

Building Indian Health Dementia Models of Care: Introduction & Grantee Models of Care Presentations

March 10th, 2026

Indian Health Service



March 10th – Pre-Summit Agenda



8:00 am: Introduction and Welcome

8:15 am – 12:00 pm: Grantee Presentations

9:50 am – 10:00 am: Stretch Break

10:00 am – 11:00 am: Grantee Presentations

11:00 am – 11:10 am: Stretch Break

11:15 am – 12:00 pm: Grantee Presentations

12:00 pm – 12:55 pm: Lunch on Your Own

1:00 pm – 3:00 pm: Lightning Round Table Discussions

3:15 pm – 4:00 pm: Poster Presentations

Each presentation will be 10 minutes with a 2-minute transition period

Grantee Presentation's – 8:15 am -12:00 pm



8:15 am: Oklahoma City Indian Clinic
8:27 am: Chickahominy Indian Tribe
8:39 am: Denver Indian Health Family Services
8:51 am: First Nations Community Healthsource
9:15 am: Tuba City Regional Healthcare Corporation
9:27 am: Santo Domingo Pueblo
9:39 am: Confederated Tribe of the Grand Ronde
Community
9:50 am: Stretch Break

10:00 am: Cherokee Nation
10:12 am: Indian Health Council
10:24 am: Fallon Paiute Shoshone Tribe
10:36 am: Indian Health Board of Minneapolis
10:48 am: Seattle Indian Health Board
11:00 am: Stretch Break
11:12 am: Northern Valley Indian Health
11:24 pm: Nez Perce - Nimiipuu Health
11:36 am: Norton Sound
11:48 am: Absentee Shawnee of Indian of Oklahoma
12:00 pm: Lunch Break

Each presentation will be 10 minutes with a 2-minute transition period

2026 IHS National Clinical and Community Workforce Summit

Building Indian Health Dementia Models of Care

Oklahoma City Indian Clinic

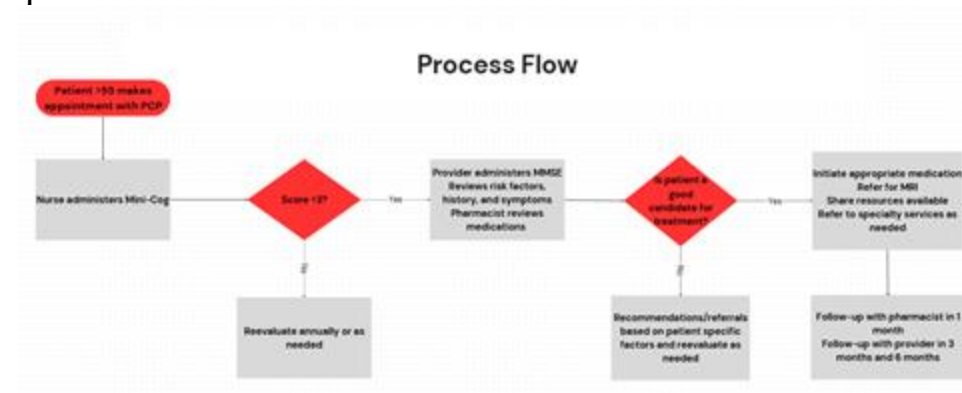


Increase **Awareness and Recognition** of Dementia

- Lunch and learn sessions for staff
- Virtual Dementia Tour
- Education and caregiver support groups in partnership with Alzheimer's Association
- Outreach events:
 - Elder Health Fair
 - FAM TEK Fest
 - Screen dementia documentary
- Media presence:
 - Social media posts
 - Advertise program in clinic's quarterly magazine

Make an **Accurate and Timely Diagnosis**

- Enhance current processes:
 - MMSE vs. MoCA
 - MoCA training
 - Dementia hotline
- Increase rate of screening on primary care teams:
 - Scrub schedules to identify patients
 - Track screening and follow-up in Dementia Registry
- Multidisciplinary approach:
 - Referral to specialty departments
 - PHQ screening for depression
 - Medication review
- Incorporate lab testing for appropriate patients
 - ATN profile available through Labcorp



Provide **Interdisciplinary Assessment** to Identify Needs and Develop Appropriate Care Plans

- Utilize specialty services at our clinic
 - Care plans
- Medication Therapy Management
 - Deprescribing if feasible
 - High-risk medications on GDR plans
 - Patient counseling

Provide Comprehensive, Person-Centered **Management and Referral** to Meet Needs

- Enhance current process using the 4M's Framework
 - Care plans
 - Partner with OFMQ to become an Age-Friendly Health Care Site
- Periodically review care plans
 - Follow-up on referrals
 - Address changes in level of care as needed

Support for Caregivers

- CARES Training
 - Site license to access all training materials
 - Coordinate training for appropriate staff
- Savvy Caregiver in Indian Country
 - Training for appropriate staff and caregivers
- Conduct a Caregiver needs assessment
- Host Alzheimer's Association support group
- Create culturally sensitive binders for patients/caregivers
 - All pertinent health information in one location
 - Resources
- Assistive devices as needed

“Claim to Fame”

Date	Month	Name	DOB	Chart Number	Provider	Team	Mini Cog Word Recall	Mini Cog Clock	Mini Cog Score	Status	Mini Mental Score
9/18/2025	September				Forrester	Sage	2	Yes/2	4	Negative	
9/18/2025	September				Forrester	Sage	2	Yes/2	4	Negative	
9/23/2025	September				Hixon	Blue	2	Yes/2	4	Negative	
9/24/2025	September				Thomas	Gold	3	Yes/2	5	Negative	
9/26/2025	September				Hixon	Blue	2	No/0	3	Borderline	
9/29/2025	September				Mohamm.	Sage	1	No/0	1	Positive	28
9/30/2025	September				Knight-Gl.	Gold	3	Yes/2	5	Negative	
10/1/2025	October				Kong	Sage	2	Yes/2	4	Negative	
10/8/2025	October				Hixon	Blue	1	Yes/2	3	Borderline	
10/9/2025	October				Kong	Sage	3	Yes/2	5	Negative	
10/9/2025	October				Kong	Sage	3	Yes/2	5	Negative	
10/14/2025	October				Hixon	Blue	2	Yes/2	4	Negative	
10/15/2025	October				Hixon	Blue	3	Yes/2	5	Negative	
10/21/2025	October				Bartl.	Blue	2	Yes/2	4	Negative	
10/21/2025	October				Hixon	Blue	2	Yes/2	4	Negative	
10/28/2025	October				Forrester	Sage	2	Yes/2	4	Negative	
11/8/2025	November				Kong	Sage	3	Yes/2	5	Negative	
11/10/2025	November				Hixon	Blue	3	Yes/2	5	Negative	
11/14/2025	November				Kong	Sage	3	Yes/2	5	Negative	
11/17/2025	November				Mohamm.	Sage	2	Yes/2	4	Negative	

The beginnings of a Dementia Registry is in place for our clinic. We are tracking cognitive testing results, provider, and team. We are planning to add tribal affiliation and care planning details this year.

Driver	Measure(s)	Data Collection Method	Quarterly Results (Quantitative)	BRIEF Narrative on Results/Impact and Qualitative Findings
Awareness & Recognition	Lunch & learn attendance	Attendance log	<ul style="list-style-type: none"> Virtual Dementia Tour: 18 	<i>Staff that participated in the VDT indicated that they found the experience to be eye-opening and valuable.</i>
	Outreach event attendance	Attendance log		
	# of households receiving quarterly magazine and # of views on social media	Community development		
Accurate and Timely Diagnosis	# of staff MoCA trained	Google drive	<ul style="list-style-type: none"> 80 patients screened 	<i>Screened patients can be further evaluated. Of the 80 patients screened, 12 patients screened positive on the Mini-Cog.</i>
	% of patients screened	Google drive/iCare		
	# of patients with PHQ2/9 and medication review	Google drive/RPMS report		
Interdisciplinary Assessment	# of referrals	Chart review	<ul style="list-style-type: none"> 0 	<i>Pending DCN</i>
	# of medication interventions	Google drive	<ul style="list-style-type: none"> 0 	
Management and Referral	# of binders created	Google drive	<ul style="list-style-type: none"> 0 	<i>Pending DCN</i>
	# of CARES training		<ul style="list-style-type: none"> 0 	
Support Caregivers	QOL measure TBD	e.g., Focus groups, interviews, pre-post burden or depression scales, post-session evaluation survey	<ul style="list-style-type: none"> Totals and/or averages 	<i>Pending DCN</i>
Other Grantee-Defined Measures	*TBD* <i>Specific metrics tailored to the project – quantitative or qualitative</i>	Custom data sources	<ul style="list-style-type: none"> Totals and/or averages 	<i>Pending DCN</i>



Nicolette Casula
Dementia Care Navigator



Morgan Masterson, PharmD, BCGP
Principal Investigator
GerScholar



Thank You



The Indian Health Service, Department of Health and Human Services (HHS) provided financial support for this project. The award provided 100% of total costs associated with the program, including supplies, training, travel as well as 25% salary of the Principal Investigator, and 100% salary for the Dementia Care Navigator. The contents are those of the author. They may not reflect the policies of IHS, HHS, or the U.S. Government.

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Building Indian Health Dementia Models of Care

Site: Chickahominy Indian Tribe

Increase Awareness and Recognition of Dementia

Secondary Drivers	Strategies
Increase knowledge about dementia signs and symptoms	Expand culturally relevant educational programming about dementia signs and symptoms in the Chickahominy community.
	Identify or develop culturally relevant educational resources about recognizing signs and symptoms of dementia.
Increase knowledge about risk factors for cognitive decline	Expand culturally relevant educational programming about dementia signs and symptoms in the Chickahominy community.
	Identify or develop culturally relevant educational resources about brain health risk reduction.
Increase participation in ongoing tribal and community wellness programming for diabetes management, healthy eating and exercise.	Promote wellness programs to tribal citizens in the context of improving or maintaining brain health.
Reduce stigma associated with dementia	We created a public service announcement from the Brain Health Navigator about brain health awareness.
	Provide culturally relevant educational programming about cognitive screening to demystify the process.

Make an Accurate and Timely Diagnosis

Secondary Drivers	Strategies
Cognitive screening available to Tribal citizens	Connecting tribal citizens to resources at the local IHS clinic, tribal brain health navigator or other primary care sites for cognitive screening in the community.
	Identify or develop culturally relevant education resources about cognitive screening; train tribal brain health navigator for mini-cogs.
Clinical resources available for accurate dementia diagnosis	For individuals with positive screening, coordinate through primary care to connect them to resources for appropriate diagnostic workup at a regional health system.
	For individuals with positive screening, connect them to the tribal brain health navigator.
Diagnostic process is culturally competent	Tribal brain health navigator assesses the experience of the tribal citizen through the diagnostic process, works with partner to choose the proper assessment tool and develop pathways
	Tribal Brain Health Navigator provides targeted education and resources when issues arise.

Provide Interdisciplinary Assessment to Identify Needs and Develop Appropriate Care Plans

Secondary Drivers	Strategies
Assess for age-friendly health care around mobility, mind, medication, and what matters	Tribal brain health navigator assesses and connects individuals to interprofessional clinical resources for age-friendly healthcare through primary care or regional health systems; works with partner to choose the proper assessment tool and develop pathways.
Assess social needs	Tribal brain health navigator screens for social drivers of health and connect to tribal and community resources (e.g., Area Agency on Aging, food banks, transportation); works with partner to choose the proper assessment tool and develop pathways.
Include brain health and dementia in ongoing needs assessments	Revise current Tribal Elder needs assessment to include needs related to brain health, dementia, and caregiving; Provide dementia capable culturally relevant training for tribal brain health navigator in collaboration with partners (VCU, the Area Agency on Aging, Alzheimer’s Association and VGEC)

Provide Comprehensive, Person-Centered Management and Referral to Meet Needs

Secondary Drivers	Strategies
Map availability of services for both Tribal Citizens living with dementia and their caregivers	Convene the Area Agency on Aging, Alzheimer's Association, local provider, and regional health systems' representative to identify available services to support Tribal Citizens and their caregivers.
	Identify opportunities to improve the cultural relevance of available services.
Connect both Tribal Citizens living with dementia and their caregivers to needed services	Utilize tribal brain health navigator to connect to needed services, monitor outcomes and provide ongoing care navigation as needs evolve.
	Implement a client management or tracking software/technology that is HIPAA compliant to improve trust in the security of the data system.

Support for Caregivers

Secondary Drivers	Strategies
Assess caregiver supports and needs	Tribal brain health navigator will screen for caregiver supports and needs and connect to tribal and community resources (e.g., Area Agency on Aging, Alzheimer’s Association)
Connect caregivers to culturally relevant resources	Expand relationships with community partners (area agency on aging, Alzheimer’s Association, etc.) to adapt partner programming to better meet the needs of tribal caregivers.
	Develop a local support group (format TBD) or programming for caregivers based on meeting their needs.
	Identify and promote respite opportunities
Further develop the skills of tribal elder care staff to support both patients living with dementia and their caregivers	Provide ongoing training for tribal elder care staff on best practices for caring for both tribal citizens living with dementia and their caregivers.

Our Claim to Fame is...

Supportive community partners!

We have had enormous support from various local and state organizations such as the Richmond Chapter of the Alzheimer's Association, the local Capital Area on Aging, Virginia Commonwealth University (VCU) Health, Virginia Memory Project and our local IHS clinic (Mid Atlantic Tribal Health Center).

Performance Measures

Driver Category	Metric	Year 1 Outcome / Goal	
Awareness and Recognition	Create a PSA from the Tribal Brain Navigator about brain health awareness	Emailed out to citizens and posted to our closed tribal Facebook group	10 new citizen connections / yr
Management and Referral	Implement a client management or tracking software/technology that is HIPAA compliant	Excel workbooks/MS forms created to track data	Appropriate client management system is identified and implemented



Photo from our recent Site Visit

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DIHFS Healthy Aging

Denver Indian Health and Family Services

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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. <i>Measures:</i> <i># of screenings</i> <i># of patients indicating improved knowledge</i>	1.1 Conduct outreach at elders’ luncheons and community events	Host/Participate at 5 Elder’s Luncheon Participate in 3 major community events (for example Rock Your <u>Mocs</u> , Community Health Fair, Denver March Powwow, or Orange <u>Shirt day</u>)
	1.2 Promote awareness of dementia-related issues through our established social media channels and newsletters	Develop 12 social media posts Develop 4 Healthy Aging newsletter articles Get materials approved through committee Post on <u>Facebook</u> , Instagram, and email newsletter
	1.3 Incorporate dementia education and detection components into our routine programming	Educating regarding diabetes control and connection to dementia risk Prevention: Heart Healthy Diet, movement, quit smoking, social connection
	1.4 Conduct an outreach campaign through our EHR system to patients aged 50 and older	Create custom campaign for patients ages 50+ related to Healthy Aging Care Send to population set

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><i>Measures:</i></p> <ul style="list-style-type: none"> <i># of patients with a care program</i> <i># of staff certified in MoCA administration</i> 	<p>Conduct MoCA screenings for patients aged 65 and older with Medicare Part B during their Annual Wellness Visits, as well as for others when symptoms are reported</p>	<p>Conducted in clinic, performed by Pharmacist-led interdisciplinary team</p>
	<p>Implement <u>MiniCog</u> screening across all departments as part of routine protocols for patients aged 50 and older, regardless of insurance status</p>	<p>Implemented in Primary Care</p>
	<p>Build staff capacity by providing training required to administer the MoCA and <u>MiniCog</u></p>	<p>Identify 6 staff to complete screenings</p> <p>Attend training for <u>moca</u></p> <p>Attend training for <u>minicog</u></p>
	<p>Build staff capacity through <u>GeriScholars</u> Program participation (supported by TRIAD)</p>	<p>Project Director to participate in <u>Gerischolars</u> Nurse program</p>
	<p>Build staff capacity by attending relevant TRIAD webinars</p>	<p>Identify 6 staff to participate</p> <p>Attend 2 TRIAD webinars</p>

Provide an Interdisciplinary Assessment to Identify Needs and Develop Appropriate Care Plans

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 an Interdisciplinary Assessment to identify the need for services and an appropriate plan of care, for individuals living with dementia and their caregivers. <i>Measures:</i> <ul style="list-style-type: none"> • # of patients demonstrate improved medication <u>adherence</u> • # of patients showing improvement in mood symptoms 	1. Primary care providers assess cognitive health, monitor disease progression, and prescribe medications	Trainings will support primary care team in modern and effective methods in caring for patients with dementia
	2. Pharmacy staff provide medication management assessments	Pharmacy staff review patient med list and send recommendations to Primary Care Provider
	3. Behavioral health staff support patients experiencing mood disorders	Psychiatry in house for management of mood disorders, common with the co-occurrence of dementia BH support patient experiencing mood disorders
	4. Personalized SDOH assessments are provided for individuals who screen positive for or are being monitored for cognitive changes	Combination of Project Director and Peer Navigators will

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. <i>Measures:</i> <i># of patients with improved medication adherence</i> <i># of patients who receive follow up</i>	1. Provide medication management appointments	Methods for management include blister packs, CGM's tied to caregiver phone _____ _____ _____
	2. Create and maintain a dementia registry	Create criteria for a Dementia registry for appropriate RN case management (Track falls, hospitalizations, ER visits) _____ _____ _____
	3. Conduct home visits	Safety and Fall assessments Medication Management Patient vitals and routine lab work _____
	4. Connect patients with Medicaid benefits and assistance programs	Refer patients to Peer Navigation Establish list of resources (including on site Medicaid enrollment, transportation resources, etc) _____ _____ _____

Support for Caregivers

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>
Support Caregivers. <i>Measures:</i> <ul style="list-style-type: none"> • # of patients who attend specialty appointments • # of caregivers with increased confidence • # of caregivers report increased access to support services 	Transportation to specialty appointments, as needed	Create visit type to track encounter and diagnosis code Develop Transportation Policy Complete NEMT training
	Provide caregivers with guidance on care coordination for those under their care	Training by Project Director on tips and proper care for patients
	Caregiver Support appointment (support group referrals, caregiver support funds)	Warm Handoff with peer navigators Peer navigator SDOH assessment and appointment

Our Claim to Fame is

Routine screening with Mini-Cog starting at 55+:

- Based on clinical research indicating higher risk for early onset Alzheimer's in AI/AN populations (Apostolou, et al. 2024)
- Mini-Cog screening across all Primary Care providers **at annual visits**
- Full MOCA screenings conducted for Medicare Annual Visits
- Helps to catch any younger patients exhibiting signs and start preventative treatment early

Contributing successes:

- Our Project Director, Frances Holliday RN, RN experience of 30, 25 years of Elder and Dementia care
- We have begun MOCA screenings (specialized for First Nations and Indigenous populations)

Citation: Apostolou A, Kennedy JL, Person MK, Jackson EMJ, Finke B, McGuire LC, Matthews KA. Alzheimer's disease and related dementia diagnoses among American Indian and Alaska Native adults aged ≥ 45 years, Indian Health Service System, 2016-2020. *J Am Geriatr Soc.* 2024 Sep;72(9):2834-2841. doi: 10.1111/jgs.19058. Epub 2024 Aug 8. PMID: 39115437; PMCID: PMC11875228.

Performance Measures

- Performance Measure is
 - Numerator: **# of patients screened for cognitive function/**
 - Denominator: **# of patients eligible using screening guidelines**
- How?
 - Mini-cogs and MOCA screening are captured using our Electronic Health Record. Age and visit type data will give us a list of eligible patients
 - Project Director Frances, manages the dementia patient registry and monitors screening workflow

Photo Page



**Brandy Shahin, MSN,
APRN, CNP, RNFA, FNP-C**
Director of Primary Care



Frances Holliday, BSN, RN
RN Clinic Manager



Leah Fitzgerald, PharmD
Director of Pharmacy



Kristina Brown
Peer Navigator



Madison Homuth
Grants and Contracts Manager



Trini Somasundaram
Grants Program Administrator



Megan White
Financial Officer

2026 IHS National Clinical and Community Workforce Summit

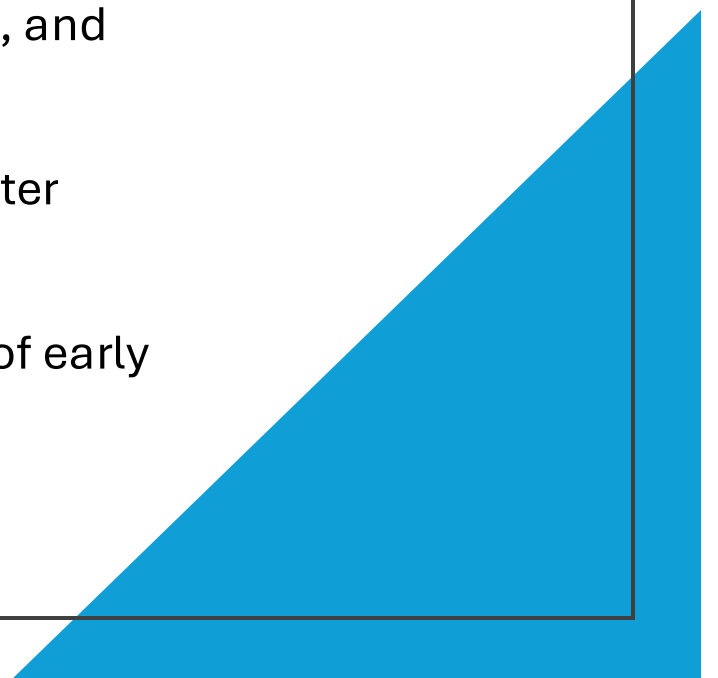
Building Indian Health Dementia Models of Care

Site: First Nations Community HealthSource

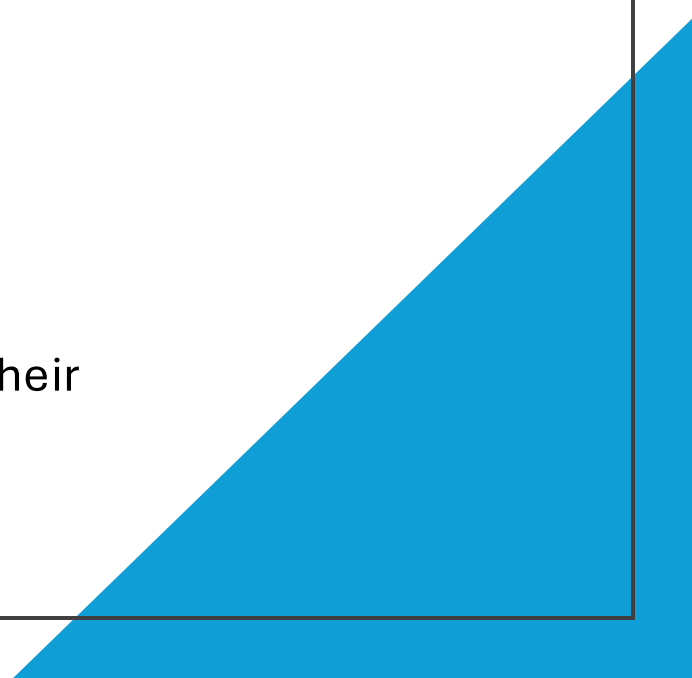
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INCREASE AWARENESS AND RECOGNITION OF DEMENTIA


- Educate staff and community members about the importance of early detection and screening of dementia, associated risks, warning signs, and available resources.
- Collaborate with the New Mexico Alzheimer's Disease Research Center (NM ADRC) to provide dementia education and training.
- Incorporate dementia education information, including the benefits of early detection, at community outreaches conducted by FNCH's outreach programs.



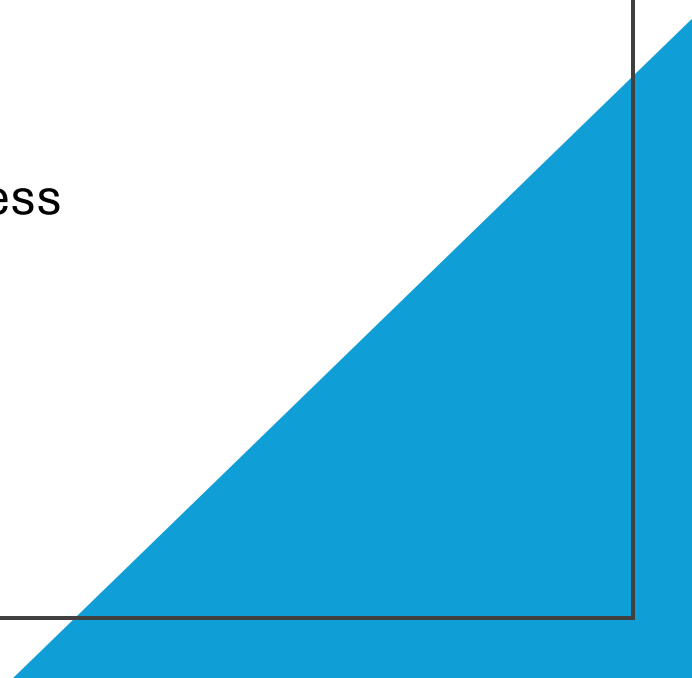
MAKE AN ACCURATE AND TIMELY DIAGNOSIS

- Use evidence-based dementia screening tools (6 CIT Dementia Test and Mini-Cog).
 - Incorporate the 6 CIT Dementia Test into the EHR system.
 - Identify key community partners (e.g., NM ADRC) to conduct timely evaluations, diagnostic assessments, and early intervention.
 - Train providers in the administration of the dementia screenings and dementia diagnoses.
 - Conduct follow-up with patients referred to NM ADRC to determine their evaluation outcomes.
- 

PROVIDE AN INTERDISCIPLINARY ASSESSMENT TO IDENTIFY NEEDS AND DEVELOP CARE PLANS

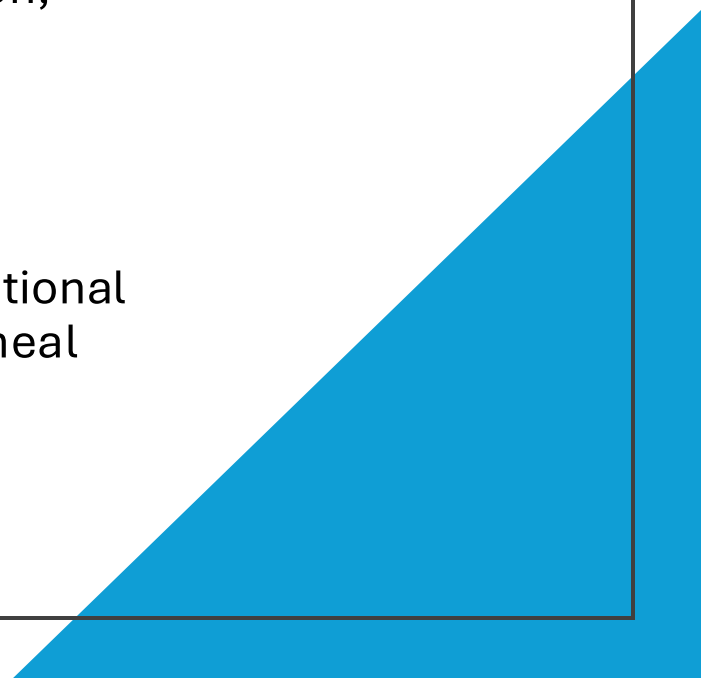
- CHW will complete social determinants of health (SDOH) screenings (e.g., PrePare) to identify social and other needs.
 - CHW will develop individualized care plans that address unmet SDOHs and quality of health needs (e.g., health, behavioral health, oral health, cultural and social support needs)
 - CHW will engage in multidisciplinary program referrals and communication to address SDOH and care plan needs and avoid duplication of services.
- 

PROVIDE COMPREHENSIVE, PERSON-CENTERED MANAGEMENT AND REFERRALS TO MEET NEEDS

- Project staff will engage patients and caregivers in the development and implementation of care plans.
 - Project staff will track completion of care plan goals.
 - Project staff will collaborate with patients and caregivers to address barriers that impede progress in completing care plan goals.
 - Project staff will conduct referrals and follow-up to FNCH and community programs to address needs.
- 

SUPPORT FOR CAREGIVERS

- Involve caregivers in project activities.
- Offer self-care education, including mindfulness activities, meditation, physical activities, etc.
- Provide caregiver support resources.
- Refer caregivers to various community organizations for support.
- Offer opportunities to participate in the center's programs (e.g., Traditional Wellness Program, Behavioral Health Services, ANWHC social and meal programs, etc.).



inly need necessary to extend life"	"Medical marijuana card assistance"
childcare, giving food boxes, hygiene"	"Food, clothing, shelter, transportation"
inacks"	"Massage therapy for chronic pain"
separate age groups to make appointment ticker"	"Transportation, translators for medical terminology"
quick processing to assist patients, clear explanation of care being provided"	"I'm really not the one to ask because I haven't used the services, but the biggest problem I've seen is the abuse problems"
medical interpreters services on phone or Dec"	"Classes for elderly with police or fire"
helping patients get Medicare coverage"	"Long term case management"
mental"	"More doctors!"
specialized case management to help veteran houses after they have passed away receive benefits"	"Home visit at regular hours daily or 3 days a week for household work and transportation"
ill care is good"	"Can't think of anything at the moment"
having a locking locker for personal items"	"Being patient with people"
family counseling, gym membership"	"Mental/emotional help"
senior programs"	"More for seniors"
terminal testing and care"	"Podiatry and social work"
urgent care facility"	"Help signing up for Medicaid and Medicare"
fast track into housing programs, food assistance, and food boxes"	"Food delivery for us who have trouble getting from place to place"
medical, BHS, dental, vision, xrays, and pharmacy"	"They provide plenty"
cash assistance and vouchers for stuff"	"Radiology"
inutile for the 60+ clients, issuing jackets too"	"I don't get homecare, which I need everyday"
free housing"	"I wish I could get help with buying groceries"
everything is great from First Nations"	"More assistance with transportation availability and assistance with knowing where I need to go"
medical interpreter services by phone or video"	"I don't know"

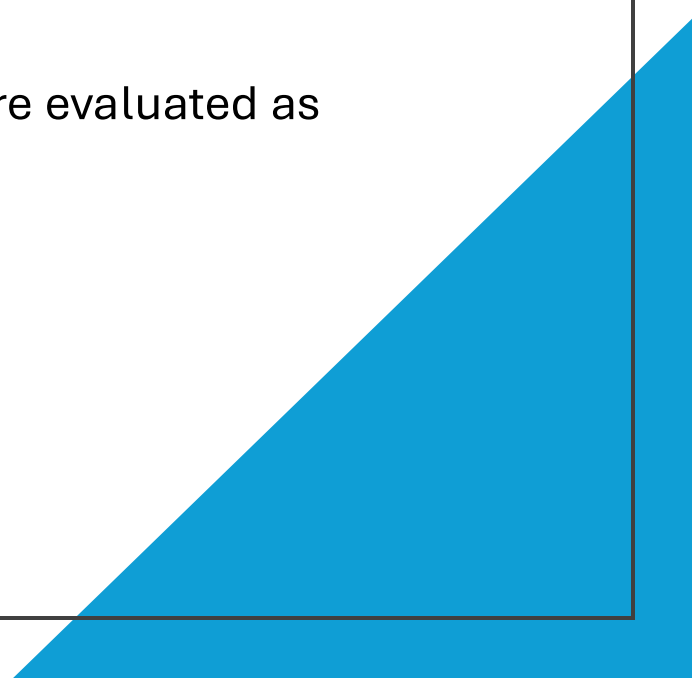
CLAIM TO FAME

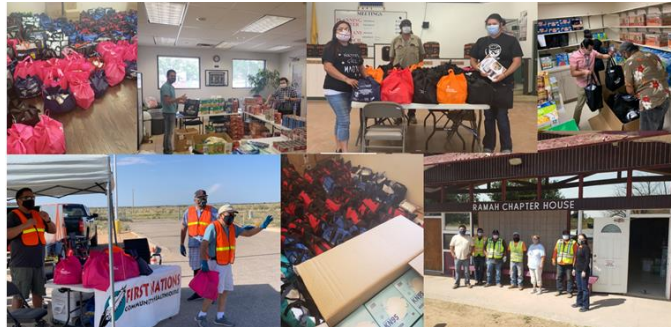
-Comprehensive Elder Needs Assessment Completed in 2025

-Surveyed 80 elders aged 60 and older- Foundation for FNCH's Dementia Screening Project



PERFORMANCE MEASURES

- Total number of individuals who completed the 6CIT and Mini-Cog.
 - Total number of individuals who screened positive on the 6CIT and Mini-Cog.
 - Total number of individuals who screened positive who were referred to the NM Alzheimer's Disease Research Center for further evaluation.
 - Total number of referred individuals evaluated by NM ADRC who were evaluated as experiencing symptoms consistent with dementia.
 - Total number of individuals who completed an SDOH screening.
 - Total number of individuals who completed a care plan.
 - Total number of individuals who completed care plan goals.
 - Total number of individuals with a caregiver.
 - Total number of caregivers referred to support activities.
- 



First Nations Community HealthSource

Supporting Native Community Members in Albuquerque and the Surrounding Areas

2026 IHS NATIONAL CLINICAL AND COMMUNITY WORKFORCE SUMMIT

BUILDING INDIAN HEALTH DEMENTIA MODELS OF CARE

Tuba City Regional Health Care Corporation

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LeChee Health Facility
Page AZ, 86040

Sacred Peaks Health Center
6300 US 89, Flagstaff AZ, 86004

Tuba City Regional Health Care Corporation
167 Main St, Tuba City, AZ 86045



Tuba City
Regional Health Care Corporation

Mission Vision

Tuba City Regional Health Care Corporation Dementia Program provides respectful, culturally sensitive care for individuals living with dementia and their caregivers. Our goal is to increase awareness, improve early diagnosis, and ensure patients receive coordination care, person-centered services. We'll work closely with families, providers, and community partners to create a supportive network of care that reflects the values and needs of our Native communities.



Awareness and Recognition

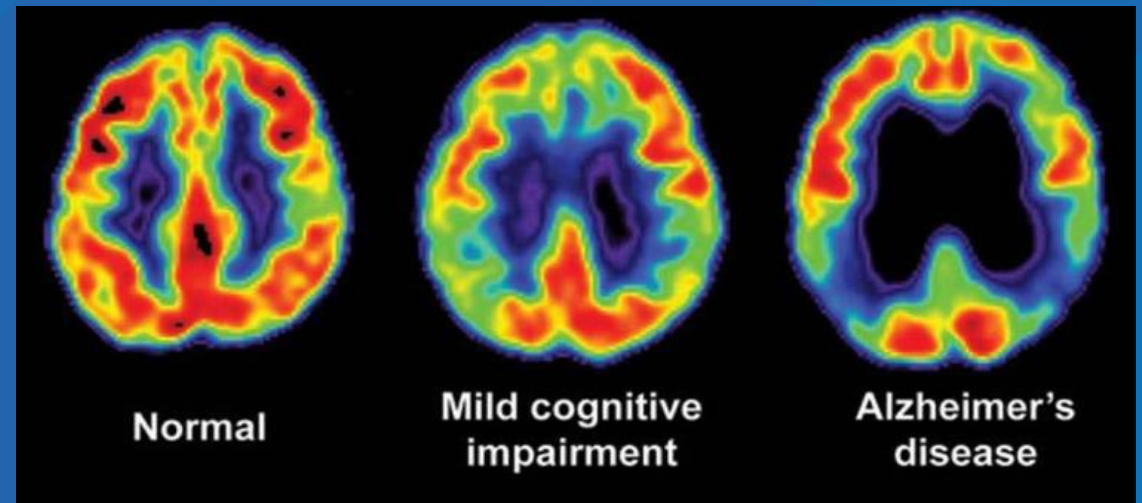
- Culturally-appropriate patient education materials
- Incorporate new materials into TCRHCC's patient education library
- Community presentation
- Lunch and Learn with staff
- Establish caregiving training
- Navajo voiceover brochure (PowerPoint)
- Informational program webpage within the company website
- Presented at Hopi Health Care
- Memory Clinic presentation
- Alzheimer's Association & So'Tsoh Foundation



Accurate and Timely Diagnosis

Screening tools

- MoCA testing
- Memory Loss – Patient Pre-Appointment Form and history
- Radiology (Brain Imaging)
- Labs



Interdisciplinary Assessment

Meet with departments such as:

- Dietary, PT/OT/Speech, Primary Care, and Psychiatry
- Workflow with Laboratory, Radiology, and the Infusion Clinic (for patients who receive Leqembi medication/treatment)
- Training staff to conduct MoCA screens
- Track identified measures using Altera EHR system



Management & Referral

Memory Clinic

- Work with our client services technician (CST) and CMA's to track of referrals that are incoming and outgoing
- Purchased Referred Care (Contract Health) when needed

Infusion Patient

- Patient registry using excel sheet of patient treatment, doctors visit, and referrals
- Organize outside referrals with Dr. Harris, Infusion RN & Program Coordinator if needed



Caregiver Support in a Rural Area

- Northern Arizona Alzheimer's and Dementia Alliance
- Alzheimer's Association
- So'Tsoh Foundation Measure
- Education level, Confidence, and Stress
- Support Groups in Flagstaff
- Caregiving training & 24/7 Hotline
- Navajo culturally appropriate caregiving and education
- Pre and post questionnaires & numeric rating scale



Claim to Fame

Building code within Python:

- That included real-time and feedback of patients enrolled the dementia program

Core Elements:

- Initial comprehensive evaluations
- Follow-up clinical encounters
- Diagnostic testing results (laboratory, imaging, and neuropsychological testing)
- Medication treatments and therapeutic adjustments
- Outside referrals and specialist coordination
- Active care tasks, pending items, and follow-through tracking

Goal: show what services have been completed and what services remain outstanding for each patients.



Neurotrack/Python

Monitoring

MRN: 2284-8891

ELIGIBILITY

✔ mAb Eligible

PRIMARY DX
Early Stage Alzheimer's Disease

BIRTH DATE
[REDACTED] (75y)

LAST EVALUATION
Oct 14, 2023

AI INSIGHTS

- MoCA score of 22 is consistent with mild cognitive impairment and supports the current diagnosis of early-stage Alzheimer's disease.
- At age 75, the patient requires regular functional assessments to monitor for a transition from mild cognitive impairment to dementia.
- The monitoring status indicates a need for longitudinal tracking of cognitive scores to evaluate the rate of disease progression.

MOCA Score Trend BASELINE: 26

Infusion Tracking LECANEMAB

Course Completion Cycle 4 of 12

Safety & ARIA

Next Safety MRI
Scheduled for Dec 15 (2 weeks)

ARIA Status: CLEAR
Last MRI: Sept 20, 2023

Clinical Master Topics

Select a module for simplicity of use and detailed history.

All
Clinical
Treatment
Diagnostics
Social

Core Identity
Patient demographics, contact info, and identity verification.

Visits
History of previous encounters and future scheduled...

DX (Diagnosis)
Primary and secondary neuro-cognitive diagnoses.

MOCA Score
Montreal Cognitive Assessment tracking over time.

Functional Status
ADLs, IADLs, and clinical staging (CDR-SB, GDS).

Imaging
CT, MRI, and PET scan records and reports.

Labs (Biomarkers)
Blood work, CSF biomarkers (p-tau, Amyloid beta).

Comorbidities
OSA, HTN, Diabetes, and other concurrent conditions.

Referrals
Interdisciplinary referrals (PT/OT, Psych, Social Work).

Driving Status
Legal driving status, family concerns, and testing results.

POA & Legal
Power of Attorney status, Advanced Directives, and legac...

Caregiver Info
Primary contact, caregiver burden assessment, and...

Medication Safety
Polypharmacy review, anticholinergic burden,...

SDOH/Barriers
Social Determinants of Health: housing, food, transportation.

mAb Eligibility
Criteria verification for monoclonal antibody therapies.

Amyloid Confirm
PET or CSF confirmation of amyloid pathology.

Baseline MRI
Detailed findings from baseline MRI prior to treatment.

ARIA Monitoring
Scheduled MRI safety checks for amyloid-related imaging...

Infusion Tracking
Real-time tracking of treatment cycles and side effects.

6-mo Registry
Mandatory documentation for long-term safety registries.

Clinical Master Topics

Select a module for simplicity of use and detailed history.

All
Clinical
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Performance Measures

PERFORMANCE MEASURE TABLE

Driver	Measure	Current	Goal	Status
Awareness & Recognition	Educational materials, training, community outreach	50/100 50%	>50	Meets
Accurate & Timely Diagnosis	Percentage of eligible patients screened for cognitive impairment using a standardized tool (e.g., MoCA).	78/157 41%	>25	Meets
Accurate & Timely Diagnosis	Percentage of dementia patients received memory loss-patient pre-appointment form	31/157 20%	<2	Not meet
Interdisciplinary Assessment	Formalize interdisciplinary team, tools and processes	7/12 2%	>6f	Meets
Management and Referral	Launch newest FDA approved monoclonal antibody infusion program, including providing education to providers, patients and families on treatment process	1/78	<0%	No/yes Only one patient but the program is set
Management and Referral	Specialty Services, PT, OT, Radiology -Based Referral Rate	20/78 26%	>25	Meets
Support Caregivers	Distribute educational materials to caregivers at appointments	54/78 69%	>50	Meets



Photo's



2026 IHS National Clinical and Community Workforce Summit

Building Indian Health Dementia
Models of Care

Site: Santo Domingo CHR

Increase Awareness and Recognition of Dementia

Activities	Accomplishments
<ul style="list-style-type: none">• Conduct community dementia education through outreach events, workshops, and conferences• Distribute culturally appropriate dementia education materials at community events and clinics• Implement public awareness campaigns during key observance months (June, September, November)• Share dementia education through Tribal newsletter and social media platforms	<ul style="list-style-type: none">• Increased visibility of dementia education• Improved understanding of dementia and available supports• Expanded access to culturally appropriate education• Strengthened conversations around memory and brain health• Increased awareness of dementia-related services

Make an Accurate and Timely Diagnosis

Activities	Accomplishments
<ul style="list-style-type: none">• Train CHR/CHWs annually on dementia recognition, screening, and referral• Implement dementia screenings (Mini-Cog, AD-8) in community and home-based settings• Train primary care providers and clinic staff on dementia diagnosis and referral pathways• Implement dementia screenings (Mini-Cog, AD-8) in community and home-based settings	<ul style="list-style-type: none">• Strengthened CHR/CHW capacity to support early identification and referral• Increased provider awareness and readiness to diagnose dementia• Implemented community-based dementia screening practices• Advanced development of a coordinated diagnostic and referral workflow with clinic partners

Provide Interdisciplinary Assessment to Identify Needs and Develop Appropriate Care Plans

Activities	Accomplishments
<ul style="list-style-type: none">• Establish an interdisciplinary dementia care team (CHR, clinic, behavioral health, senior center, PHNs)• Conduct quarterly interdisciplinary case review meetings for high-priority cases• Develop and pilot comprehensive assessment tools and care planning processes• Integrate cognitive screening tools (AD-8, Mini-Cog, RUDAS) into assessments	<ul style="list-style-type: none">• Assessment tools and intake process under development• Quarterly interdisciplinary meetings• Ongoing updates to assessment protocols based on best practices and community needs

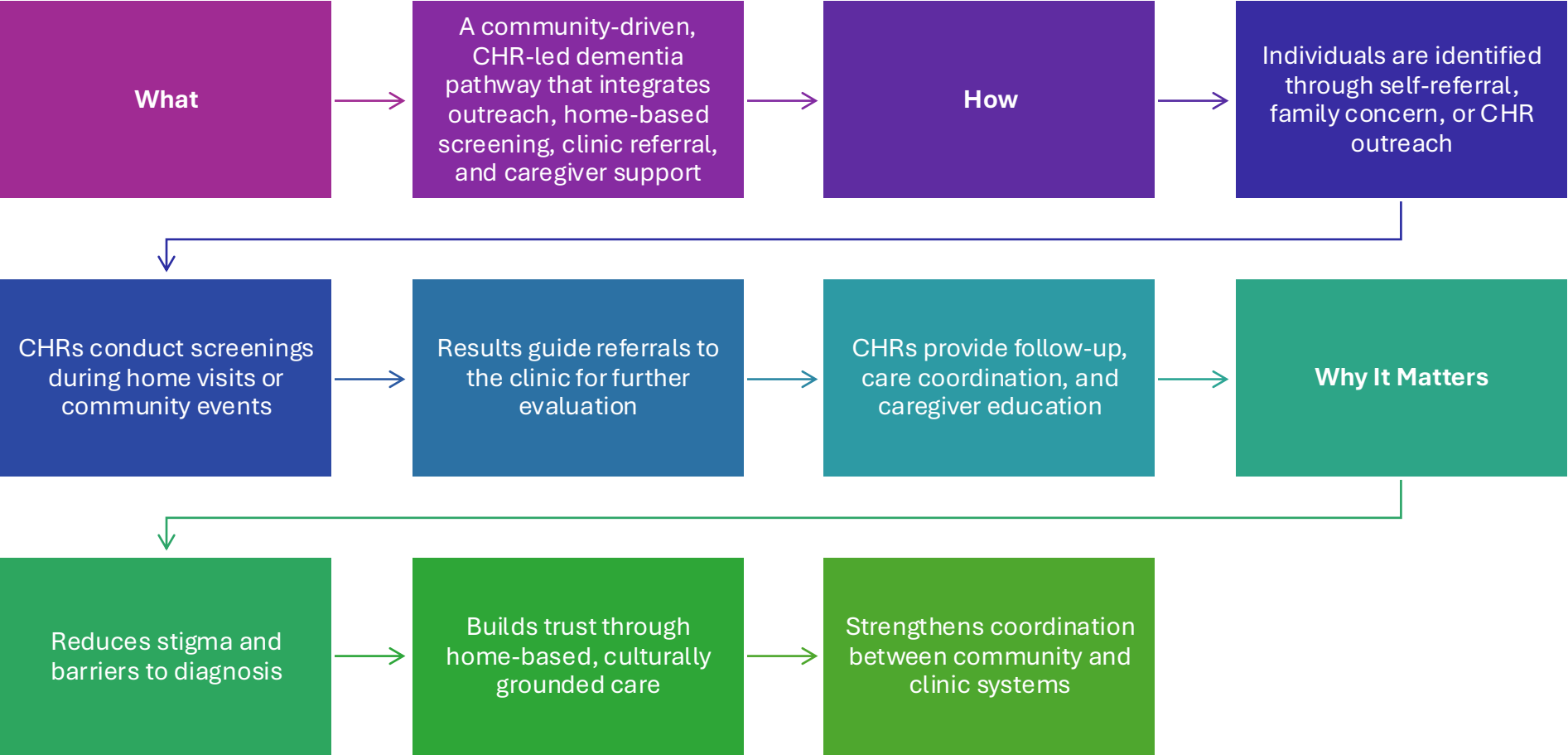
Provide Comprehensive, Person-Centered Management and Referral to Meet Needs

Activities	Accomplishments
<ul style="list-style-type: none">• Refine CHR-to-clinic referral processes and communication pathways• Develop care coordination protocols between community and clinical teams• Create individualized care plans for individuals living with dementia• Provide ongoing follow-up and reassessment for patients and caregivers	<ul style="list-style-type: none">• CHR referral process actively in use and being refined• Care coordination training delivered to CHRs• Continuous follow-up and support ongoing

Support for Caregivers

Activities	Accomplishments
<ul style="list-style-type: none">• Facilitate monthly caregiver support groups in collaboration with clinic partners• Provide respite care during caregiver support group sessions• Adapt and distribute caregiver-specific educational resources• Explore evidence-based caregiver interventions (REACH, Savvy Caregiver)	<ul style="list-style-type: none">• 10 clients supported• 6 caregivers participating in support groups• 3 patients enrolled in respite services• Planning underway to implement Savvy Caregiver program (2026)

Our Claim to Fame: CHR-Led Dementia Screening, Referral, and Care Coordination Model



This directly supports Drivers 2-4

Performance Measures

• Dementia Screening	Caregiver Support	Accurate & Timely Diagnoses
<ul style="list-style-type: none">• Y1: ~15 people screened• Y2 (as of 02/05/2026): 11 people screened with Mini-Cog	<ul style="list-style-type: none">• 10 clients supported• 6 caregivers participating in support groups• 3 patients enrolled in respite services	<ul style="list-style-type: none">• 12 CHR/CHWs trained (Y1)• ~10 primary care providers trained (Y1)

Santo
Domingo CHR
Healthy Aging
Team



Grant Acknowledgment

The Indian Health Service, Department of Health and Human Services (HHS) provided financial support for this Powerpoint presentation and the Culturally Tailored Care: Strengthening Dementia Support Networks in Indigenous Communities project. The award provided \$199,716 of total costs in support of this project. The contents are those of the author. They may not reflect the policies of IHS, HHS, or the U.S. Government.

2026 IHS National Clinical and Community Workforce Summit

Addressing Dementia in Indian Country Grant

Site: Confederated Tribes of Grand Ronde Community Health Department

The Indian Health Service, Department of Health and Human Services (HHS) provided financial support for this project, and work associated with the Brain Health Program. The award provided 100% of total costs associated with the program, including vehicle purchase, supplies and training as well as 25% salary of the Community Health Department Manager, and 100% salary for the Community Health Dementia Care Specialist and totaled \$198,603.00. The contents are those of the author. They may not reflect the policies of IHS, HHS, or the U.S. Government.

Increase Awareness and Recognition of Dementia

Secondary Drivers

Expand the Healthy Living Initiative to include three new wellness modules focusing on brain health for midlife adults (ages 50-64)

Increase the number of Elders and at-risk adults from receiving routine cognitive screenings by 10% from the 2024 baseline

Strategies

- Modules to focus on dementia risk reduction, incorporating traditional foods, language, physical activities, and stories. Each module to prioritize prevention, nutrition, and chronic disease education
- Incorporate educational programming into existing Elder gatherings, health fairs, and family wellness events
- Community led, in-home cognitive screening assessments on all case managed clients who meet criteria (55+)
- Medical clinic completing cognitive assessments as part of AWV and/or when concerns of cognition are present

Make an Accurate and Timely Diagnosis

Secondary Drivers	Strategies
Implement improved screening capabilities through DEMQOL	<ul style="list-style-type: none">• Dementia Care Specialist and trained CH staff will travel to homes and community centers to conduct screenings using validated tools and culturally safe approaches• Community led, DEMQOL screenings completed, and documented within EHR system on all dementia diagnosed case managed patients
Achieve 80% compliance for follow up visits after positive cognitive screening results	<ul style="list-style-type: none">• All screening outcomes will be integrated into the EHR, enabling streamlined referrals and automated alerts for follow-up care• Collaborate with primary care and behavioral health providers to implement EHR based care-coordination protocols
Increased training on cognitive health	<ul style="list-style-type: none">• Regular training will be provided on trauma-informed, culturally respectful communication about cognitive health, reducing stigma, and increasing acceptance of dementia diagnosis led by the CH Dementia Care Specialist

Provide Interdisciplinary Assessment to Identify Needs and Develop Appropriate Care Plans

Secondary Drivers

Implement a standardized interdisciplinary assessment protocol for individuals with positive screening results, with care plans developed for 90% of those assessed within 30 days of diagnosis

Strategies

- Develop protocol of interdisciplinary assessment usage for both diagnosed and non-diagnosed patients
- Develop protocol for Care Plan development with focus on patient facing and goal oriented in collaboration with Elder and support network
- These protocols will be developed with key stakeholders including CH Dept. Mgr., Dementia Care Specialist, and Case Managers
- Collaborate with NextGen Report writers to run monthly report of all dementia diagnosed patients

Provide Comprehensive, Person-Centered Management and Referral to Meet Needs

Secondary Drivers	Strategies
Integrate traditional brain health teachings and Tribal values into all educational, clinical, and caregiver materials	<ul style="list-style-type: none">• Collaborate with cultural department on traditional brain health teachings• Continue expanding Memory Café' model, integrating traditional food, crafts, songs, and cultural exchange to reduce social isolation and increase engagement• Education materials and caregiver handbooks, co-created with Tribal Elders and cultural consultants, revised annually
Embed dementia care into the Tribe's strategic health plan and operating budget; including dedicated FTE for dementia program leadership and care coordination	<ul style="list-style-type: none">• Maintain accurate referral records, and services provided to dementia patients and their caregivers• Secure long-term sustainability, budgeting for 1 FTE Dementia Program Lead

Support for Caregivers

Secondary Drivers

Launch a caregiver peer mentorship network featuring at least 3 trained Tribal Caregiver Champions and reaching 15 active caregiver participants

Strategies

- Offer caregiver support groups in person, virtually, and 1:1 – identify champions
- Caregiver/Dementia capable workshops to be offered quarterly
- Workshops and support group topics will be developed with key stakeholders including the caregivers in attendance, maintaining open dialogue, and room for shared discussion to further lead the future care groups
- Deliver comprehensive education and training series tailed to two primary care groups: (1) professional caregivers; (2) non-paid family caregivers

Our Claim to Fame is Support for our Caregivers

Selecting a book that was written from the perspective of a caregiver of someone living with dementia or from someone themselves living with dementia, allows for a person-centered approach. Additionally, allowing the individual chapters to lead our conversations with prompts specific to the chapters, allows for those who may not be comfortable sharing their personal situations, still a chance to learn and ask questions as they relate.

Our hopes is that as the book club continues, our "Mind Readers" will become more comfortable with each other as each session is the same members at each meeting, that they will then ask questions and share their personal experiences, stories, and learn from each other.

Additionally, with the book club, we are hopeful that we will be able to identify Tribal Caregiver Champions who will be valuable in supporting both our caregiver of our newly diagnosed elders, as well as the seasoned caregiver.

Starting Tue. February 24th!

CAREGIVER BOOK CLUB

MIND READERS

EVERY
1ST & 3RD
TUES.

10:00-11:30 AM
&
3:30-5:00 PM

CTGR Tribal
Library

9615 Grand Ronde Rd. Grand Ronde, OR

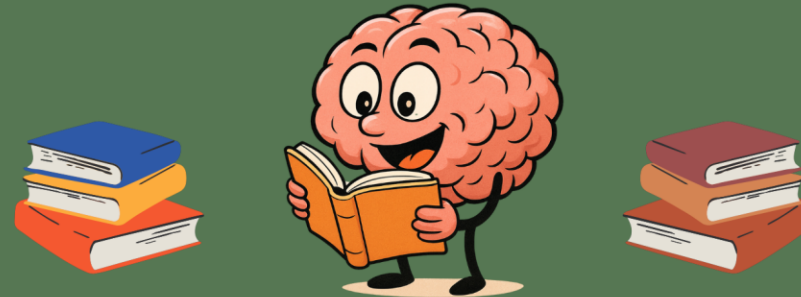


Join the Mind Readers Book Club—a new, free, supportive space for caregivers to learn, connect, and grow through reading. Designed for those caring for loved ones with memory loss, dementia, or Alzheimer's.

Books are FREE & provided for all CTGR members

PRE-REGISTRATION REQUIRED BY 2/1/26!

(Please specify your preferred book club time)



CALL COMMUNITY HEALTH TO REGISTER 503-879-2078

"The Indian Health Service, Department of Health and Human Services (HHS) provided financial support for this project, and work associated with the Brain Health Program. The award provided 100% of total costs associated with this handout. The contents are those of the author. They may not reflect the policies of IHS, HHS, or the U.S Government."

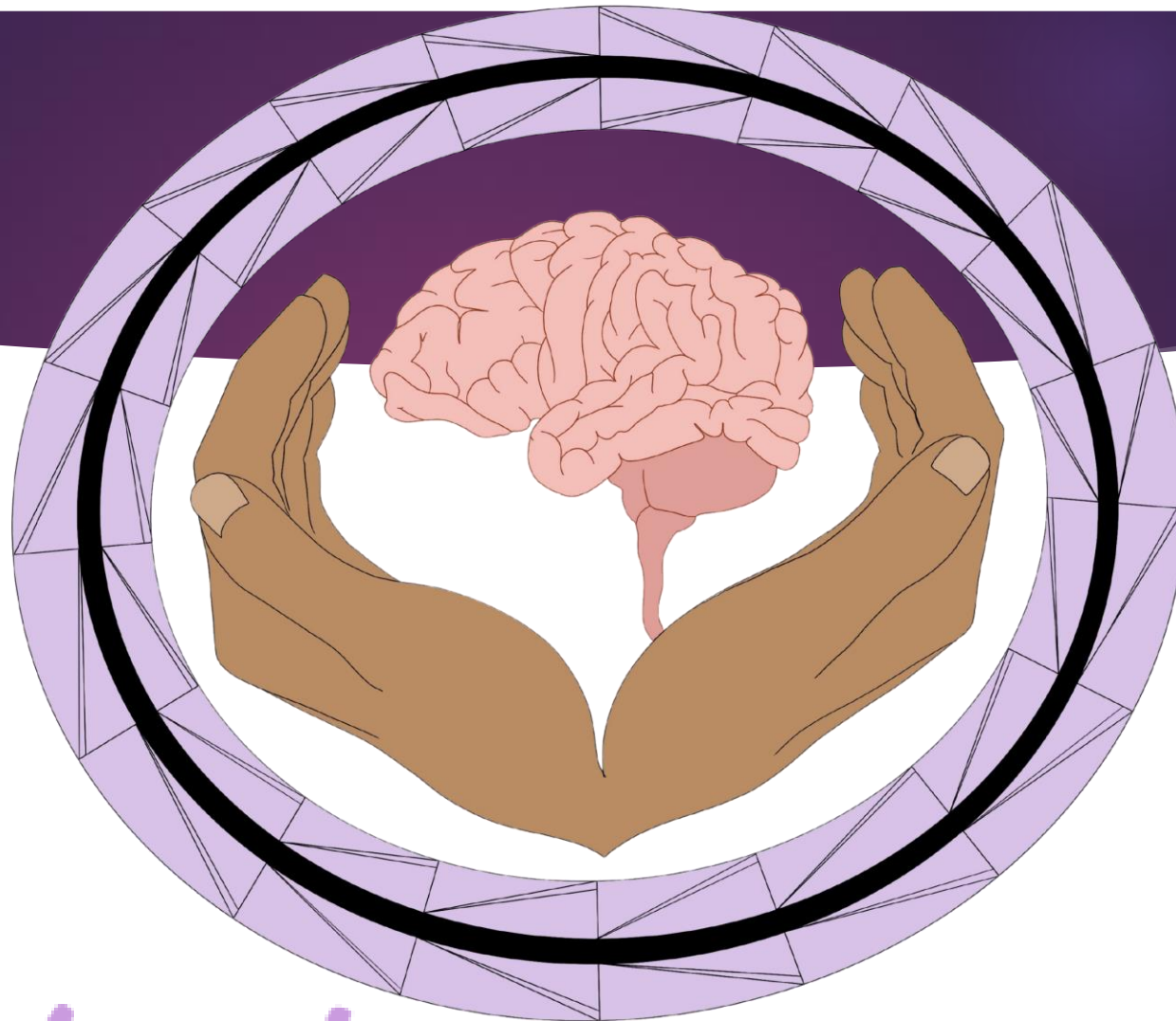
Performance Measures:

RED: Did not meet goal/GREEN: Met/Meeting Goal/Yellow: On Track for Meeting Goal

Driver Category	Metric	Year 1 (outcome/goal)		Yr 1 %	Year 2 (outcome/goal)		Yr 2 %	Notes
Awareness & Recognition	Healthy Living Brain Health Modules	0	3 per yr (n=3)	0		3 per yr (n=3)		
	Culturally integrated educational materials	100	Educational materials updated (n=100%)	100%		Educational materials updated (n=100%)		
Accurate & Timely Diagnosis	Routine Cognitive Screenings	31	Increase of 10% (n=87) – active population of 622	46.97%		Increase of 10% (n=87) – active population of 622		
Management & Referral	Care Coordination Follow Up upon positive screening	5/13	Compliance Rate for follow-ups within 30 days (n=80%)	63.25%		Compliance Rate for follow-ups within 30 days (n=80%)		
Interdisciplinary Assessment	Interdisciplinary Assessment Protocol	4/4	Care Plans completed within 30 days of diagnosis (n=90%)	100%		Care Plans completed within 30 days of diagnosis (n=90%)		
Support for Caregivers	Caregiver mentorship network	0	Number of trained champions (n=3)	0		Number of trained champions (n=3)		
		0	Number of active participants (n=15)	0		Number of active participants (n=15)		
Other Grantee-Defined Measures	Strategic integration and FTE Planning	MEETS	Meets/Does Not Meet	MEET		Meets/Does Not Meet		



COMMUNITY HEALTH TEAM



tush xumxum



**Stretch Break – Be back
in 10 minutes**

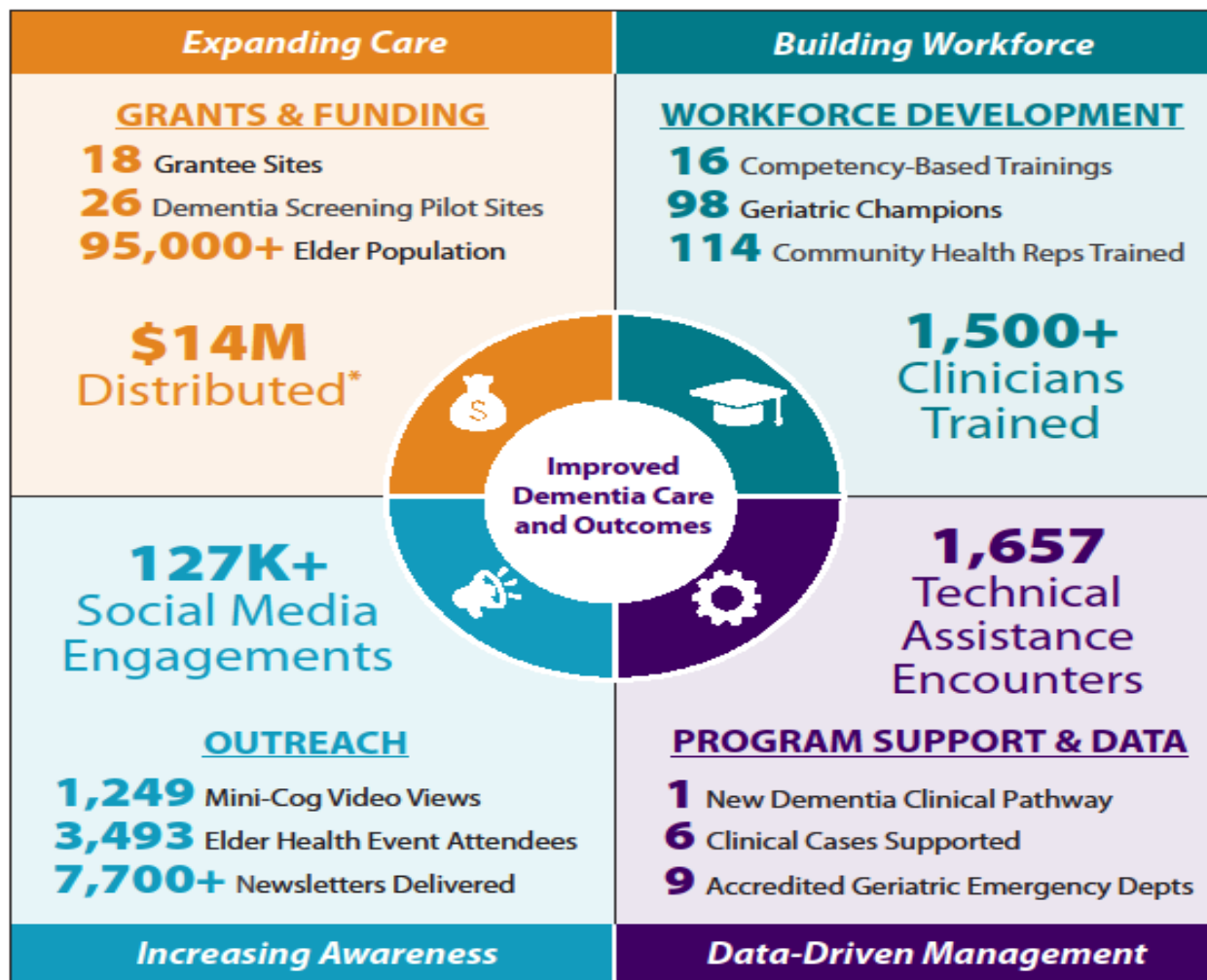


IMPACT OF ELDER HEALTH AND ALZHEIMER'S PROGRAM

American Indian and Alaska Native elders experience high dementia rates yet face significant disparities in early detection and culturally responsive care. In 2021, IHS received first-time funding to improve dementia care and services.



A tribally driven, coordinated approach



*2022-2028 grant obligations and 2022-2025 program distribution



2026 IHS National Clinical and Community Workforce Summit

Addressing Dementia in Indian Country Grant

Site: Cherokee Nation

The Indian Health Service, Department of Health and Human Services (HHS) provided financial support for this project. The award totaled \$600,000.00. The contents are those of the author. They may not reflect the policies of IHS, HHS, or the U.S. Government.



Increase Awareness & Recognition of Dementia

- **Media Campaign:** Cherokee Nation Health Services social media and signage throughout the reservation
- **Community Education:** Partnership with the Alzheimer's Association for training and content
- **Guest Speakers:** Experts from the Alzheimer's Association and Human Services have provided presentations to the public and staff
- **Outreach Events:** Attending at-large gatherings, district community meetings, Walk to End Alzheimer's, Cherokee Nation Elder Summit, and other tribal/community events



Make an Accurate and Timely Diagnosis

- **Health Care Navigation:** Patient Navigator provides guidance for diagnosis process
- **Primary Care:** Comfortable with initiating diagnosis process and making appropriate referrals
- **Resident Clinic:** Offering screenings using the RaDar screening tool through a PI project
- **Staff Education:** Internal promotion of our Patient Navigator and guidance for where patient/caregiver should be directed for assistance
- **Screening Events (TBD):** Hopeful to host Mini-Cog screening event in the future
- **Cherokee MoCA (TBD):** Working with Neurology & MoCA to develop Cherokee adaptation



Provide Interdisciplinary Assessment to Identify Needs and Develop Appropriate Care Plans

- **Individualized Care:** Patient Navigator works with patients/caregivers to identify individual needs and facilitate care across disciplines – develops care plans and paths in collaboration to ensure that goals/treatment are aligned
- **Workgroup:** Internal workgroup with representation from various CNHS departments
- **Advance Care Planning:** Patient Navigator meets with patients/caregivers to discuss future preferences



Provide Comprehensive, Person-Centered Management and Referral to Meet Needs

- **Personalized Care Management:** Patient Navigator provides assistance with internal/external referrals and any other health care navigation needs – help remove any barriers to accessing care
- **Patient Registry:** Complete list of all patients with an existing diagnosis – allows our team to initiate contact
- **Focus Groups (TBD):** Hopeful to host focus groups to identify opportunities to better serve this population



Support for Caregivers

- **Caregiver Support Groups:** Partnership with the Alzheimer's Association for training and advertisements
- **One-On-One Caregiver Coaching:** Patient Navigator works with caregivers to assist in needs identification, resource connection, and more
- **Collaboration:** Working with PACE, Human Services, and others to help caregivers address needs
- **Caregiver Needs and Burden Assessment (TBD):** Funds allocated to create safer environments & meet caregiver needs and relieve burdens




Our Claim to Fame is: Caregiver Support

- Patient Navigator provides 1:1 consultations
 - Forms ongoing relationships with caregivers/patients to provide individualized guidance as needs evolve
 - Provides assistance navigating health care and holistic needs to improve quality of life
- Partnership with Alzheimer's Association has been instrumental in establishing caregiver support groups and community education
 - Attendance has picked up since December – media campaign success
 - Create a sense of community and fellowship
 - Guest speakers provide additional insight
 - Follow-up “newsletter” sent out to attendees to inform them of resources
- Useful giveaways such as Apple AirTags and Travel Vouchers
- Working through logistics for Caregiver Needs and Burden Assessment
 - Plan to partner with Cherokee Nation departments to meet the identified needs and address common themes related to caregiver needs & burdens







2026 IHS National Clinical and Community Workforce Summit

Addressing Dementia in Indian Country Grant: Models of Care

Site: Indian Health Council, Inc.

Increase Awareness and Recognition of Dementia

Drivers	Activities	Measures
<p>Increase ability to recognize cognitive impairment in the community and clinical settings</p>	<ul style="list-style-type: none"> • Increase clinical and community-based staff understanding of dementia • Improve the ability of clinical and the community to detect cognitive impairment • Use Data to identify patients at risk 	<ul style="list-style-type: none"> • Cognitive health screenings completed (SLUMS, Mini Cog, MMSE) • New diagnoses of cognitive impairment/dementia
<p>Build on cultural strengths and resources to increase dementia awareness in the community</p>	<ul style="list-style-type: none"> • Provide education and offer screenings at Tribal and Community gatherings • Gather input at Elder mtgs to build culturally appropriate materials 	<ul style="list-style-type: none"> • Focus groups • Qualitative assessments
<p>Increase awareness in Tribal and health services leadership to build partnerships with Tribal programs</p>	<ul style="list-style-type: none"> • Integrate into health system governance • Address dementia with Tribal Leadership • Build partnerships with Tribal Leadership • Develop Data Sources for Tribes or Urban Populations 	<ul style="list-style-type: none"> • Meet with tribal leaders • Coordinate with Elder communities

Make an Accurate and Timely Diagnosis

Drivers	Activities	Measures
Increase clinical capability in evaluation of cognitive impairment and diagnosis of dementia	<ul style="list-style-type: none">• Train providers in evaluation and diagnosis• Train on specific tools for evaluation of cognitive impairment• Develop internal geriatrics expertise	<ul style="list-style-type: none">• Use outside consultants for education on evaluating cognitive impairment and its diagnoses (eg. UCLA-ADC, Alzheimer's San Diego)• Storytelling
Build systems to support evaluation and diagnosis	<ul style="list-style-type: none">• Use standardized approaches to evaluation and diagnosis• Build standard workflow supported by the EPIC EHR• Capture reimbursement for evaluation of cognitive impairment	<ul style="list-style-type: none">• Assess approaches to diagnosis in provider assessments (eg. Bellantoni presentation/SOP)• Assess reimbursements in those diagnosed (UCLA-ADC 99348)
Develop external resources to support evaluation and diagnosis	<ul style="list-style-type: none">• Develop specialty referral resources	<ul style="list-style-type: none">• Assess use of external resources (Neurology Center, E-Consult, Dementia ECHO)

Provide Interdisciplinary Assessment to Identify Needs and Develop Appropriate Care Plans

Drivers	Activities	Measures
<p>Individualized assessments for the individual with cognitive impairment or dementia and their care partners</p>	<ul style="list-style-type: none"> • Establish a care pathway from diagnosis through Assessment and Plan of Care • Engage multiple disciplines in support of assessment and care planning • Define the assessments/care plans • Judicial Support and Review for complex cases 	<ul style="list-style-type: none"> • Include assessed patients in cognitive health registry • Review clients in Interdisciplinary Case Management meeting monthly
<p>Integrate community-based assessment and clinical assessment in a unified plan of care</p>	<ul style="list-style-type: none"> • Build standard workflows supported by EPIC • Capture workflow for Assessments and Planning • Assess presence of advanced directive, financial/social POA or conservatorship 	<ul style="list-style-type: none"> • Coordinate with Epic Electronic Medical Recorded ESAs for Workflow • Increase the percentage of patients referred to ICM

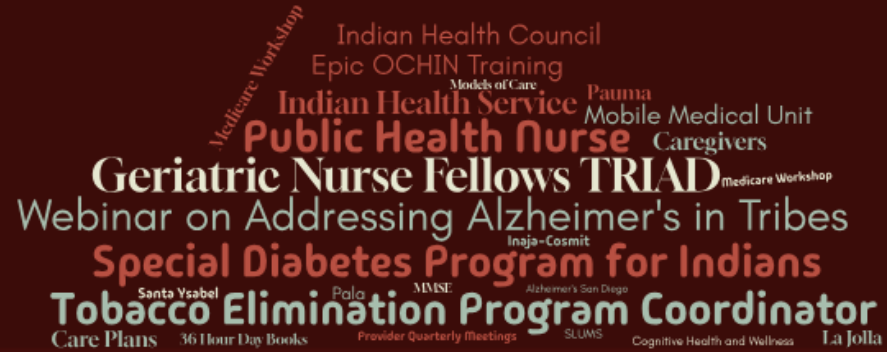
Provide Comprehensive, Person-Centered Management and Referral to Meet Needs

Drivers	Activities	Measures
Care management and navigation	<ul style="list-style-type: none"> Proactive management and periodic assessment with support for individuals living with dementia Maintain an integrated registry for clinical and community-based management 	<p>Assess effect on patients Quality of Life Measures (DEMQOL > ADC QOL)</p> <p>Partner with Chronic Care Mgt (CCM) Visits</p> <p>Partner with RPM (Remote Patient Monitoring) Visits</p>
Develop clinical consultation and referral resources	<ul style="list-style-type: none"> Develop relationship with referral resources for specialty dementia management Referral Resources for VA E-Consult for Neurology 	<p>Coordinate care and establish working professional relationships with the community</p> <p>Assess patient and caregiver satisfaction</p>
Develop Tribal and Community based resources	<ul style="list-style-type: none"> Grow referral relationship with Tribal and community-based organizations 	<p>Collaborate with tribe biannually on resources for patients and families</p>

Support for Caregivers

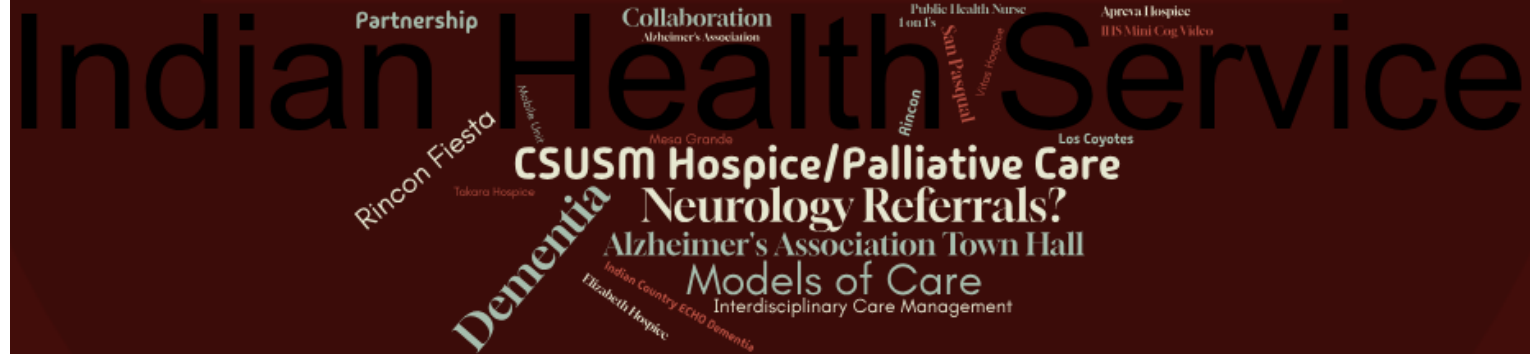
Drivers	Activities	Measures
Identify caregivers and assess needs	<ul style="list-style-type: none"> • Incorporate identification of care partner in all health records (eg. DPOA, DPR) • Incorporate assessment of caregiver need into the care of individuals with cognitive impairment 	<ul style="list-style-type: none"> • Assess QOL measure for caregivers once identified in Epic medical record (DEMQOL > UCLA ADC)
Education and support for Caregivers	<ul style="list-style-type: none"> • Provide “just-in-time” education and support for caregivers and family during visits • Provide a systematic, evidence-based program of caregiving support for families 	<ul style="list-style-type: none"> • Determine # of dementia patients for education at home along with Mini-cog screening • Number of 36 Hour Day Books given
Provide respite care for caregivers	<ul style="list-style-type: none"> • Collaborate with Tribal Programs or Community-based services for respite care services (Tribal Rest Care Facility) 	<ul style="list-style-type: none"> • # of Tribal Program/Community-based contacts
Increase understanding of dementia and caregiving in the community	<ul style="list-style-type: none"> • Incorporate education on important topics related to dementia caregiving into community outreach and education opportunities 	<ul style="list-style-type: none"> • # Assess knowledge with simple community assessments • UCLA ADC Caregiver Survey

Our Claim to Fame is: Collaboration!!



A word cloud of various projects and programs. The most prominent words are 'Public Health Nurse', 'Geriatric Nurse Fellows TRIAD', and 'Tobacco Elimination Program Coordinator'. Other visible words include 'Indian Health Council', 'Epic OCHIN Training', 'Mobile Medical Unit', 'Webinar on Addressing Alzheimer's in Tribes', 'Special Diabetes Program for Indians', 'Inaja-Cosmit', 'Alzheimer's San Diego', 'Santa Ysabel', 'Pala', 'MMSE', 'Care Plans', '36 Hour Day Books', 'Provider Quarterly Meetings', 'SLUMS', 'Cognitive Health and Wellness', 'La Jolla', 'Medicare Workshop', 'Models of Care', 'Pauma', and 'Caregivers'.

Our Claim to Fame is:



A word cloud of various collaborations and partnerships. The most prominent words are 'Indian Health Service' and 'CSUSM Hospice/Palliative Care'. Other visible words include 'Partnership', 'Collaboration', 'Alzheimer's Association', 'Public Health Nurse', 'Apreva Hospice', 'BBS Mini Cog Video', 'Rincon Fiesta', 'Mesa Grande', 'Los Coyotes', 'Neurology Referrals?', 'Alzheimer's Association Town Hall', 'Models of Care', 'Interdisciplinary Care Management', 'Indian Country ECHO Dementia', 'Elizabeth Hospice', 'Takarua Hospice', 'Mesa Grande', 'Rincon', 'Santa Pascual', 'Vista Hospice', 'Los Coyotes', 'Mesa Grande', 'Rincon', 'Santa Pascual', 'Vista Hospice', 'Los Coyotes', 'Mesa Grande', 'Rincon', 'Santa Pascual', 'Vista Hospice', 'Los Coyotes'.

Performance Measures n= 127 (142) registry pts

Driver Category	Metric	Year 1 (outcome goal)	Yr 1 %	Yr 2	Notes
Awareness & Recognition	#POC with outside agencies N=12 (10)	Greater than 10	100%		Approx. value based on service area and established contacts
Accurate and Time Diagnosis	#tribal members POC n= TBD	Goal for POC Tribal Members: >150	100%		(Note: POC n=150 acquired at large tribal gathering)
	Build support for optimal care IDT n = 13	Optimal Care: goal ~127 (142)	13/125 = 10% (13/142 = 9%)		
	Develop Resources for support N=11	Develop Resources: goal ~ 20	11/20 = 55% (N/C)		
Interdisciplinary Assessment	Number of cases reviewed ICM Mtgs N = 11 (N=13)	Cases reviewed: goal ~ 125 (142)	9/125 = 7% (13/142 = 9%)		Approx. value based on service area and established contacts
	Develop Ext Resource (POC) N=24	Develop Ext. Resource: goal ~ 50	24/50 = 48% (N/C)		
Management and Referral	Number of referrals to ICM N=5	Number of referrals to ICM: goal ~ 142	5/142 = 3.5%		Approx. value based on service area and established contacts
	Neurology referrals N=16	Neurology referrals: goal ~ 125 (142)	16/125 = 12% (1/142 = 0.7%0)		
	Develop referral resources for pts and caregivers N= 11 (5)	Develop referral resources for pts and caregivers: goal ~30	11/30 =37% (5/30 = 16%)		
	Formal tribal relations/ community based orgs. N=2 (Pala, SY, SP, LJ)	Formal tribal relations/ community based orgs: goal ~ 9 (9 consortia tribes)	4/9 = 44% (2/9 = 22%)		
Support for Caregivers	Implement "Community of Care" for pts/tribes N=5	Implement "Community of Care" for pts/tribes: goal ~ 9	5/9 = 55% (N/C)		(9 consortia tribes)
	Develop culturally adapted resources for pts/caregivers N=1/9 (N=tbid)	Develop culturally adapted resources for tribal* pts/caregivers: goal ~ 9 *tribal is new	1/9 = 11% (0/142 = 0%)		
Quality of life measure	DEMQOL measure: In progress	DEMQOL measure: goal ~ 142	0/142 = 0%		

Indian Health Council, Inc Cognitive Health and Wellness Program Indian Health Service Models of Care

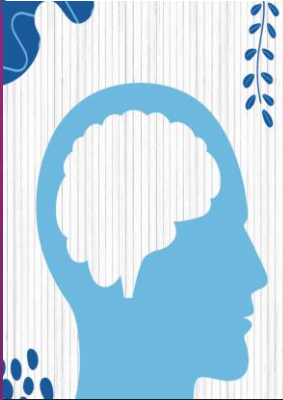


INDIAN HEALTH COUNCIL
MOBILE MEDICAL UNIT

We are excited to announce our new Mobile Medical Unit will be visiting Pauma Reservation!
Every 1st Thursday starting February 5, 2026
9AM - 1PM

- Acute sick visits
- DM Checks/follow up
- Hospital follow ups
- Wellness checks
- Cognitive screenings
- General checkups

We will be located at
Pauma's Church Parking Lot
Must be a registered IHC patient.
Walk-ins are welcome, or call for an appointment: 760-749-1410



Promoting Dementia Awareness



INDIAN HEALTH COUNCIL, INC.
MEDICAL DEPARTMENT
www.indianhealth.com





FALLON TRIBAL HEALTH CENTER

Addressing Dementia in Tribal and Urban Communities

2026 IHS National
Clinical and
Community Workforce
Summit

H1H8IHS0024-01-00 This project was awarded by The Indian Health Service, Department of Health and Human Services (HHS) and provided financial support in the amount of \$184,996.00. The contents are those of the author. They may not reflect the policies of IHS, HHS, or the U.S. Government.



Increase Awareness and Recognition of Dementia

The Dementia program will continue to inform and educate our community and providers on how important it is to get diagnosed in the early stages of Alzheimer's and Dementia so our clients can live a healthy and prosperous life.

- Caregiver Support Groups meet by-monthly at the Stillwater Tribal Senior Center
- Present the film Pesa Sooname-A story of identity, community, and dementia
- DEER Program- University of Nevada Reno Dementia Program-Summit
- American Heart Association Collaboration
- Dementia 5k walk
- Steering Committee meets monthly to discuss the dementia program goals
- Provider Meetings every Tuesday to help with communication and proper dx
- Newsletters- Delivered to the entire Tribal and Health Center population
- Mobile Clinic to reach those in remote areas with limited access to care
- Educational awareness booth are available at every tribal event





Make an Accurate and Timely Diagnosis

FTHC providers are implementing and assessing elderly clients during their medical screenings, which gives them an accurate diagnoses for further care management.



Screening at all Medicare annual visits

Patient Advocate and Dementia Care Specialist are teamed up to ease navigating through the medical process:

Helps with private access to appointments

Improves timely diagnosis with providers as they are aware of concerns prior to appointment



Comfort and support to family and caregivers

Providers are trained on our pathway to care. We discuss challenges, patient progress and hand off assessment to patient advocate for further resources such as:

Audiology

Neurology

Wellness-Dietician-Exercise

Behavioral health-substance abuse-mental illness-mental health



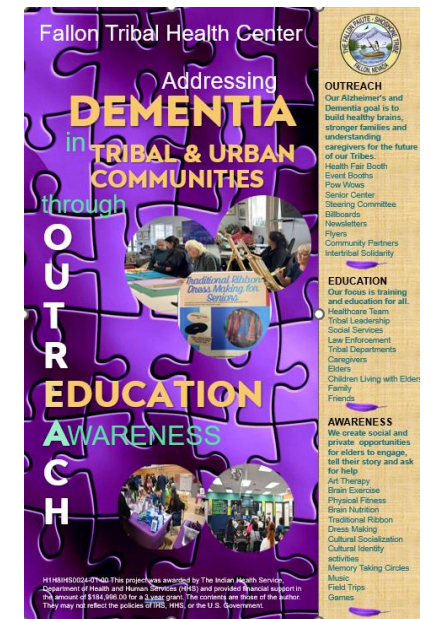
Provide Interdisciplinary Assessment to Identify Needs and Develop Appropriate Care Plans

Our entire steering committee members are completing Mini Cogs and MOCAS during medical appointments or patient encounters. They have had outstanding acceptance and participation with our elders wanting to be tested. New biomarker testing will allow us to tests for pre dementia markers.

1. This year we are implementing Biomarker testing through our lab



2. Education for our CHR transporters, IHHA, Housing, Law enforcement and other frontline workers to collaborate, identify and handle effectively when interacting with patients dealing with Dementia. This is done through team meetings and trainings



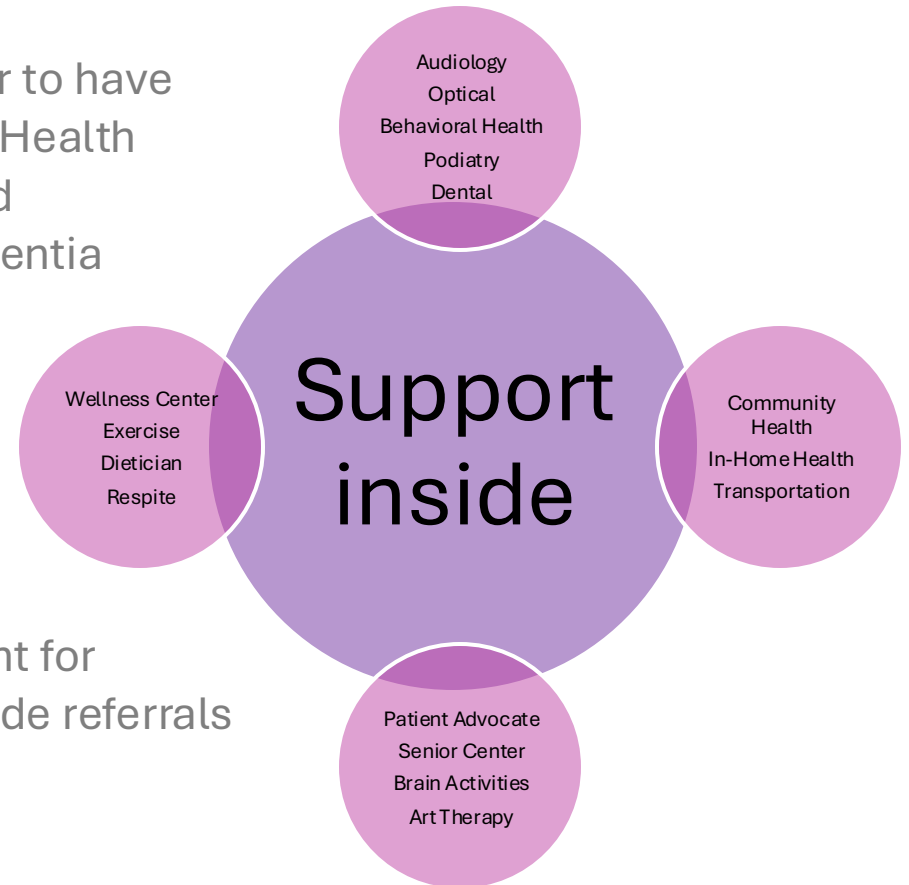
Provide Comprehensive, Person-Centered Management and Referral to Meet Needs

We are very lucky at our Tribal Health Center to have our very own Patient Advocate, Community Health Nurse and In-Home Health Aide, CHR's, and Behavioral Health as resources for our Dementia program



Discrete Scheduling
Family Engagement
In-Home Health Services

We have a very engaged referrals department for access to outside care, resources and outside referrals



We evaluate through Greenway EHR care plan feature, which allows us detailed tracking on each patient placed in the Dementia Care Plan

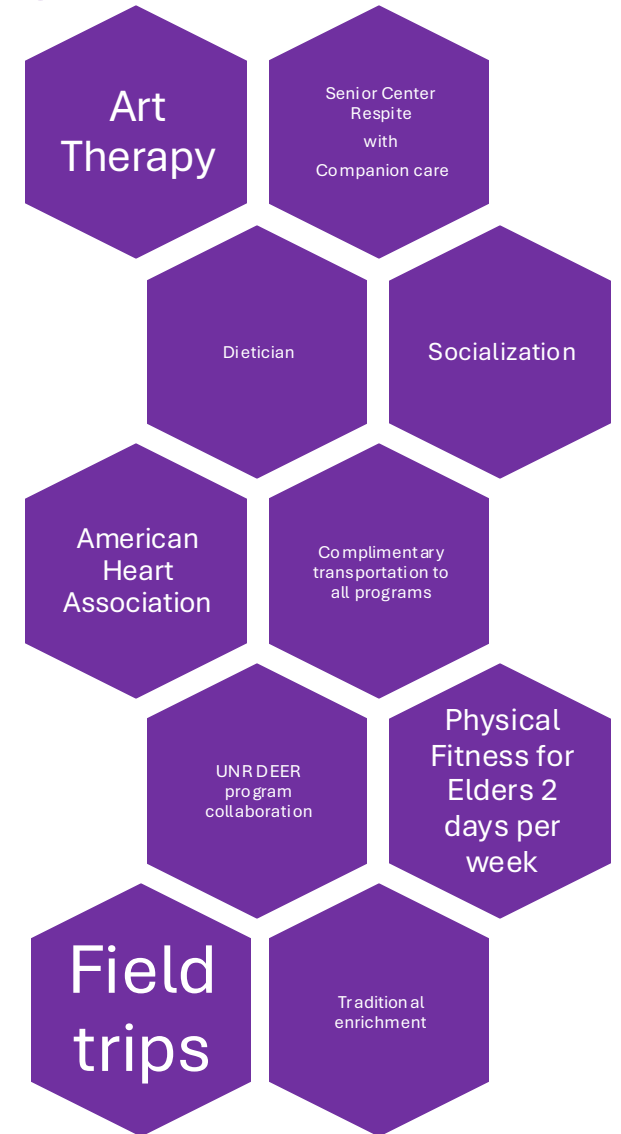


Support for Caregivers

The Fallon Tribal Health Center Dementia Program provides **support groups** for families, dementia clients, and community members two times a month. The meetings are a place for attendees to feel safe and can discuss the challenges that they are facing and what to expect while caring for their loved ones.

This year we are adding caregiver trainings targeted toward specific caregiver needs, respite and self care.

All events are tracked by attendance





Our Claim to Fame: Team Collaboration and Dementia Registry





Performance Measures (include numerator and denominator):

We are tracking all patients that flow through the pathway to care by adding anyone diagnosed to our Greenway care plan. The Greenway care plan is a tag in the EHR chart that tracks all medical data for us such as appointments, referrals, outcomes

	Metric	Year 1 Outcome	Year 1 Goal	% Over/Under	Year 2 Outcome (Partial Year #'s)	Year 2 Goal	% Over/Under
Outreach and Awareness	Flyers and Newsletter	8	16	50%	4	16	25%
	Art Therapy	N/A	N/A	0%	24	48	50%
	In Person Care Planning	1	25	4%	22	31	71%
	Fitness Activity/Dietician	2	48	4%	24	48	50%
	Events	2	8	25%	7	16	44%
Assessments & Greenway care plan tracking	Mini Cogs	5			21		
	Greenway EHR Care Program Tracking	19 active in tracking program			45 active in tracking program		
Care Giver Support	Support Groups	6	24	25%	14	24	58%
	Wellness/Senior Center Programs	1	52	2%	24	52	46%
Steering Committee/Provider Training	Training/Meeting on dx and pathway to care	2	12	16%	24	12	150%



2026 IHS National Clinical and Community Workforce Summit



Peesha U
from the entire FTHC Team

2026 IHS National Clinical and Community Workforce Summit

Building Indian Health Dementia Models of Care

Site: Indian Health Board of Minneapolis



Increase Awareness and Recognition of Dementia

Cognitive screening in the community

Elder's Brain Health Day

Dementia education series (9-week class series)

Elder's First Prevention group

Screening of "Missing Pieces" by Nimiipuu Health to all IHB staff

Collaboration with community partners

Outreach events



Make an Accurate and Timely Diagnosis

Cognitive Screenings in the clinic

Interdisciplinary approach to Medicare Annual Wellness Visits

Lunch and learn with Dr. Bellantoni

Dementia Champion team

The image shows two pages from a test manual. The left page is titled "Mini-Cog" and "Instructions for Administration & Scoring". It includes sections for "Step 1: Three Word Registration", "Step 2: Clock Drawing", and "Step 3: Three Word Recall". A table lists six versions of the test with their respective word lists. The right page is titled "Clock Drawing" and features a large circle for the drawing task, along with a "References" section listing several academic papers.



**Indian
HEALTH BOARD**
COMMUNITY TRADITION WELLNESS

Provide Interdisciplinary Assessment to Identify Needs and Develop Appropriate Care Plans

Interdisciplinary team began January 2025 – monthly meetings

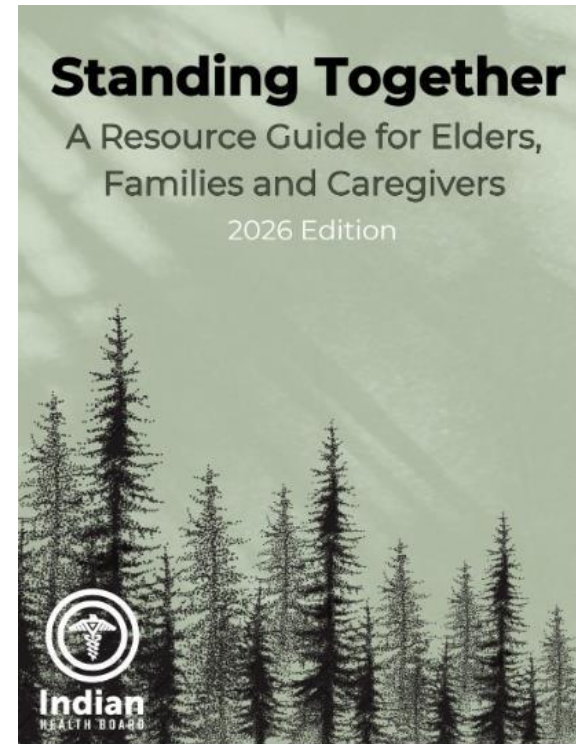
- PCP, LICSW, RN, Psychologist, Pharmacist, CHW
- Assessment protocol in process



Provide Comprehensive, Person-Centered Management and Referral to Meet Needs

Resource guide

Community partnerships



Support for Caregivers

LICSW completed 40-hour Care Ecosystem training

IHB Elder and spiritual advisor, Richard Wright, provides support for both community members with dementia and their caregivers



Our Claim to Fame is

Elder's First Prevention Group

- Weekly group of 12 elders – focus on prevention, social connection, and creating community ambassadors
- Topics covered: Dementia Friendly training, Virtual Dementia tour, spirituality, chair exercises, brain games, cultural crafting, health topics, other aging related topics



Performance Measure

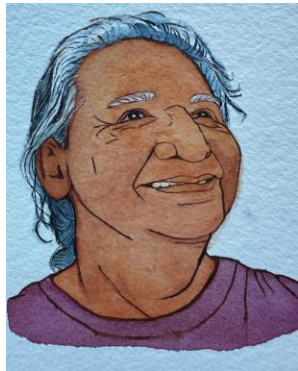
Number of mini-cogs completed in the community and in the clinic

Community: offered at large IHB community events, classes, groups, and outreach events – using count/quarter data to estimate reasonable quarterly goals

Clinic: Numerator = number of mini cogs given

Denominator = number of visits in the clinic age 55+

Screening type	Baseline (3 months prior)	Year 1 Q1	Year 1 Q2	Year 1 Q3	Year 1 Q4	Year 2 Q1
Community	0	8	14	63	31	14
Clinic	0/245 (0%)	0/313 (0%)	2/261 (<1%)	2/293 (<1%)	8/258 (3%)	32/317 (10%)



The Indian Health Service, Department of Health and Human Services (HHS) provided financial support for this project. The award provided 100% of the total costs and totals \$200,000 per grant year (3-year award). The contents are those of the author. They may not reflect the policies of IHS, HHS, or the US government.

2026 IHS National Clinical and Community Workforce Summit

Addressing Dementia in Indian Country: Models of Care

Thomas Lawrence, Public Health Services Director

Rhiannon Dempsey, Public Health Services Program Manager

Seattle Indian Health Board

Site: H1H8IHS0029-01-00

The Indian Health Service, Department of Health and Human Services (HHS) provided financial support for this project. The award provided 100% of total costs and totaled \$200,000. The contents are those of the author. They may not reflect the policies of IHS, HHS, or the U.S. Government.



Awareness and Recognition

Culturally attuned resources and programming activities

Making healthy lifestyle choices may reduce your risk of dementia. Here are some things you can do that may help reduce your risk.

- Control high blood pressure
- Sleep well
- Eat a healthy diet
- Connect with family and friends
- Keep physically active

Learn more about these and other healthy choices you can make at: iasquared.org/brain-health/

SIHB

HELP REDUCE YOUR RISKS OF DEMENTIA

Early Life

- Learn something new

Mid Life

- Keep a Healthy Weight
- Manage Blood Pressure

Later Life

- Prevent & Treat Hearing Loss
- Do Not Smoke
- Connect with Friends & Family
- Be Active
- Avoid Air Pollution
- Treat Depression
- Manage Diabetes

Seattle Indian Health Board | SIHB.ORG

10 Early Signs of Abnormal Memory Changes

Timely and Accurate Diagnosis

- Culturally adapt diagnostic tools



Multidisciplinary Assessment

TRADITIONAL MEDICINE

Holding Traditional Medicine at our center

With Traditional Medicine informing everything we do as an organization, we can be intentional in the way we approach healthcare for Native people.

HEALTH & HUMAN SERVICES

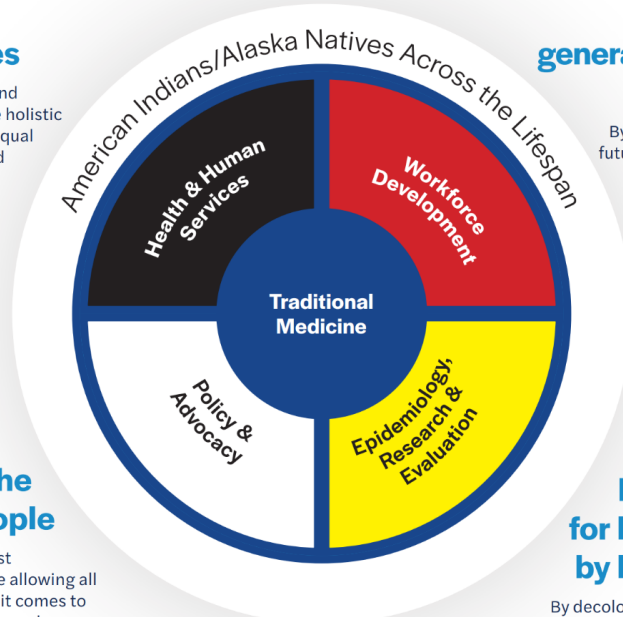
Holistic care for all of our relatives

By fully integrating our health and human services, we can provide holistic care for our patients that pays equal attention to the mind, body, and spiritual components of a person's health.

WORKFORCE DEVELOPMENT

Training the next generation of healthcare professionals

By investing in our staff and training future generations, we are promoting and expanding culturally attuned healthcare throughout Indian Country and beyond.



POLICY & ADVOCACY

Advocating for the health of our people

By ensuring that the federal trust responsibility is honored, we are allowing all Native voices to be heard when it comes to policies and funding for Native people.

EPIDEMIOLOGY, RESEARCH & EVALUATION

Decolonizing data for Indigenous people by Indigenous people

By decolonizing data, we are identifying the resiliencies and gaps in our communities and addressing them by using techniques rooted in Indigenous knowledge.

IMPACT

Walking in a Culture of Wellness

Leading an environment, anchored in tradition, that empowers our community to walk in a culture of wellness.

- Document workflows and tools needed for multidisciplinary assessment



Management and Referral



- Dementia care in current integrated care teams
- Create training for providers on referral processes



Caregiver Support

- Identified caregiver support resources for SIHB relatives
- Culturally adapting caregiver support services



Claim to Fame

Dementia Bingo – culturally adapted educational activity

Dementia Bingo

1 in 6	Dementia	3 times	Age
High Cost	Caregivers	Alzheimer's Disease	25%
53%	Cure	Improve	Signs or Symptoms
Family	3 seconds	Traditional Foods	Leaders and Storytellers



Performance Measures

- Number of resources provided
- Year to Year increase of relatives who have received screening / diagnosis as part of primary care
- % of relative who have documented interdisciplinary assessments
- % of Relatives retained in care
- Number of Caregiver supported annually





Thank You!

Seattle Indian Health Board



**Stretch Break – Be back
in 10 minutes**



Indian Health Service

Dementia Clinical Support Line

Providing expert on-demand clinician-to-clinician support for Native communities

1-833-998-4897

Available Monday-Friday

12pm to 8pm ET

Email: uw-triad@uw.edu



The Dementia Clinical Support Line offers expert advice on cognitive impairment, Alzheimer's disease, and other types of dementia. The Support Line serves Indian Health Service, tribal, and urban Indian health care staff. **Expert consultants** offer support and answer clinical questions about **dementia screening, assessment, diagnosis, management, and care planning.**

We welcome calls and emails from physicians, advanced practice providers, nurses, pharmacists, dentists, behavioral health specialists, and other clinical staff.

Call or email with questions like these:

How do I assess cognition in a patient who cannot read?

What medications should be avoided if my patient has cognitive complaints?

What do I do next if my patient tests positive for cognitive impairment?

To get answers to your questions about dementia screening, evaluation, diagnosis, management, and care planning, call 1-833-998-4897, or email uw-triad@uw.edu. Consultants are available Monday through Friday from 12 p.m. to 8 p.m. ET.

The Dementia Clinical Support Line is provided as a service by the University of Washington, an IHS contractor, and their partners at the University of California, San Francisco's Dementia Care Aware program.



Indian Health Service
Training and Resources for the IHS
on Alzheimer's and Dementia (TRIAD)



2026 IHS National Clinical and Community Workforce Summit

Building Indian Health Dementia Models of Care

**Site: Northern Valley Indian Health
Chico, CA**

Increase Awareness and Recognition of Dementia

- **Improve clinical staff and the community's knowledge about dementia, including understanding its importance, how to recognize it, and what resources are available.**
 - Conduct a needs assessment for the community and medical staff.
 - Provide educational sessions that have a pre and post survey to evaluate the individuals understanding.
 - Present dementia awareness resources bi-yearly at the providers meeting.
- **Expand opportunities for identifying cognitive impairment.**
 - Encourage group visits for patients 55 years and older.
 - Home visits for patients 55 years and older.
 - Offer incentives for Mini-Cog screening.
- **Develop or adapt culturally appropriate materials.**
 - Adapt the 10 warning signs of cognitive impairment to be culturally relevant for Tribal communities.
 - Collaborate with media to create culturally appropriate awareness materials.
- **Enhance awareness among Tribal and health services leadership while fostering partnerships with Tribal programs.**
 - Build partnerships with Tribal programs, elders services, adult protective services, Tribal administration and senior centers in each region.
 - Develop data sources on rates and types of dementia in the Tribes or Urban populations served.
 - Obtain local/state epidemiologic data from the epicenter if available.
 - Develop reports from the electronic health records (EHR).

Make an Accurate and Timely Diagnosis

- **Increase clinical capability in evaluation and diagnosis of cognitive impairment.**
 - Provide training for all new medical providers and offer refresher courses on recognizing the early signs of dementia.
 - Offer presentations led by outside consultants on the evaluation of cognitive impairment and the diagnosis of dementia.
 - Identify a “champion” in each clinic for dementia awareness.
 - Attend trainings to help enhance dementia awareness program.
- **Create structured support for optimal performance.**
 - Create standardized, culturally adapted methods for evaluation and diagnosis.
 - Use EHR templates to document screenings and send internal and external referrals.
 - Use clinical data in the EHR system to help create case load.
 - Use CPT code 99483, for billing, to capture reimbursement for cognitive assessment and care plan services.
- **Develop referral sources.**
 - Create a list of referral sources in each region.
 - Continue the partnership relationship with the regional Alzheimer’s Association chapters.

Provide Interdisciplinary Assessment to Identify Needs and Develop Appropriate Care Plan

- **Establish interdisciplinary team and their roles.**
 - Collaborate with medical, dental and behavior health to develop the interdisciplinary care management team.
 - Provide training for team members.
 - Use case conference and monthly Community Health and Outreach meetings to address caseload.
- **Continue supporting patient's pathway from diagnosis to assessment and care plan.**
 - Solidify the referral process for patients that are diagnosed with dementia.
 - Route all referrals with a positive screening to the interdisciplinary case management team.
 - Share referral process at all sites to ensure that all staff understand the process.
- **Continue to develop external resources to meet identified needs not provided by the program.**
 - Identify and establish referral partners for comprehensive evaluation if needed.
 - Connect patients to external organizations and services such as Alzheimer's Association, Veteran's Administration, and county services such as family support and transportation services.
- **Establish monthly case conferences to review and update care plans.**
 - Schedule monthly case conferences with care team.
 - Train team members on effective interdisciplinary collaboration and communication.
 - Ensure that care plans are comprehensive, up-to-date, and reflect the input of the interdisciplinary team.

Provide Comprehensive, Person-Centered Management and Referral to Meet Needs

- **Continue active case management and provide ongoing support for individuals with early signs of dementia and those living with the condition.**
 - The Dementia Program Coordinator is to oversee the case management of patients being referred to the program to ensure the patient and their family are getting the support and referrals they need.
 - Create a standardized referral for Tribal and community-based services that ensures a closed loop on the referral.
 - Consistent updates to the registry to track and manage patients living with dementia.
- **Periodically review, reassess, and revise the care plan to ensure the patient is being referred to all specialist and resources needed.**
 - Collaborate with interdisciplinary care management team to get scheduled appointments for team meeting with the patient.
 - Refer patients to additional services as needed.
 - Continue to develop relationships with referral resources and specialists that can help with dementia care management.
- **Update internal and external workflows to eliminate gaps in care.**
 - Maintain and update a list of external organizations and what services they provide to help support patients living with dementia and their families.
 - Use the EHR referral pathway to support referrals to specialists and community services.

Support for Caregivers

- **Identify the caregivers and assess their needs for support.**
 - Identify the caregivers in the chart and their role in the patients' life that is living with dementia.
 - Conduct a needs assessment for the caregiver.
- **Provide education, resources, and training to caregivers.**
 - Provide evidence-base caregiving coaching that address the caregivers concerns and where they need support.
 - Integrate caregiver support into ongoing case management with the interdisciplinary care management team.
 - If available, partner with respite care resources local to each clinic and Tribal community.
 - Hold in clinic Memory cafés as respite care.
- **Increase understanding of dementia in the community.**
 - Incorporate education on important topics related to dementia caregiving into community outreach.
 - Attend a Tribal luncheon to provide education to the community.
 - Share education, trainings, and resources on social media.
- **Establish community partnerships to develop caregiver resources.**
 - Share findings from the needs assessment with stakeholders to find partnerships to fill the gaps of care that the caregiver faces.
 - Establish a caregiver resource hub on the NVIH website.

Our Claim to Fame:

Our Dementia Care Pathway

- Dementia screening is paired with intentional follow-up and ongoing support for patients and caregivers.
- Interdisciplinary teams collaborate regularly to review cases, adjust care plans, and coordinate internal and external referrals.
- Community Health & Outreach staff provide hands-on navigation, education, and follow-up throughout the dementia journey.
- Community partnerships are integrated into the pathway to extend education and support beyond the clinic and into trusted community spaces.
- Education and connection opportunities support caregiver engagement and continuity of care for individuals experiencing cognitive decline.

One of the most important things we learned this year is that dementia education doesn't always come from providers. Our community told us Outreach matters – and that insight is shaping how we think about sustainability and impact moving forward.

Performance Measures

Driver Category	Metric	Year 1 & 2 (outcome goal)		%	Notes
Awareness & Recognition	Improve clinical staff and community's knowledge about dementia.	17	Training of new staff	100%	Community Health and Outreach (CH/OR) staff received training in dementia screening and awareness as part of the orientation and onboarding process.
	Expand opportunities for identifying cognitive impairment.	22	4 week class quarterly (n=32)	69%	On track for year 2
	Develop of adapt culturally appropriate materials.	2	2 documents to be created (n=2)	100%	Completed
	Increase awareness of Tribal and health services leadership and build partnership with Tribal programs.	1	Meet with Tribal staff	100%	Completed
Accurate & Timely Diagnosis	Increased clinical capability in evaluation and diagnosis of cognitive impairment	1	Provider training (n=2)	50%	Opportunity for Medical Director to partner with CH/OR staff to schedule trainings and provide oversight into the development of the clinical workflow of care
	Create structured support for optimal performances	0	Create EHR template to manage caseload	0%	Utilizing Excel spreadsheet until IT has EHR updates for developing caseload template
	Develop referral sources	6	Network with outside resources	100%	Engaging in networking opportunities to expand resources.

Performance Measures

Driver Category	Metric	Year 1 & 2 (outcome goal)		%	Notes
Interdisciplinary Assessment	Establish interdisciplinary team and their roles	4	Established team at each site (n=4)	100%	Interdisciplinary teams are established
	Community Needs Assessment	35	Complete Community Needs assessment throughout all sites (n=20)	175%	Increased community awareness and understanding of dementia care
	Continue to develop external resources to meet identified needs not provided by the program	4	Network with outside resources	100%	Engaging in networking opportunities to expand resources
	Establish monthly case conferences to review and update care plans	6	Case conferences are held monthly with each primary care clinic throughout the year (n=36)	17%	On track for 2026
Management & Referral	Continuing active case management and support of individuals with early sign and living with dementia	20	Mini-Cog screenings	100%	Offering care management services to support patient in navigating the complex services of care
	Periodically review, reassess and revise the care plan to insure patient is being referred to all specialist and resources needed	9	Continued review of care plans	100%	Represents the number of patients who have been reassessed
	Update internal and external workflows to eliminate gaps in care	1	Creating current workflow (N=2)	50%	Progressing in workflow development with analysis on challenges, barriers and successes

Performance Measures

Driver Category	Metric	Year 1 & 2 (outcome goal)		%	Notes
Support Caregivers	Identify the caregivers and assess their needs for support	16	Caregiver identified during screenings	100%	Exploring opportunities to expand this with patient navigation
	Provide education, resources and training to caregivers	8	Education provided during Brain Health class (n=16)	50%	On track to complete for year 2
	Increase understanding of dementia in the community	7	Number of opportunities to share education information with the communities (n=25)	28%	Share education during Brain Health classes, Luncheons where Cognitive decline is discussed, Health Fairs On track for 2026
	Establish community partnerships to develop caregiver resources	3	Local resources with established partnership (n=3)	100%	Alzheimer's Association, Passages, and Butte County Public Health

The Indian Health Service, Department of Health and Human Services (HHS) provided financial support for this Stronger Together – Dementia Awareness Program. The award provided 100% of total costs and totaled \$200,000. The contents are those of the author. They may not reflect the policies of IHS, HHS, or the U.S. Government.



2026 IHS National Clinical and Community Workforce Summit

Building Indian Health Dementia Models of Care

Site: Nimiipuu Health, Lapwai
ID (Nez Perce Tribe)

THE MIND MAY NOT REMEMBER
BUT THE HEART WILL NOT FORGET
ALZHEIMER'S / DEMENTIA
AWARENESS



Increase Awareness and Recognition of Dementia

Secondary Driver	Strategies
Implement an Early Detection Strategy	<ul style="list-style-type: none"> • Implement standard screening tool (AD-8/SLUMS) • Train Nimiipuu Health staff (CHRS/Providers/Memory Care Program Staff) on how to administer the AD-8/SLUMS • Collaborate with NMPH Community Health to send referrals to the NMPH Memory Care Program for resource sharing and cognitive assessment for PTS/families/caregivers • Require Nimiipuu Health medical providers complete dementia training • Continue training staff. NMPH Medical Providers get approved and trained to use AD-8/SLUMS
Create opportunities for detection of cognitive impairment	<ul style="list-style-type: none"> • Train Nimiipuu Health staff, collaborating partners on detection of signs/symptoms of dementia • Use Well Elder Visit as an opportunity to assess for cognitive impairment • Train caregivers on signs/symptoms of dementia. Provide them with referral resources for support • Provide incentive for elders who complete an AD-8
Educate in the warning signs of dementia and Alzheimer's	<ul style="list-style-type: none"> • Train Nimiipuu Health, Tribal partners, Nez Perce Tribal Law Enforcement, caregivers/families and elders on dementia • Expand efforts to share the NMPH Dementia Documentary. NMPH share Press Release about the film and share within all three communities Lapwai, Orofino and Kamiah. Also share documentary with other tribes/programs
Coordinate services with tribal or local programs that work with elders	<ul style="list-style-type: none"> • Educate community on signs/symptoms of dementia and provide resources to: • Nez Perce Tribe Circle of Elders, Senior Advisory Committee • Nez Perce Tribal Social Services Program • Nez Perce Tribal Law Enforcement • Nez Perce Tribal Housing • Meet with collaborating partners quarterly to share resources
Coordinate with Nimiipuu Health Community Health Manger to evaluate tribal elders who are in the local nursing homes to identify needs for elders	<ul style="list-style-type: none"> • Providing training, resources or printed educational materials on dementia to nursing home staff if needed, in-home care services, etc
Provide dementia education to the community	<p>Education can be provided through:</p> <ul style="list-style-type: none"> • Alzheimer's Awareness Month Community Events • Social Media Outlets (Nimiipuu Health Facebook page, KIYE radio station) • Printed education materials • Billboard displays • Short films, documentaries

Make an Accurate and Timely Diagnosis

Secondary Driver	Strategies
Increase confidence and capacity for evaluation in primary care	<ul style="list-style-type: none">• Nimiipuu Health staff education on AD-8• Nimiipuu Health education on PHQ2/PHQ9 and GAD-7 to assess anxiety, depression• Include dementia agenda item in monthly staff medical meetings• Train Memory Care Coordinator in care management/grant writing• Organize additional training for NMPH Medical Providers on dementia
Standardize the approach of evaluation and diagnosis of dementia	<ul style="list-style-type: none">• Target high risk patients for dementia for cognitive assessments, education/resource sharing• Collaborate with Nimiipuu Health SDPI Grant• Collaborate with Nimiipuu Health Behavioral Health Program (assessments for depression, anxiety, PTSD, substance abuse, trauma)• Collaborate with the IT Department on receiving PT data records for reporting
Establish referral resources for dementia diagnosis	<ul style="list-style-type: none">• Participate in case-based Northwest Elder's Project ECHO sessions• Participate in IHS Dementia Information Workshop sessions• Establish resources for neuropsychiatric testing and evaluation• Establish in-house NMPH Memory Care Program referral process for clinic and for the community to refer individuals with memory loss concern for screening or resources

Provide Interdisciplinary Assessment to Identify Needs and Develop Appropriate Care Plans

Secondary Driver	Strategies
Complete comprehensive assessment of patient needs	<ul style="list-style-type: none"> • Assessment which includes: Comprehensive patient history and exam, functional assessment, staging of dementia using standard instruments and medication review • Build upon Memory Care Patient Registry to help with standard approach to medical needs, social needs, and potential referral needs • Assessment of home safety for patient needs in collaboration with the Nez Perce Tribal Housing Authority • Assessment of social supports and caregiving resource • Assessment of depression, anxiety, and challenging behaviors using standardized tools such as the PHQ9 and GAD-7
Continue collaboration with partners <ul style="list-style-type: none"> • Internal and external 	<ul style="list-style-type: none"> • Nez Perce Tribal entities • Alzheimer’s Association • Dementia Friends • Indigenous Aging Squared • Northwest Portland Indian Health Board • Idaho Department of Health and Welfare • LC Valley Community Action Partnership • Indian Country ECHO • IHS Dementia Caregiving Informational Workshop • HBI Roadmap for Indian Country • Center for Disease Control • With other tribes
Improve communication with internal/external collaborating partners	<ul style="list-style-type: none"> • Nimiipuu Health Departments: • Community Health, Diabetes Program, Pharmacy, Optometry, Benefits Coordinators, Dental, Communications • ENT (Ear, Nose, Throat Assessment) providers, ST Joe Radiology

Comprehensive, person-centered Management and Referral

Secondary Driver	Strategies
Care management and navigation for persons living with memory loss	<ul style="list-style-type: none">• Develop care plan, perform regular review and revision• Create patient registry for individuals with memory loss for care management and resource sharing purposes• Identify available resources for care• Identify gaps in care• Complete caregiver needs assessment• Ensure regular follow up and periodic care plan review and revision as needed• Train Memory Care Program staff in Case Management
Create referral process with tribal and community-based organizations	<ul style="list-style-type: none">• Develop a referral process and referral form as a resource• Educate Nimiipuu Health staff, collaborating partners and tribal/community organizations about the Memory Care Program
Build upon/develop resources to refer PT with memory loss/caregiver/family for additional support	<ul style="list-style-type: none">• Establish working relationships with ADRD programs as referral resource for patient and caregiver(s)• Establish working relationships with Advance Care Planning Programs• Establish working relationships with support groups for the caregiver(s) and for the patient with memory loss• Collaborate with Seattle Indian Health Board to train NMPH Memory Care Program on implementing focus groups

Support for Caregivers

Secondary Driver	Strategies
Identify caregivers and assess their needs	<ul style="list-style-type: none">• Implement a Caregiver Assessment• Host caregiver focus groups to gather data on what supports they need• Input caregiver data into EHR to comprehensively address caregiver needs• Create a community survey assessing caregiver needs
Provide caregiver training	<ul style="list-style-type: none">• Collaborate with the Alzheimer’s Association/Dementia Friends to coordinate cultural appropriate caregiver trainings. Provide culturally sensitive educational materials• Host Lunch and Learn activities to provide caregiver education• Host self-care educational events for caregivers with incentives• Train NMPH Memory Care Program staff more on caregiver support• Create caregiver bundles with dementia educational material and an activity for the caregiver and their loved one to enjoy together within their own homes
Establish working relationships with Advance Care Planning Programs	<ul style="list-style-type: none">• Continue to work closely with the Nez Perce Tribe Adult Protection Services and gather more information on Advance Care Planning resources to share with PT/caregiver/family• Continue to work closely with the Community Action Partnership Program to gather more information on Advance Care Planning resources to share with PT/caregiver/family

Support for Caregivers

Secondary Driver	Strategies
Care management and navigation for persons living with memory loss	<ul style="list-style-type: none">• Develop care plan, perform regular review and revision• Create patient registry for individuals with memory loss for care management and resource sharing purposes• Identify available resources for care• Identify gaps in care• Complete caregiver needs assessment• Ensure regular follow up and periodic care plan review and revision as needed
Continue to establish working relationships with local support groups (in-person and virtual) to share with PT/caregiver/family	<ul style="list-style-type: none">• Continue to work closely with LC Valley Community Action Partnership, the Alzheimer's Association support group facilitators
Gather resource needs/requests from previous caregivers	<ul style="list-style-type: none">• Gather information through individualized caregiver support groups/caregiver assessment on needs or gaps in needs to support future caregivers
Collaborate and develop respite care programs with other tribal departments/local respite agencies	<ul style="list-style-type: none">• Collaborate with caregiving agencies to provide respite to the caregiver/families of those with memory loss• Collaborate with tribal programs such as the Senior Program or Social Services to coordinate respite services

Our Claim to Fame: our dementia documentary featuring an elder/family from our community: **Missing Pieces: Colleen's Story**



Missing Pieces: Colleen's Story

Post-Production Planning and Activities

- Community showings in our community-Lapwai and Kamiah
- Created 11 dementia education short clips highlighting the film providing ADRD education throughout the clips
- Dementia Friends showcase film at one of their events
- Community Action Partnership Caregiver Support Group showcased film at their event
- About 12 tribes, ADRD programs asked for film to view, some showcased the film in their communities, some shared film through their list serve
- Indigenous Aging Squared shared film on their List Serve
- BOLD/Northwest Portland Indian Health Board shared on their List Serve
- Shown at 3 conferences (IHS Conference May 2025, Tribal Brain Health and Dementia Summit (Portland 2025), Nimiipuu Health Women's Wellness Conference 2025
- Jackson family featured in another documentary filmed by IHS . Has not been released yet
- Since filming this documentary, Nimiipuu Health Memory Care Program has been featured in three documentaries sharing about their dementia program and this project in particular
- Submitted film to 6 film festivals for potential award



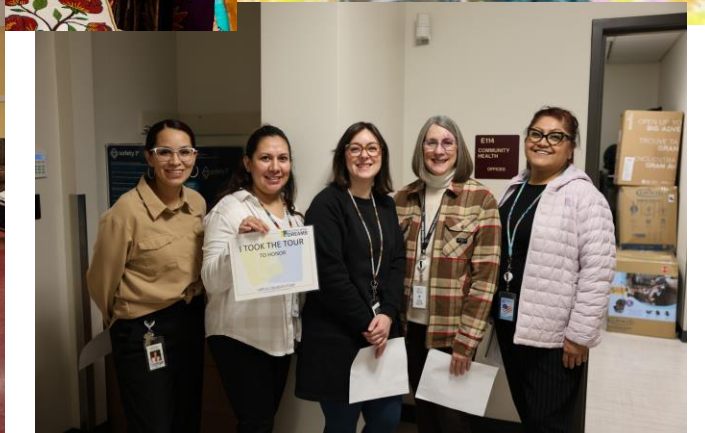
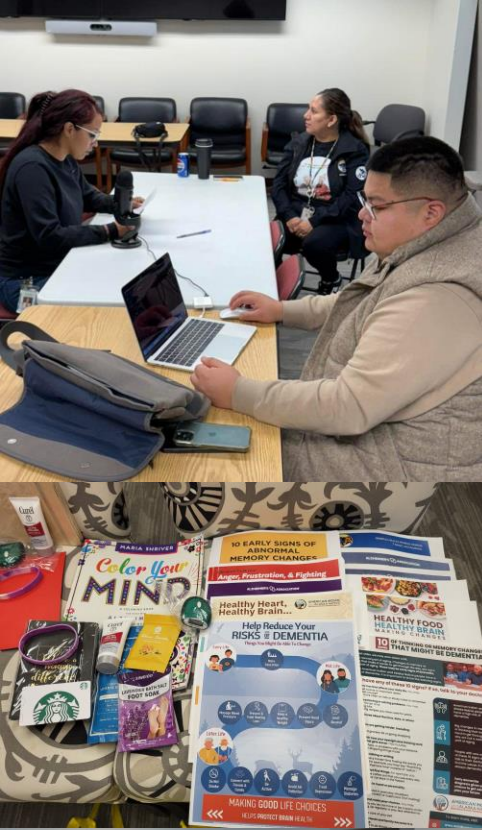
Performance Measures

<p><u>Awareness and Recognition</u> Implement detection strategies to assess memory</p>	<ul style="list-style-type: none"> • Train NMPH staff to implement the AD-8/SLUMS • Complete AD-8 during Elder Annual Wellness Visit • Train medical providers on implementing the AD-8/SLUMS 	<ul style="list-style-type: none"> • Increase the # of AD-8/SLUMS completed • Increase # of patients with potential dementia to receive memory services • Increase NMPH staff knowledge on dementia
<p>Create opportunities for detection of cognitive impairment</p>	<ul style="list-style-type: none"> • Train new NMPH staff to recognize the signs/symptoms of dementia • Provide dementia training during Medical meetings • Require NMPH providers to complete dementia training • Collaborate with tribal programs that provide services to elders on dementia education 	<ul style="list-style-type: none"> • Increase NMPH staff knowledge on dementia • Increase NMPH provider confidence in assessing for cognitive decline • Increase # of PTs referred to the Memory Care Program • Increase # of AD-8 completed • Increase PTs who receive ADRD resources
<p>Educate on warning signs of dementia</p>	<ul style="list-style-type: none"> • Train Tribal organizations that work directly with elder services on how to recognize signs/symptoms of dementia • Educate caregiver(s)/family on how to recognize signs and symptoms of dementia • Educate elders on dementia and how to recognize signs and symptoms of dementia • Provide incentives for elders who complete a memory assessment 	<ul style="list-style-type: none"> • Increase # of referrals to the Memory Care Program • Increase confidence in community and tribal organizations being able to recognize signs/symptoms of dementia • Reduce stigma attached to dementia • Increase social interaction with our elders in our community • Increase opportunity to share about the Memory Care Program and share resources • Create more opportunities to build relationships and trust with elders in our community
<p>Coordinate services with Tribal or local elder programs</p>	<ul style="list-style-type: none"> • Train tribal police officers on ADRD • Access new ADRD sources/programs • Meet with collaborating partners, to share ADRD resources • Coordinate with NMPH Community Health Manager to evaluate tribal elders who are in local nursing homes. • Provide dementia education to youth • Provide dementia education at community events • Include Memory Care Program overview in new hire orientation 	<ul style="list-style-type: none"> • Educate first responders on ADRD • Increase # of referrals to the Memory Care Program • Increase security and safety for those with ADRD • Increase confidence in caregivers that our First Responders are educated in ADRD • Increase collaboration/partnerships • Increase awareness about the Memory Care Program as a resource • Build a relationship between tribal elders in nursing homes • Implement AD-8 with tribal elders in nursing homes • Increase ADRD education among our youth • Increase ADRD education amongst the community • Reduce stigma on memory loss/dementia • Provide ADRD education community wide • Increase ADRD education to new NMPH staff

<p>Conduct ADRD screenings for older adults aged 55 and older using the Mini-Cog</p>	<ul style="list-style-type: none"> • Train appropriate NMPH staff on how to administer the AD-8/SLUMS • Increase # of AD-8/SLUMS's completed 	<ul style="list-style-type: none"> • Enhance community health outcomes • Increase identification of individuals with potential dementia • Increase referrals to Memory Care Program
<p>Raise dementia awareness among clinic staff</p>	<ul style="list-style-type: none"> • Increase Alzheimer's Association trainings • Increase number of ADRD educational and training sessions for NMPH staff • Present on ADRD for all NMPH staff 	<ul style="list-style-type: none"> • Increase NMPH staff knowledge regarding ADRD • Increase #s of patients assessed using the AD-8/SLUMS
<p><u>Accurate and Timely Diagnosis</u> Increase confidence and capacity for evaluation in primary care</p>	<ul style="list-style-type: none"> • Educate new NMPH staff on the AD-8/SLUMS • Educate NMPH Behavioral Health staff providers on PHQ9, GAD-7 to assess patients for anxiety and depression • Host more ADRD educational sessions at NMPH Medical Meetings 	<ul style="list-style-type: none"> • Introduce ADRD education to new NMPH employees • Enhance ADRD education for all NMPH staff • Increase #s of AD-8/SLUMS completed • Increase # of referrals to the Memory Care Program • Increase # of PHQ9/GAD-7 assessments completed
<p>Standardize the approach for evaluation and diagnosis of dementia</p>	<ul style="list-style-type: none"> • Collaborate with the NMPH Diabetes Program on high-risk patients • Collaborate with the NMPH IT Department to receive PT data records including dementia diagnoses • Memory Care Program Coordinator participate in Case Management training • Collaborate with the NMPH Diabetes Program/SDPI to reduce the risk of dementia by staying active • Collaborate with the NMPH Behavioral Health Program to provide resources 	<ul style="list-style-type: none"> • Reduce risk of developing diabetes/dementia • Increase healthier lifestyle for patients • Increase PT education about eating healthy/diet/brain health foods • Provide support for PT/caregiver(s) • Provide opportunity to share education on the link between diabetes and dementia • Open opportunity to provide case management for PTs • Increase physical activity
<p>Collaborate with other ADRD programs to establish a referral resource</p>	<ul style="list-style-type: none"> • Participate in Indian Country Dementia ECHO sessions with the BOLD Project/NWPIHB • Participate in IHS Dementia Workshop sessions • Create internal referral form 	<ul style="list-style-type: none"> • Increase collaborations • Add to resources • Network • Increase # of referrals to the Memory Care Program • Increase NMPH Memory Care Program awareness to other programs • Increase diagnosis of dementia • Increase support to PTs with dementia

Driver/Strategy	Outputs	Outcomes
Enhance Memory Care Program staff dementia education/collaborations	<ul style="list-style-type: none"> Participate in dementia related healthcare conferences Establish new professional collaborations 	<ul style="list-style-type: none"> Opportunity to provide ADRD education or information about the NMPH Memory Care Program at conferences or trainings
<p><u>Interdisciplinary Assessment</u> Complete assessment of patient needs</p>	<ul style="list-style-type: none"> Complete assessments of PTs with potential dementia Complete Home Safety Assessments with PT/caregiver(s) Complete assessment to address social supports and caregiver needs Collaborate with NMPH Behavioral Health on assessments for PTs with potential dementia Review NMPH Provider Survey, Youth Survey. Tailor program goals around the needs/interest of the community. 	<ul style="list-style-type: none"> Address memory concern with PTs with potential ADRD Access home safety concerns for PT Assess social supports and needs for PT and caregiver(s) Assess behavioral health concerns for PT Provide resources for PT, caregiver(s), family Increase # of referrals to the NMPH Memory Care Program Increase # of referrals to NPT Housing for home safety modifications Create opportunity to partner with the Nez Perce Tribal Housing Program Increase referrals to NMPH Behavioral Health
Continue to develop collaboration with partners (internal and external)	<ul style="list-style-type: none"> Collaborate with Northwest Indian College (NWIC) Collaborate with the Nez Perce Tribe's Senior program/Title VI Program 	<ul style="list-style-type: none"> Increase social interaction with elders in our community Increase opportunity to share about the NMPH Memory Care program and resources Increase # of AD-8/SLUMS's completed Increase # of sources provided to our elders Create an opportunity to build relationships and trust with elders in our community
Collaborate with health and community organizations to increase dementia awareness	<ul style="list-style-type: none"> Engage with health and community organizations Attend and participate in healthcare and dementia related conferences and meetings 	<ul style="list-style-type: none"> Increase dementia awareness Increase awareness of NMPH Memory Care Program Resource building Networking Enhance ADRD knowledge
<p><u>Management and Referral</u> Care management and navigation for persons living with memory loss</p>	<ul style="list-style-type: none"> Develop a comprehensive care plan, perform regular review and revision for PTs Connect with other grantees who are receiving the "Addressing ALZ in Tribal Communities Grant" to gather samples of their care plans to gather ideas Review care plan with PTs/caregiver(s)/family quarterly to ensure progress and remove barriers Create referral process for PT with memory loss Create a Memory Care Program PT Registry 	<ul style="list-style-type: none"> Track PT concerns Track PT progress Collaborate with ALZ Grantees for PT Care Plan Create workflow to support PTs with ADRD and their caregiver(s) Provide resources to PTs and caregiver(s) about ADRD

Driver/Strategy	Outputs	Outcomes
Create referral process with tribal and community-based organizations	<ul style="list-style-type: none"> • Connect with other “Addressing ALZ in Tribal Communities’ grantees to seek samples of their referral process. Gather ideas to create our own • Work closely with Dr. Wilson to develop a referral process for further dementia testing. • Inform collaborating partners, NMPH staff of the NMPH Memory Care Program referral process 	<ul style="list-style-type: none"> • Enhance referral/management process for PTs with ADRD • Increase # of Memory Care PT intakes • Increase # of AD-8’s completed • Provide support/resources for PT/caregiver(s) • Increase # of NMPH Memory Care Program referrals • Increase community knowledge of NMPH Memory Care Program and the services the program can provide
Create workflow diagram for patient	<ul style="list-style-type: none"> • Enter caregivers into PT EHR • Memory Care Program PT Registry completed • Establish protocol for PT medication review collaborating with NMPH Pharmacy • Establish protocol to receive EHR reports on high-risk dementia PTs 	<ul style="list-style-type: none"> • Improve care coordinator and management for Memory Care PTs • PT registry will help Memory Care Program with case management for PT and caregiver(s) • Medication review may potentially open doors to eliminate medications that may be contributing to memory loss • Creating a Care Team will increase the # supports for the PT and caregiver(s)
<p><u>Support Caregivers</u> Build upon/develop resources to refer patient, caregiver/family for support</p>	<ul style="list-style-type: none"> • Build a connection with new ADRD resources to share with PT/caregiver(s) • Establish a relationship with a program that provides information/resources on Advance Care Planning • Establish a relationship that hosts ADRD support groups • Develop a focus group of former or current caregiver(s) to gather information about the needs of caregivers and resources • Memory Care Program staff trained by Seattle Indian Health Board to host culturally sensitive focus/support groups tailored for NA/AI Communities 	<ul style="list-style-type: none"> • Collaborations with programs who work within the dementia field • Build upon resources for PT/caregiver(s) • Increase # of Advance Care Plans completed • Encourage PTs/caregiver(s) to attend support groups • Increase # of ADRD PT, caregiver(s) to attend support groups • Expands resources for ADRD PT, caregiver(s)
Implement training programs on ADRD/ Increase number of trained caregivers	<ul style="list-style-type: none"> • Share education about dementia and ADRD resources with caregiver(s) • Provide caregiver training to caregivers • Begin hosting caregiver support groups • Develop, print, and distribute educational materials on memory care featuring elders from our community • Record sessions of Memory Care/Caregiver PSAs • Host Art Therapy sessions partnering with local artist/studio • Publish educational materials featuring some of the Nez Perce language • Create formal assessment for caregivers to assess gaps in their care and their needs for care. 	<ul style="list-style-type: none"> • Increase caregiving awareness and knowledge of resources to caregiver(s). • Provide ADRD education to caregiver(s) • Assess caregivers about ADRD knowledge • Increase community knowledge about ADRD through Memory Care Program materials and PSAs • Increase socialization for PTS with ADRD and for caregivers through Art Therapy • Create opportunity for Memory Care Program to build relationships with PTs and Caregivers through Art Therapy sessions • Add cultural component to our publications



Memories Matter

"Tha Dog always loved being around his grandchildren and teased us. I will always remember him and his smile."
-Marcisio Noriega

Marcisio & his grandpa, Tom "Tha Dog" Reuben

ENGAGING OUR ELDERS

Memories Matter

Three beautiful women in my life...

My YaYa Agnes Mccrea

Maternal Grandmother Genevieve "Gigi" Freidlander

Paternal Grandmother Pauline Ford

"I have special memories with all three of these ladies. My yaya was always the first one I'd hug and kiss at family gatherings. She was also known as "Tupes". She was the matriarch of our family. My grandmother Gigi- I remember all the laughter, teasing, and fun. My granny, Pauline was my best friend. My childhood, teenage years & adult years are filled with so many memories of her and I. I was blessed to have each of these ladies in my life. I'm grateful for all the memories they've left me with. Memories I share with my children."
-Jessica Ford

Memories Matter

"This picture is our mom holding her great grandson. This captures the immense JOY of new life! It is Whitney & Manny's son."

"This is me and my mom attending church. Faith is important to her and I wanted to connect her to that. She had been suffering from Dementia/Alzheimer's by this time. The pastor was glad to see her. He gave her a hug. Our mom knew the pastor's wife since she was a baby. So much history."
-Jeanette Jackson



1 IN 3 AMERICAN INDIAN PEOPLE AGES 65+ DEVELOPS DEMENTIA.

Concerns about memory loss?

CONTACT NIMIIPUU HEALTH MEMORY CARE PROGRAM

208-843-2271



*THE MIND MAY NOT REMEMBER
BUT THE HEART WILL NOT FORGET*

*A L Z H E I M E R ' S / D E M E N T I A
A W A R E N E S S*



**qe'ciyéw'yew'
(Thank You)**

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Memory Care Assistant, Shayna Padilla
Gomez
Shayna.Gomez@nimiipuu.org

2026 IHS National Clinical and Community Workforce Summit

Building Indian Health Dementia Models of Care



NORTON SOUND

HEALTH CORPORATION

Qulit nalunaitqutit Iktigiinilaq

10 Signs of Dementia

Ugua qulit nalunaitqutiqaaviin? Aasiin qaniqatilu taaktin.
Do you have any of these 10 signs? If so, talk to your doctor.

1 Itqanaiguvin iluanjitiugaatin ublum inuusian
Memory loss that affects your daily life

2 Sagiqnaavaktiugaatin siunaziuguvin
Trouble planning or solving problems

3 Killukuaqfiuqtutin taimmamik, taqqimik, uuniin naniittuatin
Getting confused about the time, date, or where you are

4 Ugua ublum sawaksrai sagiqnaasimata
Daily tasks are becoming harder

5 Sagiqnaazimata qiniqnaimiklu isumaanaimiklu taapkuak azignauvakmata
Trouble with how your eyesight and brain work together

6 Sagiqniulavaguvin qaniqtuni uuniin aglaktuni
Trouble talking or writing

7 Taamaiguvinlu paginaguvinlu sugautinik samma ugua
Often losing and cannot find objects

8 Attagiyaaguniaguvinlu nalliagaiguvinlu
Acting different or making poor choices

9 Attalaa irrusian simaituaq,
Changes in mood or personality

10 Ilagiignailui ilanatinlu ilatinlu qanu'atta sagiqnaatuq maliguaglui.
Pulling away from friends and family

To learn more, visit AIANBrainHealth.org or cdc.org/aging



The Indian Health Service, Department of Health and Human Services (HHS) provided financial support for this project. The award provided \$200,000. The contents are those of the author. They may not reflect the policies of IHS, HHS, or the US Government.

Increase Awareness & Recognition of Dementia

Key accomplishments:

- Provided dementia and brain health education through regional community health fairs.
- Shared dementia awareness messages via:
 - Working with our local radio station KNOM and with NSHC radio show “Suwat” (Inupiaq: “What’s up?”) to deliver messages to the region.
 - Kanjqsirugut (Inupiaq: “We understand”) Newsletters - mailed to approximately 3,100 households.
- Recognized National Family Caregiver Month and Alzheimer’s Disease Awareness Month through NSHC communications.
- Began translating dementia education and brain health information into Alaska Native languages for broader community access.



Make An Accurate & Timely Diagnosis

Key accomplishments:

- Expanded diagnostic capacity through on-site and contracted psychology services for neuropsychological evaluation.
- Implemented standardized cognitive screening tools across clinical settings.
- Embedded dementia screening into Primary Care quality and HRSA goals.
- Approved and began standardizing culturally appropriate assessment tools, including:
 - Canadian Indigenous Cognitive Assessment (CICA)
 - GLEAN (Goodness of Life for Every Alaska Native).
- Preparing CICA assessment kits for use across departments to support consistent, culturally responsive dementia evaluation.
- Provided ongoing provider education on dementia screening and diagnostic processes.
- Improved early identification of dementia, allowing timely referral to supportive services.

The Final Goodness of Life for Every Alaska Native (GLEAN) Scale

The following questions are about your quality life as an Alaska Native person. In other words, all the things that makes your life good. For each question choose the response that best describes what is most true about your life now.

	Not at all	A little	Somewhat	Very much	Completely
1. Taking care of myself is important to me	0	1	2	3	4
2. Education is important to me	0	1	2	3	4
3. Setting goals are important to me	0	1	2	3	4
4. Making positive choices are important to me	0	1	2	3	4
5. Cultural activities are important to me	0	1	2	3	4
6. My traditional values are important to me	0	1	2	3	4
7. My traditional language is important to me	0	1	2	3	4
8. Learning form my Elders is important to me	0	1	2	3	4
9. I spend time in nature	0	1	2	3	4
10. I gather from the land	0	1	2	3	4
11. Subsistence is important to me	0	1	2	3	4
12. I feel connected to my family/friends	0	1	2	3	4
13. I have family/friends who are supportive of me	0	1	2	3	4



Provide Interdisciplinary Assessment to Identify Needs & Develop Appropriate Care Plans

Key accomplishments:

- Held monthly Dementia Multidisciplinary Team (MDT) meetings to review complex patient cases.
- Included interdisciplinary representation from primary care, village clinics, behavioral health, social work, in-home support, and ancillary services.
- Reviewed new and follow-up dementia patients to identify medical, functional, and support needs.
- Developed interdisciplinary care recommendations and Plans of Care for patients.
- Documented MDT assessments and care plans in the Electronic Health Record to guide follow-up care.



Provide Comprehensive, Person-Centered Management & Referral to Meet Needs

Key accomplishments:

- Coordinated follow-up on MDT recommendations through primary care providers, RN case managers, Medical Social Work, and In-Home Support Services.
- Utilized standardized care pathways and referral processes to connect patients to needed services.
- Supported coordination of diagnostic testing, specialty care, and ancillary services across care settings.
- Assisted patients with medical travel coordination and appointment attendance when needed.
- Maintained an internal dementia patient tracker to support ongoing care management and continuity.



Support for Caregivers



Key accomplishments:

- Provided in-home respite care for patients with dementia through the IHS Dementia Grant, NSHC funding and Medicaid.
- Delivered paid caregiver support to reduce caregiver burden and prevent burnout.
- Identified and documented primary caregivers in the Electronic Health Record to improve communication and care coordination.
- Supported caregivers with navigation of benefits, legal planning, and care placement resources.
- Connected caregivers to regional and statewide education and support resources.



Our Claim to Fame



- A Dementia Multidisciplinary Team (MDT)– driven care coordination model that integrates screening, interdisciplinary assessment, and person-centered management across clinic, village, and home-based services.
- **What it does:** Coordinates dementia care across disciplines and care settings in a highly rural region.
How it works: MDT reviews guide care planning, referrals, and follow-up through EHR-integrated workflows and in-home services.
Why it matters: Improves access to timely diagnosis, coordinated care, and caregiver support while helping elders remain in their communities.

Performance Measures

- **Awareness & Recognition**
 - 145 staff trained in dementia screening, care, and support (*out of all targeted clinical and support staff*).
 - 20 providers attended advanced dementia training with Dr. Maria Bellantoni.
- **Accurate & Timely Diagnosis**
 - 120 patients evaluated through Dementia MDT meetings (*of all patients referred for dementia evaluation*).
 - 112 new unique patients identified and connected to dementia-related services.
 - 0.9% of the Norton Sound region diagnosed with dementia in the last year (*regional population denominator*).
- **Interdisciplinary Assessment**
 - Monthly MDT reviews conducted for complex dementia cases.
 - Interdisciplinary care recommendations documented in the Electronic Health Record.
- **Management & Referral**
 - Dementia-related service encounters across funding sources :
 - PCS, Medicaid Waiver, and Dementia/Bridge Fund services provided consistently across all quarters.
- **Caregiver Support**
 - Ongoing provision of in-home and respite services for dementia patients and caregivers.
 - Dementia/Bridge Fund utilized to support patients awaiting long-term funding sources.





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ABSENTEE SHAWNEE TRIBAL HEALTH SYSTEM



2026 I.H.S. CLINICAL & COMMUNITY WORKFORCE SUMMIT

Alzheimer's & Elder Care: Knowledge, Compassion at Work

"Building Indian Health Dementia Models of Care"

March 10-12, 2026



The Indian Health Service (IHS), Department of Health and Human Services (HHS) provided financial support for this project. The 3-year award totaled \$600,000. The contents are those of the author. They may not reflect the policies of IHS, HHS, or the U.S. Government.

AWARENESS & RECOGNITION

- **Vodcast – Unlocking Alzheimer’s-Innovative Diagnosis Tools, released 9.3.2025, features:**
 - ❖ Dr. Raphael Francisco, Primary Care Physician, I.H.S. Geri Scholar
 - ❖ Atheda Fletcher, Grant Project Director
 - ❖ Mindy Longhorn, AST Media Director-Host

- **ASTHS Video – features**
 - ❖ Interprofessional Team (Physicians, Specialists)
 - ❖ Collaborative Care Team (RNs, LPNs)
 - ❖ Clinical Team/Medical Staff (Nursing Assistants, Technicians)
 - ❖ ASTHS Patients

- **Dementia Friendly Oklahoma partnership**
 - ❖ Joining DFO means our ASTHS is engaging in a process to become more dementia friendly in the workplace and community. Partnering with Oklahoma State Department of Health to provide DFO training to all clinic staff.

<https://candor.wistia.com/medias/nb9gks2g5s>

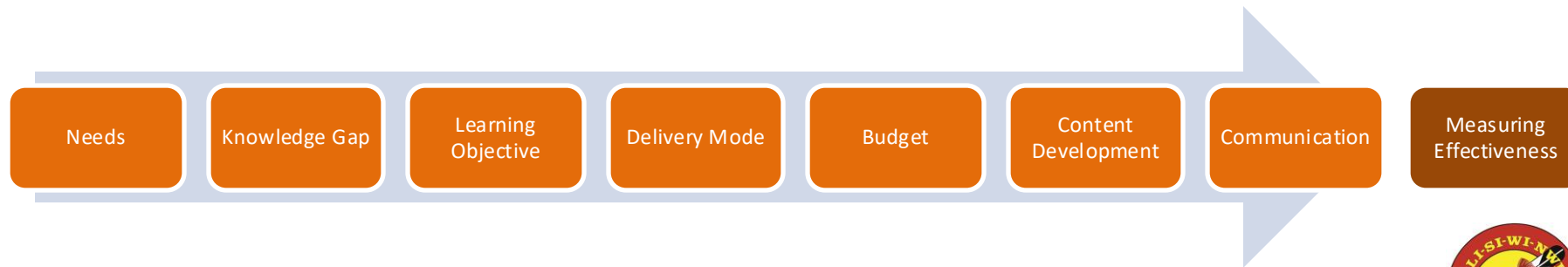


ACCURATE & TIMELY DIAGNOSIS

➤ Clinical Training Schedule

Goal: to improve diagnostic accuracy to bridge gaps to reduce mistakes and improve accuracy of diagnosis:

- ❖ Staff Dementia Readiness Assessment, 10.14.2025
- ❖ Areas identified for improvement
 - ❖ Build confidence in delivering a dementia diagnosis
 - ❖ Understanding the clinic's dementia processes
 - ❖ More training on HER automated referral system for dementia
- ❖ Currently developing clinical staff's dementia training schedule



INTERDISCIPLINARY ASSESSMENT

➤ **Established an Interdisciplinary Team (IDT)**

Goal: to provide a comprehensive, person-centered approach that improves care quality into a clear, navigable path.

➤ Key Components of the Team:

- ❖ Medical Experts: Neurologist, Primary Care Physicians (Geri Scholars), Psychiatrist
- ❖ Clinical Support: Nurses (Geri Scholar), Nurse Practitioner, Physician Assistants
- ❖ Functional & Therapeutic Specialists: Physical Therapist
- ❖ Clinical Specialist: Pharmacist, Dietitian/Nutritionists
- ❖ Support: Dementia Services Team

➤ **Assembled Stakeholders--Shawnee Elders and community to identify core cultural factors.**

Goal: Develop individualized culturally responsive assessment protocols.



MANAGEMENT & REFERRAL

- **Creating a comprehensive flow process for comprehensive care to navigate dementia care program**
 - ❖ Care coordination and management
 - ❖ Medical management
 - ❖ Assessment & monitoring
 - ❖ Care planning
 - ❖ Care navigation to reduce hospitalizations

- **Develop process/protocols for periodic re-assessment**
 - ❖ Adjusting the care plan

- **Strengthen coordination and referral system**
 - ❖ Clear, standardized protocols, tracking technology, foster consistency, & communication



SUPPORT CAREGIVERS

➤ Current Caregiver Interventions:

Intervention	Description
Savvy Caregiver in Indian Country	Evidence-based, 6-session training program tailored for NA & AN families caring for elders with dementia
Music & Memory	Therapeutic program that reduces agitation, alleviates anxiety, and often improves communication and reducing the need for antipsychotic medicines

➤ Expanding: 2 New Caregiver Interventions:

Intervention	Description
End of Life	Focuses on providing compassionate care during the final stages
Elder Abuse Awareness & Prevention	Designed to teach caregivers and staff how to recognize, prevent, and report various forms of elder abuse



CLAIM TO FAME

➤ Building on the foundation of ASTHS Dementia Services, Caregiver Support & Training:

Action	Outcome
Enhance a Diverse & Skilled Workforce	<ul style="list-style-type: none">• Improved patient quality of life• Boosted staff confidence & competence• Improved reputation
Engage & Educate the Public	<ul style="list-style-type: none">• Increased knowledge about brain health• Increased knowledge about risk factors for dementia• Community support• Trust
Strengthen Partnerships & Policies	<ul style="list-style-type: none">• Enhanced collaboration• Increased resource sharing• Increased integrations with other chronic disease efforts
Measure, Evaluate & Utilize Data	<ul style="list-style-type: none">• Improved QoL• Better safety & management• Enhanced Caregiver Support• Systemic care improvements



PERFORMANCE MEASURES

- **This table provides an initial snapshot of the dementia program's performance. The metrics presented are based on early data collection and may be refined as data changes.**
- **Projected clinical performance measures on select subject matter for time frame, Sept-Aug 2026.**

Measure	Numerator	Denominator	Rate	Desired Goal
Pre-post educational staff training / surveys	~200 attendance	407 total staff	49.14%	73.71%
Readiness Assessment	169 respondents	197 total clinic staff	86.0%	100.0%
Functional Assessment	40	1565	3.0%	4.0-5.0%
Annual Well Check/55+	565	1631	35.0%	50.0%
Caregiver Support – participants	42 active	88 referrals	48.0%	50.0%
Educational Events – Outreach	10	15	67.0%	133.33%



A PHOTO IS A MOMENT THAT NEVER FADES



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Elder Health Listserv - <https://bit.ly/3SarALn>



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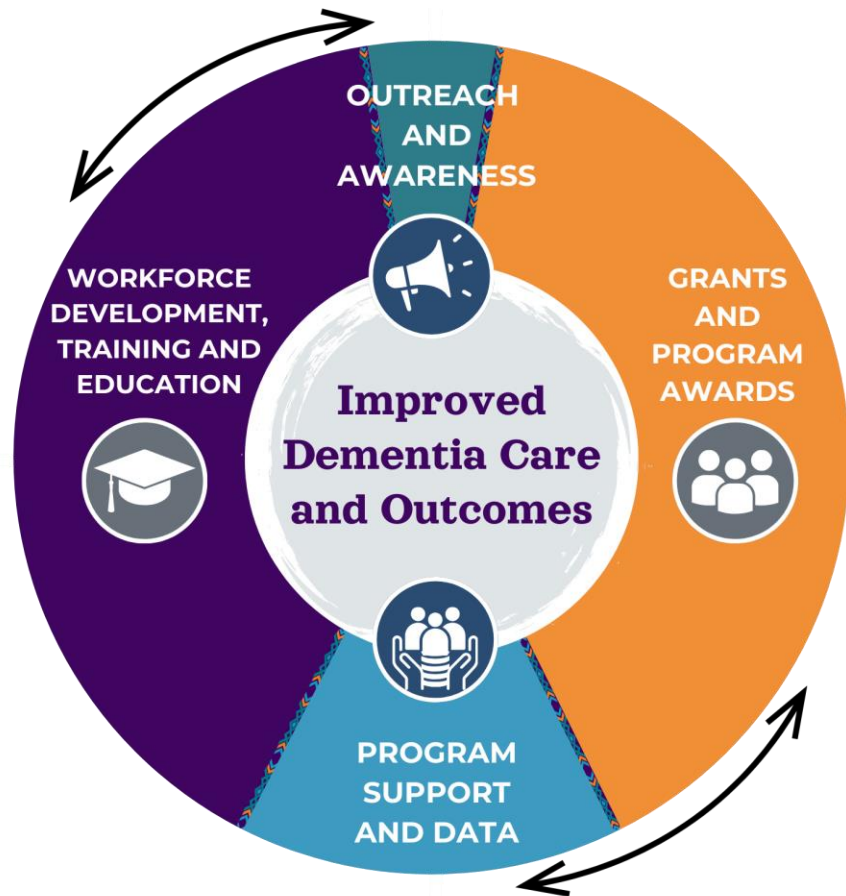


Website - www.ihs.gov/alzheimers



Technical Assistance - IHSElderHealth@ihs.gov

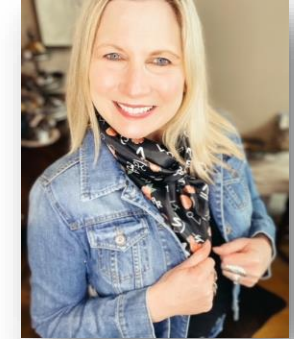
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Thank you

