this assessment piece. Supervisors and Managers also encourage RNCM compliance with this assessment piece.

Denominator: Total number of CMs, supervisors, managers within the test regions

Numerator: Total number of CMs, supervisors, managers who complete the VDT

Data Source: Training sign in sheets transferred into Community Care's internal learning system Usucceed

Measure #3 – Percentage of new Family Care RNCMs, CMs, supervisors, and managers that onboard into the test regions after 5/1/2017 having completed the VDT

Rationale – It is imperative that new Family Care IDT staff gain the same understanding of the importance of dementia screening so that they can apply the same knowledge and skill sets as their peers.

Denominator: Total number of CMs, RNCMs, supervisors and managers that onboard into the test regions after 5/2017

Numerator: Total number of CMs, RNCMs, supervisors and managers that onboard into the test regions after 5/2017 that completed the VDT

Data Source: Training sign in sheets transferred into Community Care's internal learning system USucceed, HR new hire records

Measure #4 – Comparative analysis of Pre and Post Tour Surveys

Rationale – The surveys will verify impact of the VDT on designated CCI staff

Denominator: Number of RNCMs, CMs, supervisors and managers that complete the VDT

Numerator: Number of RNCMs, CMs, supervisors and managers that completed the VDT and have pre and post survey changes

Data Source: Pre and post VDT surveys (see attachment "VDT pre post survey")

Primary OUTCOME indicator

Measure #5: Percentage of members in the study group that have a completed dementia screen (mini cog and animal naming).

Rationale: Inclusion of this primary study indicator will adequately answer the study question

Denominator: Sum of all members meeting inclusion criteria within the study group

Numerator: Sum of members from the denominator who have a completed dementia screen

Data Source: Community Care's Electronic Medical Record

Measure #6: Percentage of members in the control group that have a completed dementia screen (mini cog and animal naming).

Rationale: Inclusion of this study indicator will allow for comparison to the study group and validation of intervention.

Denominator: Sum of all members meeting inclusion criteria within the control group

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Numerator: Sum of members from the denominator who have a completed dementia screen
Data Source: Community Care's Electronic Medical Record

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4. Study Population

Describe the relevant population (all members to whom the study question and indicators apply). Make sure to clearly define the population used for the study or project, including any inclusion or exclusion criteria and any enrollment/eligibility criteria (e.g., requirements for how long members had to be enrolled).

- If data for the entire population was studied, describe how the data collection approach captured all members to whom the study question applied.

For this quality improvement project, both a study and control region were identified. The Family Care CMs, RNCMs, supervisors, and managers that received the VDT intervention were in the Calumet, Outagamie, Waupaca, Winnebago, Washington, Ozaukee, Sheboygan, Manitowoc, Fond du Lac, Waukesha and Kenosha regions. Thus the members assigned to these counties that meet inclusion criteria became the relevant population for which the study question applied. IDTs have members residing all over CCI's service area so the study group is not limited to residing within the counties that are receiving the VDT intervention.

The members that meet the inclusion criteria and are assigned to the Milwaukee, Racine and Walworth Family Care regions were the control group. As with the study group, these IDTs also have members residing throughout CCI's service area so the control group was not limited to residing within the control counties.

Eligible Study Population
Diagnosis: FC Members without a diagnosis of dementia, without an Intellectual/Developmental Disability (IDD) diagnosis, without a Traumatic Brain Injury (TBI) diagnosis
Age: ≥66 years old
Enrollment: Active FC member
Test sites: Calumet, Outagamie, Waupaca, Winnebago, Ozaukee, Washington, Sheboygan, Manitowoc, Fond du Lac, Waukesha and Kenosha Family Care programs
Exclusions: Under age 66, Diagnosis of dementia, IDD diagnosis, TBI diagnosis

Eligible Control Population
Diagnosis: FC Members without a diagnosis of dementia, without an IDD diagnosis, without a TBI diagnosis
Age: ≥66 years old
Enrollment: Active FC member
Control sites: Milwaukee, Racine and Walworth

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Exclusions: Under age 66, Diagnosis of dementia, IDD diagnosis, TBI diagnosis

5. Sampling

If sampling was utilized (data for a sample of the population was studied and findings were generalized to the entire population), explain the sampling methods used in detail (e.g., number included in the sample, sampling technique used, confidence intervals, acceptable margin of error).

Sampling was not utilized for the purposes of this Performance Improvement Project.

6. Data Collection

Study results are dependent on accurate and valid data that are collected appropriately.
1. Clearly describe the data that was collected for all project indicators. Include information about:
   a. Data sources (e.g., claims/administrative data, member files);
   b. How data was collected and by whom;
   c. Any training or educational qualifications required of data collection staff;
   d. How data was stored and aggregated (e.g., registry, database); and
   e. How data was analyzed and by whom.
2. Describe the planned and actual frequency of data collection and analysis. **Include samples of any data collection tools or instruments as an attachment to this report.**

1a: Data Sources: Community Care's Electronic Medical Record (EMR) for dementia screening results within the Family Care RNCM assessments. Animal naming and Mini Cog both completed = a complete dementia screen. Pre VDT survey.   Post VDT survey. Electronic Human Resources records (Usucceed) where all training sign in sheets are stored.
1b: Dementia Screens are collected by the Family Care RNCM staff within their comprehensive assessments. Pre and post surveys are administered by certified VDT facilitators to all CCI staff that complete the VDT. CCI Quality Management (QM) PIP Lead staff will collect all surveys during the VDT debrief process.
1c: CCI RNCM staff completed training and subsequent competency verification to be able to administer dementia screens. CCI's Behavioral Health Department validates all competency related to administration of dementia screens. QM PIP Lead staff completed Facilitator training through Second Wind Dreams which was conducted by their certified trainer. No additional training or educational qualifications required of data collection staff.
1d: Dementia screens were extracted via the EMR and aggregated monthly by CCI's Informatics Department. Composite survey data was compiled by the QM Data Specialist. Data from training sign in sheets was entered into CCI's Human Resource system (Usucceed) by a Learning and Organizational Development Specialist.
1e: CCI's Dementia Steering Committee analyzed all project data bimonthly and CCI's Quality Steering Committee (QSC) reviews project data biannually.

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Administration of dementia screens within the Family Care program is the exclusive responsibility of CCI's RNCMs. Education and competency assessment related to the provision of dementia screens is provided to all RNCM staff by CCI's BH department. Dementia screens are completed during face to face visits with eligible members during the comprehensive assessment process or they can choose to complete the screen during a separate visit however the expectation is screens need to be completed at least annually for eligible members.   There may be reasons that this screen is utilized for members outside of the eligible population however for the purposes of this project those screens are not included in the analysis. RNCMs input results for both the animal naming test and mini cognitive assessment instrument into Community Care's Electronic Health Record (Greenway Intergy EHR). When both the animal naming test and mini cognitive assessment are both completed this is categorized as a complete dementia screen. Dementia screen results were aggregated monthly by the Informatics Department and analyzed bimonthly by the Dementia Steering Committee and biannually by CCI's Quality Steering Committee (QSC).

7. Improvement Strategies

Describe the interventions initiated and/or completed.
- Explain how interventions were selected based on available data, root cause, or barrier analysis;
- Indicate the timeframes for intervention implementation;
- For continuing projects, provide documentation that focuses on interventions implemented during the current project period – *This PIP is new to CCI in 2017.*

Include documentation of continuous cycles of improvement, showing measurement and analysis of the effectiveness of the interventions.

Describe any consideration given to ensuring that interventions were culturally and linguistically appropriate. **Include any materials that were developed and/or used for interventions, such as member educational materials, practice guidelines, etc., as attachments to this report.**

As indicated within the introduction of this report, CCI has attempted traditional training methods in the past, such as power point presentations, to promote cognitive screening compliance without successful performance improvement.   The catalyst CCI chose was the Virtual Dementia Tour (VDT). Created in 1997 by multiple award-winner, P.K. Beville, the VDT has been scientifically proven to raise sensitivity, understanding and an acute awareness into the intense and debilitating reality individuals with Dementia face every single day. The VDT and its founder have been recognized and praised by participants, books, magazines, articles and both national and international news stories. An estimated 2 million people in 17 countries have experienced the VDT which is available in five languages. Linguistically, CCI would have considered offering

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alternative versions of the VDT however no staff required an alternative version. Cultural factors were not applicable to the VDT intervention. For the scope of this project, the VDT was not offered to members so no additional member educational materials were applicable. CCI does have a Dementia Care Practice Guideline along with a Dementia Screening Resource Flowsheet. These resources are always available for CCI staff to access and were not developed as the result of this project.

The VDT dynamically shows participants what it can be like to live with arthritis, neuropathy, visual impairment, hearing loss, and cognitive disorientation. Participants wear items of clothing that simulate or mimic these physical limitations while their visual and auditory senses are altered with headphones and glasses. They are then asked to perform five seemingly simple tasks of daily living, such as folding clothes and taking medication. The participants instantaneously notice that the once normal task of daily living is complicated and frustrating. For some the experience produces an overwhelming sense of emotions including sadness, anger, and loneliness. A pre and post survey is conducted along with a debrief discussion led by the certified facilitators to allow the participants a safe venue to process the impact of the experience. (Beville, 2002). During the VDT, participants exhibit behaviors such as difficulty following directions, wandering, shadowing, sub vocalization and negative thoughts during the tour.

In a study conducted by Georgia State University, 55% of students reported feeling relaxed or semi relaxed prior to the tour. After the tour 69% of students reported feeling agitated and anxious. Post tour 97% of students reported patients with dementia are justified when they exhibit inappropriate behaviors, (A.K. Lorio, PT, DPT, NCS, *et al*). The pre and post tests show a vastly different perception of their own abilities and the quality of care for people with dementia. To have the ability to manipulate VDT participants' senses to mirror that of a person with dementia creates a clear advantage to proactive care planning for that individual as well as immediacy for professionals to screen those who are at risk for this serious disease.

The VDT was conducted with ongoing Family Care RNCMs, CMs, supervisors, and managers within the test region April-May 2017. Starting in May through October 2017 all new RNCMs, CMs, supervisors, and managers that onboarded into the test region were provided the VDT as part of their new employee orientation. All Family Care regions were provided a monthly update on status of dementia screenings for team review.   This was purposefully provided to all regions to ensure that this information did not skew results in the test region and ensure validation of the designed intervention.

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8. Data Analysis and Interpretation of Study Results

Include relevant data in the report, including numerators and denominators. Include baseline and final data, **as well as periodic data reviewed according to the prospective data analysis plan.**

Provide a discussion of initial, repeat, and final measurement results and how these were interpreted. **Include tables, charts or graphs, when applicable; present numerical results accurately and clearly.**

Analyze and address the impact of identified study limitations or barriers. Include any hypotheses and related analysis when improvement has not been achieved. Document actions taken as a result of analysis.

PROCESS indicators

Measure #1 – Percentage of ongoing Family Care RN Case Managers (RNCMs) having completed the Virtual Dementia Tour (VDT)

Denominator: 65 ongoing RNCM staff within the test regions.

Numerator: 65 ongoing RNCM staff completed the VDT

Outcome: 100% of ongoing RNCM staff completed the VDT

Analysis: The RNCM staff are solely responsible for the cognitive screening in the Family Care program so it was imperative that they all completed the VDT. 65 ongoing RNCMs completed the VDT including 1 RNCM that was on medical leave during the initial intervention period and 1 existing RNCM that transferred from Milwaukee Family Care to a split Washington/Ozaukee Family Care position. 100% ongoing RNCM completion of the VDT meets expectations for this project.

Measure #2 - Percentage of ongoing Family Care Case Managers (CMs), Family Care Supervisors, and Managers having completed the Virtual Dementia Tour (VDT)

Denominator: 149 ongoing CMs, supervisors, managers within the test regions

Numerator: 147 ongoing CMs, supervisors, managers who completed the VDT

Outcome: 98.66% of ongoing CMs, supervisors, and managers completed the VDT

Analysis – CMs, Supervisors and Managers all support the screening process so it was imperative they receive the same training that the RNCM staff did. 147 ongoing staff completed the VDT. 1 CM and 1 supervisor were unable to complete the VDT due to their own medical concerns so were excused by their managers from the simulation portion of the training. These two staff did participate in the debrief discussion along with everyone else so this portion of the tour had a completion rate was 100%. Of the 147 ongoing staff that completed the VDT, 141 remain employees of CCI. Survey information described in Measure 4 below will include data from all VDT participants. Inclusion of this data does not impact validity of the survey results.

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Measure #3 – Percentage of new Family Care RNCMs, CMs, supervisors, and managers that onboard into the test regions after 5/1/2017 having completed the VDT

**Denominator:** 13 CMs, RNCMs, supervisors and managers onboarded into the test regions after 05/2017

Numerator: 13 CMs, RNCMs, supervisors and managers onboarded into the test regions after 5/2017 and completed the VDT

Outcome: 100% of new staff that onboarded into the test regions between 5/1/17 and 10/31/17 completed the VDT.

Analysis – It is imperative that new Family Care IDT staff have the same understanding of the importance of dementia screening so that they can apply the same knowledge and skill sets as their peers. This was done at a 100% completion rate between the time frame of 5/1/17 and 10/31/17. There are an additional 5 new employees that onboarded after 10/31/17 and those staff will complete the VDT as part of their new employee orientation in Q1 of 2018.

Measure #4 – Comparative analysis of Pre and Post Tour Surveys (see charts below)

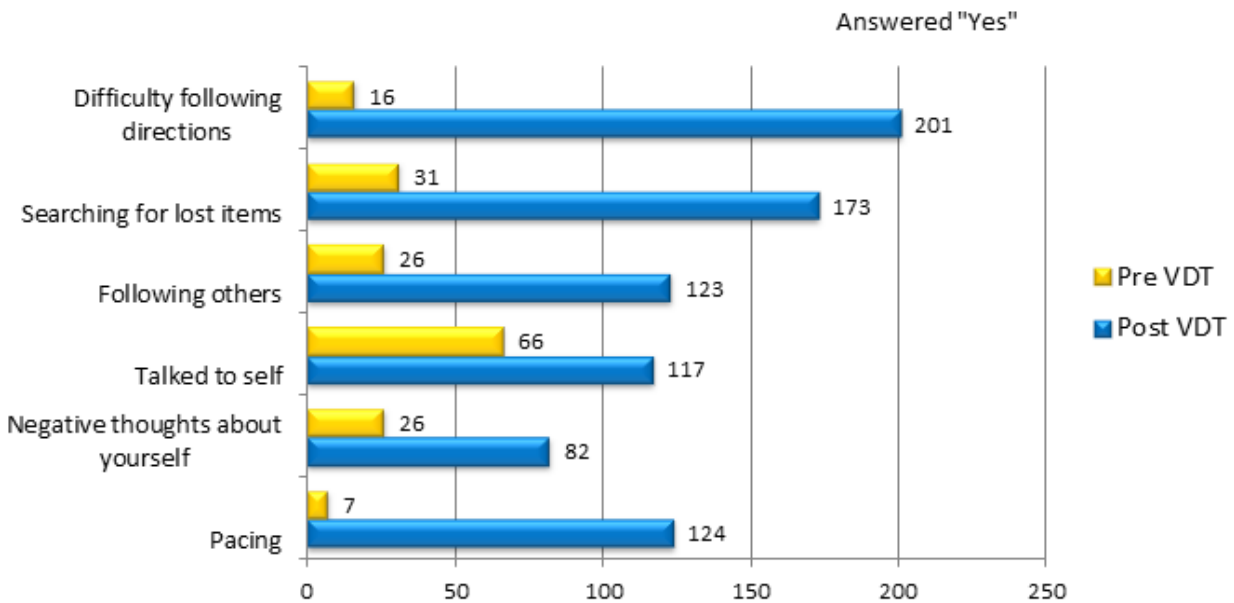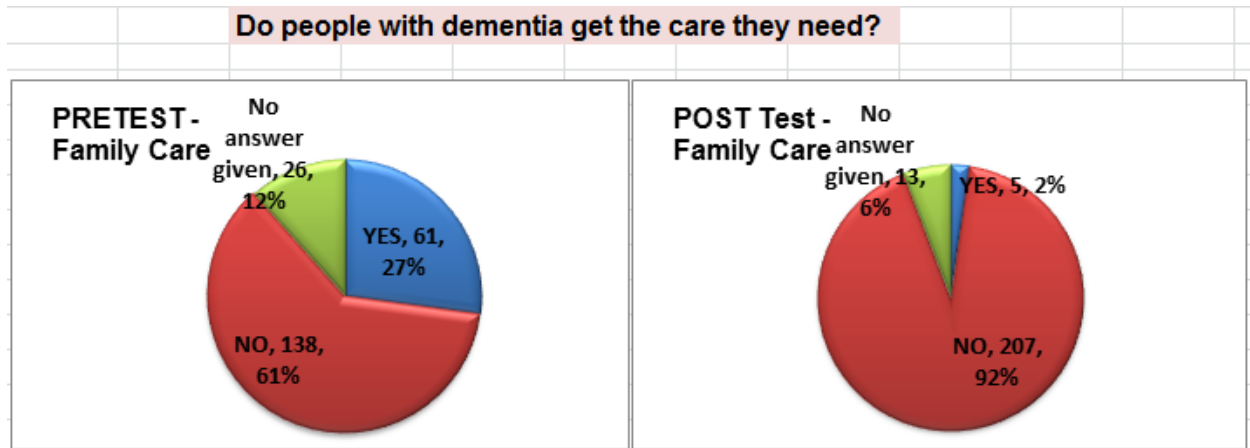Do you feel capable of carrying out simple tasks?
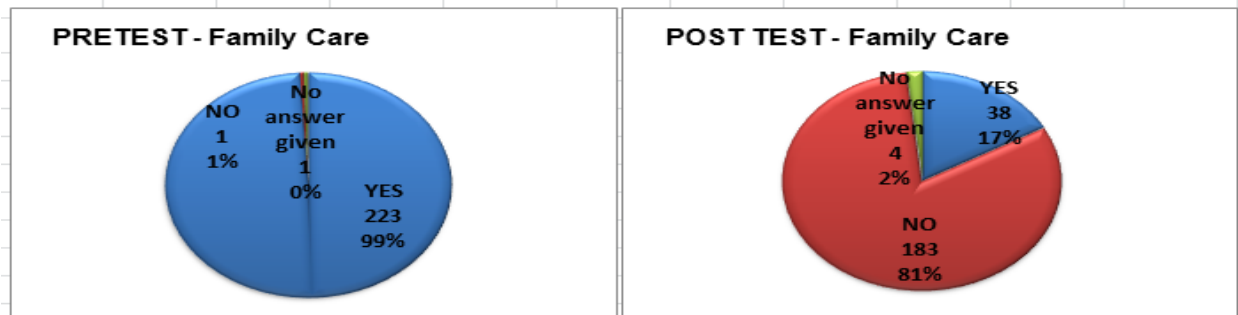
Are you relaxed?
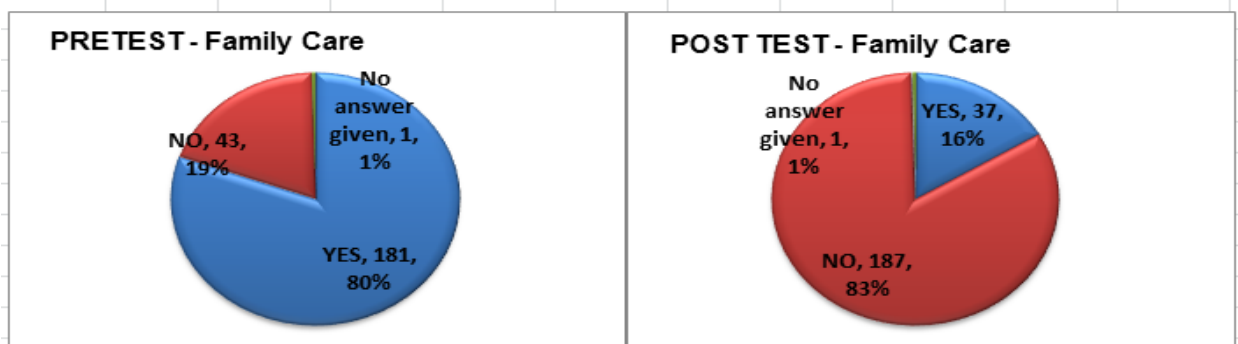
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Do people with dementia get the care they need?

PRETEST - Family Care
- No answer given, 26, 12%
- YES, 61, 27%
- NO, 138, 61%

POST Test - Family Care
- No answer given, 13, 6%
- YES, 5, 2%
- NO, 207, 92%

Answered "Yes"

Characteristic	Pre VDT	Post VDT
Difficulty following directions	16	201
Searching for lost items	31	173
Following others	26	123
Talked to self	66	117
Negative thoughts about yourself	26	82
Pacing	7	124

Analysis: The VDT Pre and Post surveys show 99% of participants reported they felt capable of carrying out simple tasks before The VDT compared to 17% after The Tour which is an 82% decrease. Next, 80% of participants classified themselves as feeling relaxed before The VDT and only 16% noted after The VDT that they were relaxed which is a 64% decrease. When asked if people with Dementia get the care that they need before the tour, 27% of staff reported that people with Dementia did get the care they needed. After the tour, only 2% of staff indicated that people with dementia get the care they needed. Finally, the pre and post tests asked participants to indicate which characteristics had applied to them in the past 10 minutes. As the chart above indicates, there was a distinct disparity in each characteristic's response reported from pre to post survey. Pre and post test comparison validates the desired impact of the project's key intervention. Quantitatively the post survey allows for written narrative of what participants may

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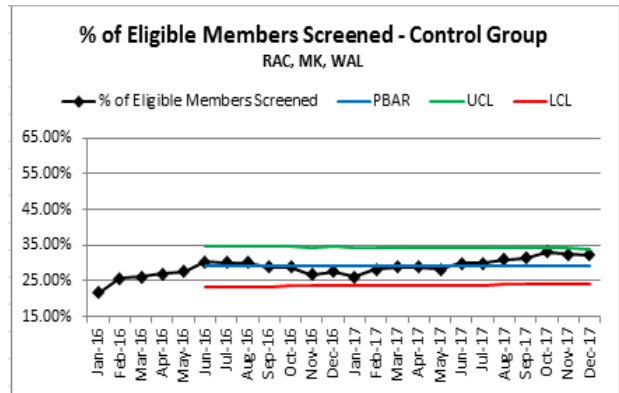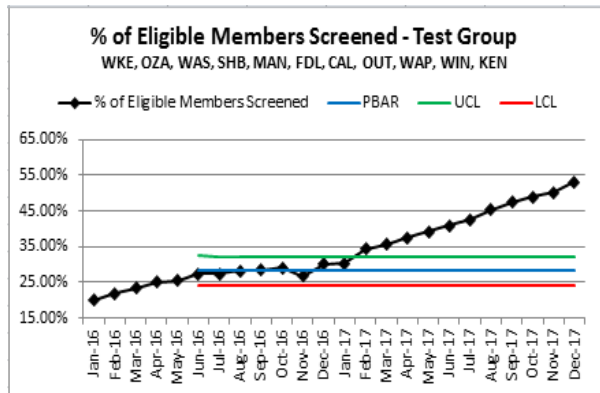External Quality Reviewers (EQR)

change after experiencing the VDT. Over half of the participants noted some sort of planned change in their approach and realization of lack of clear understanding of dementia. These results are important to note to further verify the impact of the VDT.

Primary OUTCOME indicators

Measure #5 (Study Question) & Measure #6 Combined: Percentage of members in the test and control group that have a completed dementia screen (mini cog and animal naming).

Dementia Screening - TEST Group	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Mar-Dec Averages
# Total Screens Completed (rolling year)	339	367	382	403	424	444	465	493	518	533	555	591	491.77
Total # of Eligible Members	1116	1067	1075	1073	1083	1086	1094	1090	1094	1090	1108	1113	1094.75
% of Eligible Members who had a Screen	30.38%	34.40%	35.53%	37.56%	39.15%	40.88%	42.50%	45.23%	47.35%	48.90%	50.09%	53.10%	44.97%

Dementia Screening - Control Group	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Mar-Dec Averages
# Total Screens Completed (rolling year)	173	184	191	194	197	209	209	220	225	238	236	243	216.2
Total # of Eligible Members	664	651	660	673	701	699	697	713	715	718	727	754	697.66
% of Eligible Members who had a Screen	26.05%	28.26%	28.94%	28.83%	28.10%	29.90%	29.99%	30.86%	31.47%	33.15%	32.46%	32.23%	30.59%

% of Eligible Members Screened - Test Group
WKE, OZA, WAS, SHB, MAN, FDL, CAL, OUT, WAP, WIN, KEN

% of Eligible Members Screened - Control Group
RAC, MK, WAL

Analysis: The data charts above show only 2017 data with the intervention period being March through December. For ease of comparison, the above control charts include both baseline and intervention period data for both the test and control groups. The test region average rate of cognitive screening completion increased from 26.04% in 2016 to 44.97% (March-December 2017) which is an 18.93% change and exceeds the project goal. The control region average rate of cognitive screening completion increased from 27.6% in 2016 to 30.59% (March-December 2017) which is a 2.99% change. The average percentage of change for the test group was 15.94% more than the control group.

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9. "Real" Improvement

Consider if the repeat measures utilized the same methodology as the baseline and interim measures.

Document any quantitative improvements in processes or outcomes of care associated with the study question.

Determine if any improvement appears to be "real" improvement.
- Identify if improvement is related to the interventions employed or some unrelated occurrence;
- Include information about how the effectiveness of interventions was measured, and how this correlated with the overall project measures and progress (i.e., describe how you determined that the improvement was a result of the intervention employed);
- Note if there is any statistical evidence to suggest that improvement seen is true improvement.

The VDT was a one time intervention executed in the test region March 2017-May 2017 and then new employees who onboarded into the test region May 2017-October 2017. Cognitive screening data was measured monthly via the same methodology from baseline in 2016 through PIP year 2017. As part of the debrief process, IDTs identified that the volume of information that is reviewed during a comprehensive assessment is extensive and they wanted the ability to complete the cognitive screening outside of the assessment process. The dementia steering committee approved use of the cognitive screen outside of the assessment process as a potential stand alone assessment in June 2017. This was a process improvement that was rolled out to the entire Family Care program and while this did not seem to impact scores it gives RNCMs the flexibility to complete the cognitive screen for instance if there is an observed change of condition which could be a crucial tool to ensure member's needs are met. Prompt screening vs. delaying cognitive screening for a periodic assessment could potentially impact care planning if indeed there is a change that requires MD notification and further medical assessment. IDTs are better able to focus care planning when screening is complete to consider all applicable diagnoses should they exist.

The outcome of this project far exceeded the goal which indicates performance improvement. Effectiveness of the VDT was measured with the pre and post VDT survey comparison which resulted in the rolling cognitive screening percentage to continue to increase while the control region remained flat. The roll out of the cognitive screen outside of the assessment process along with the dissemination of screening results was provided to the entire Family Care region so these would not be differing factors between the two groups. To rule out RNCM turnover the regions were compared. Family Care has 123 RNCM positions, 68 in the test region and 55 in the control region. During the intervention period the test region had 2 new RNCM hires (2% turnover rate)

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and control region 5 (9% turnover rate). Due to the low rate, RNCM staff turnover can be ruled out as a factor that could have impacted screening compliance.

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10. Sustainability

This standard will only be evaluated if improvement has been achieved and measures have been repeated over comparable time periods.
- If improvement has been sustained, describe how sustainability has been achieved.
- If improvement has only recently been achieved, describe the plan to sustain it.

In comparing the test and control regions of this project, performance improvement has been achieved however due to short approximately 9 month duration of new DHS projects, CCI plans to sustain this change over time by extending this PIP into 2018. CCI plans to expand the VDT into the control region and continue dissemination of screening data to all regions to encourage ongoing monitoring of performance at the IDT level. CCI will continue to include the VDT in new employee orientation so all RNCMs, CMs, supervisors, and managers that onboard into the Family Care Program receive the VDT. The VDT can be repeated if desired annually, so CCI will keep the VDT as a resource within its Learning and Organizational Development Library of courses should staff, a manager, or a supervisor identify the topic of dementia as a performance or learning need.

CCI has expanded the reach of the VDT beyond the initial target region of the formal PIP to include executive level staff including its CEO and CMO, Board of Directors, Regional Directors, congregate staff, behavioral health staff, therapeutic recreation staff, financial eligibility staff, PACE and Partnership staff, and external providers. CCI firmly believes in the dementia capable vision and when leaders support a vision and participate in initiatives themselves, the value further resonates with the staff that manage the care of our members. CCI will continue to offer the VDT beyond the scope of this PIP to further sustain the mission of keeping dementia screening and dementia centered care planning at the forefront of IDT priority.

SUBMISSION ATTACHMENTS: RNCM Assessment – Dementia Excerpt
                                VDT pre and post survey tools

Second Wind Dreams & Virtual Dementia Tour Credit Statement:
The Virtual Dementia Tour is a scientifically proven method of building a greater understanding of dementia through the use of patented sensory tools and instruction. The VDT was created by P.K. Beville, an award-winning geriatric psychologist, dementia expert, and founder of Second Wind Dreams, and international, nonprofit, organization recognized as the first in the nation committed to changing the perception of aging through the fulfillment of dreams for elders and the offering of innovative educational opportunities to caregivers, families, and communities. For more information about Second Wind Dreams and the Virtual Dementia Tour, please call the office at 678-624-0500 or visit online at www.secondwind.org.

Reference: EQR Protocol 3, Version 2.0
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