Brain Health Navigator
(BHN)

Davos Alzheimer's Collaborative

US5382 07/2025

Affiliation/Sponsorship/Disclosures

About the DAC Healthcare System Preparedness Program
The Davos Alzheimer's Collaborative Healthcare System Preparedness (DAC-SP) Program addresses the readiness of our healthcare systems worldwide for a global aging population, with an initial focus on improving rates of early detection and the timely and accurate diagnosis of Alzheimer's disease. DAC-SP applies implementation science methods to turn research breakthroughs into lasting improvements in clinical practice. To accelerate and scale the delivery of cutting-edge treatments and innovations globally, DAC-SP shares learnings and best practices through Learning Laboratory meetings and its Early Detection Blueprint. In collaboration with our partners around the world, DAC-SP serves as a catalyst for transformative improvement within healthcare systems.

Eisai Inc. is a funder of the Davos Alzheimer's Collaborative and provided funding for this program. To learn more about the public, private, and philanthropic support that make this project and other DAC programming possible, please visit davosalzheimerscollaborative.org.

To learn more about DAC, please scan this QR code

Disclosures

Phyllis Barkman Ferrell

Ferrell is a minority shareholder of Lilly and has conducted advising services for Gates Ventures, the Alzheimer's Drug Discovery Foundation, Not Impossible Labs, Morningside Technology Ventures, Cognito Therapeutics, StartUp Health, Longeveron, the USC Schaeffer Center, InMed Pharmaceuticals, the Global Alzheimer's Platform, SiteRx, Linus Health, Circular Genomics, TAP Neuro, and the Davos Alzheimer's Collaborative.

Donna Wilcock

Paid consultant / SAB member: Vigil Neurosciences, Longeveron, SynapsDx.

Collaborator – Eli Lilly and InMune Bio

Research funded by extramural grants from NIH (NIA and NINDS), BrightFocus Foundation, Alzheimer's Association.

Editor-in-Chief: Alzheimer's & Dementia: The Official Journal of the Alzheimer's Association

System Preparedness: Addressing the Persistent Adoption Gap

"Classic studies indicate that it takes 17–20 years to get clinical innovations into practice; moreover, fewer than 50% of clinical innovations ever make it into general usage"

The goal of DAC-SP is to catalyze healthcare system transformation that allows Alzheimer's patients and their families quicker access to life-changing innovations. DAC-SP uses implementation science methods to turn research breakthroughs into lasting improvements in clinical practice.

Bauer, Mark S. & Kirchner, JoAnn (2020). Implementation science: What is it and why should I care? Psychiatry Research. Volume 283, 2020.

Davos Alzheimer's Collaborative

DAC Healthcare System Preparedness Framework

Davos Alzheimer's Collaborative

Rt. Hon David Cameron

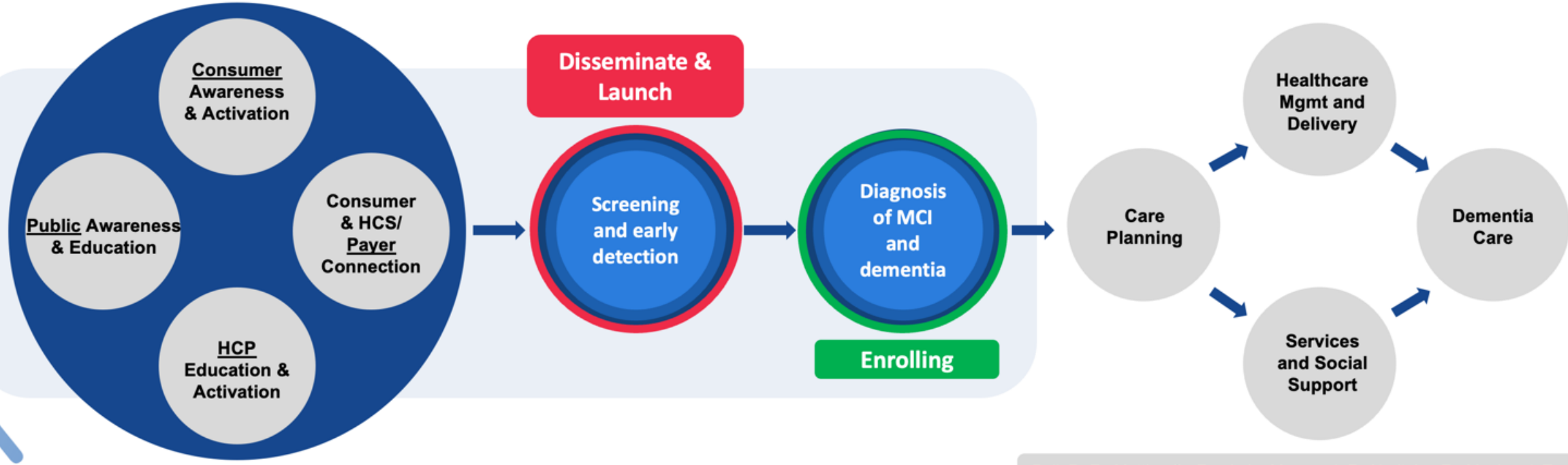
"When I kicked off the Global Action Against Dementia during my G8 Presidency in 2013, we had a vision of creating a worldwide collaboration to tackle the growing challenge of Alzheimer's disease. The framework and programmes being launched by the Davos Alzheimer's Collaborative are critical to ensure collective global action for preparing health systems around the globe,"

Prevention	Health Promotion	Integrated Healthcare	Long Term Care

Encourage Targeted Innovation

Awareness and Activation	HCS Patient Flow	Access

IHI AD-RIDDLE Program



Ball, D. E., Mattke, S., Frank, L., Murray, J. F., Noritake, R., MacLeod, T., ... & Ferrell, P. (2022). A framework for addressing Alzheimer's disease: Without a frame, the work has no aim. *Alzheimer's & Dementia*.

US Footprint

Davos Alzheimer's Collaborative

- Early Detection Flagship Program (2021-2023)
- Early Detection Grant Program (2022-2024)
- Accurate Diagnosis Program (2023-2026)
- Catalyzed Activity (Ongoing)
- U.S. Early Detection Fellowship Program (2024-2026)
- U.S. Brain Health Navigator Program (2024-2025)

Catalyst for the Brain Health Navigator Program

Davos Alzheimer's Collaborative

PCPs need simple solutions and incentives

- Under immense time pressure, PCPs treat conditions where they can make the most impact on their patient(s) with the least effort
- PCPs lack confidence in their ability to screen for cognitive decline and lack a formal structure to do so
- They believe significant work is required to assess cognitive decline for limited payoff, literally and figuratively

"What I've heard repeatedly from [PCPs] is they want an 'easy button.' They want something they can just click that then sends the referral and it gets dealt with somewhere else."

—Dr Donna Wilcock

Many patients are lost in the system

- Most patients in cognitive decline do not follow up with primary care visits or specialty referrals and are frequent "no-shows"
- They frequently reappear in the system at ERs accompanied by families or first responders
- Health care systems (HCSs) are unable to track these cases in the community

"The system doesn't know they have mild cognitive impairment cases. If they have dementia, ***the health care system misses 80% of them****."*

—Dr Malaz Boustani

Families desperately need help

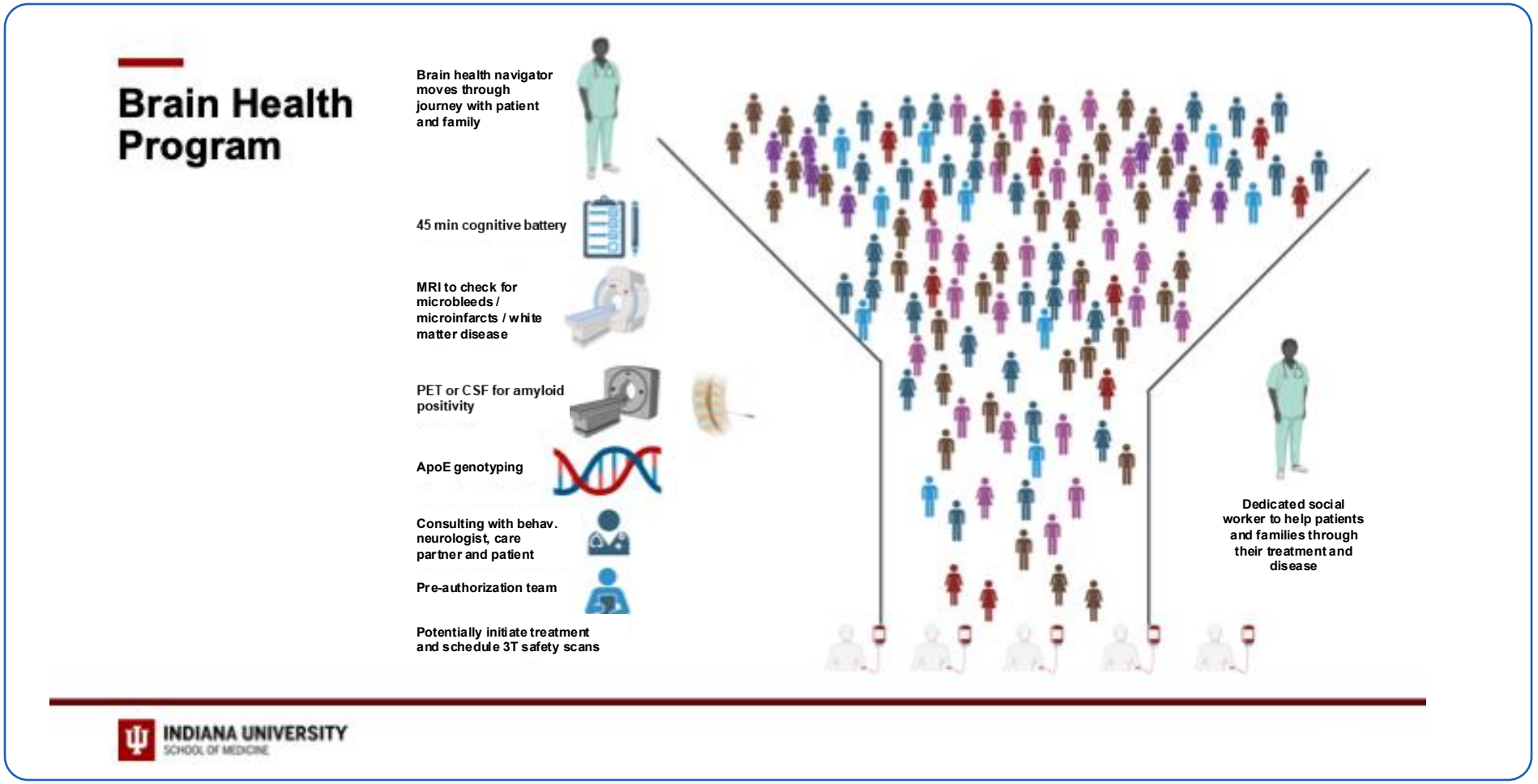
- PCPs feel the most stress when they see entire families struggle
- Patients and care partners can be easily connected to local and national support programs, but many PCPs are unaware of what is available

"If I had a BHN, I would use them ***to connect families to community resources****, get them the emotional support and education."*

—Dr Jackie Raetz

There is a need for boundary spanning role(s) to benefit patients and systems

Indiana University Early Prototype from Early Detection Flagship



IU developed an early prototype focused on mab identification, funded by DAC and then the Med School

Brain Heath Navigator: Program Overview

Program Objectives

To improve the pre-diagnosis journey by developing a brain health navigator program modeled after oncology and diabetes and piloted with existing forward-leaning health systems, which have had some contemporary real-world experience.

- Empower US health systems to rapidly identify causes of cognitive decline in the frontline setting
- Streamline the diagnostics journey for patients and health systems to specialty care, where applicable
- Connect patients experiencing cognitive decline to appropriate care and support
- Develop & evaluate a model that is both scalable and sustainable nationally, *in a wide variety of settings*

BHN Site Selection and Sites

DAC recruited a diverse range of Practices to ensure wide applicability across the US health care system

SELECTION CRITERIA

Program Leadership and Change Management - team composition and stakeholders

Contemporary Experience – of the diagnostic journey for new DMTs, including BBMs, PET, CSF, and MRIs

Patient Diversity – race, ethnicity, social determinants of health

Implementation - Readiness and Capability

Sustainability - of program beyond the grant period

ADDITIONAL CONSIDERATION FOR SELECTION:

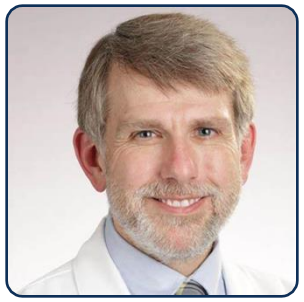
a. Variety of Health System Archetypes/Geography
b. GUIDE sites
c. Rippl Sites
d. Variety of DCA and BBM tools/experience with advanced diagnostic tools

Davos Alzheimer's Collaborative

Site Presentations

Karen Blackmon
Dartmouth Health

Cara Leahy
Memorial Healthcare



Greg Cooper
Norton Healthcare

Rhonna Shatz
University of Cincinnati

Soo Borson
Keck School of Medicine of
University of Southern California

All clinical decision making should be done at the discretion of the local licensed providers and any billing decisions should be made with local coding experts

Dartmouth Health BHN Team

Creating a sustainable brain health navigator model to improve the diagnostic journey for people with Alzheimer's disease: the experience of one health care system in New Hampshire

Poster number 101261

Corie Crane,
DNP, APRN, PMHNP
Geriatric Psychiatry Nurse Practitioner
Brain Health Navigator & Provider

Karen Blackmon, PhD.,
ABPP-CN Clinical
Neuropsychologist

Dax Volle, MD
Geriatric Psychiatrist

Dartmouth has received research funding from the Davos Alzheimer's Collaborative

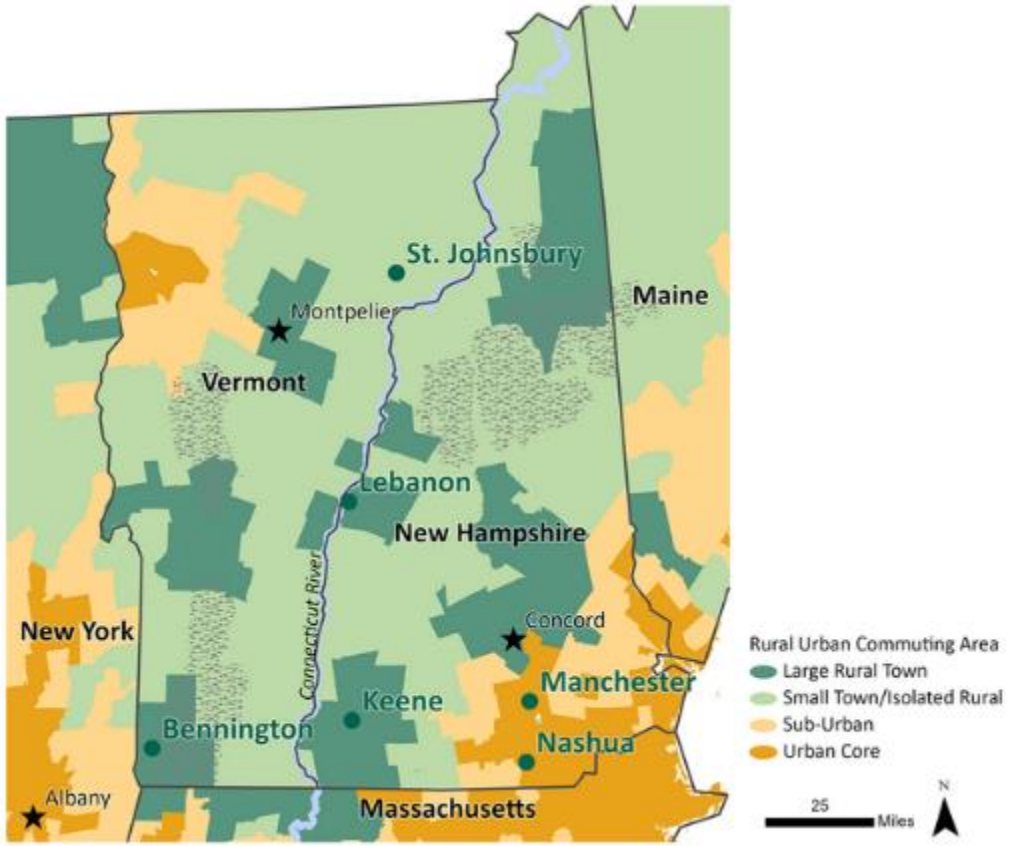
DH Brain Health Navigator Model

- Largest healthcare organization in NH
- Serves rural populations in NH, Vermont, & Maine – highest per capita senior population
- BHN housed within Geriatric Psychiatry, Dartmouth Hitchcock Medical Center
- Partners:

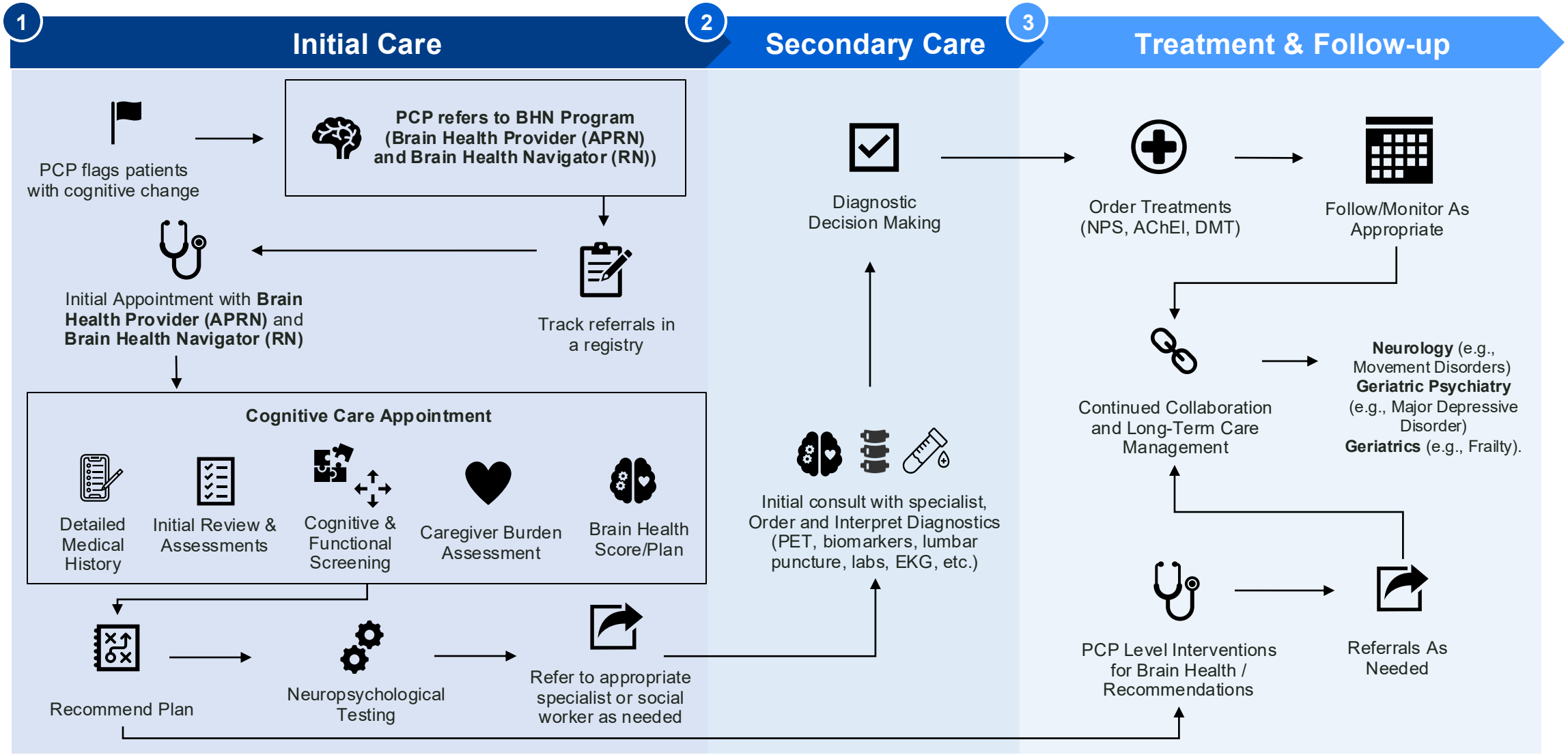
  Department of General Internal Medicine (Internal Medicine)

  Heater Road Primary Care (Family Medicine)

One Common Pathway through specialty diagnostics to arrive at early and accurate ADRD diagnosis



Dartmouth Health BHN Model Care Pathway



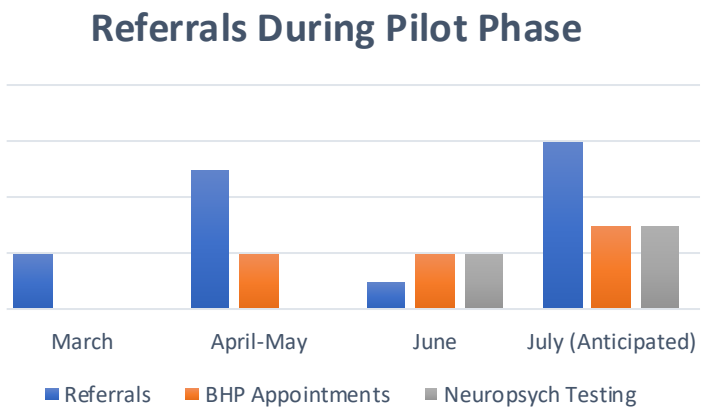
AChEI= Acetylcholinesterase Inhibitor, APRN= Advanced Practice Registered Nurse, BHN= Brain Health Navigator, DMT = Disease Modifying Treatment, NPS= Nano-pulse stimulation, PCP= Primary Care Provider, PET= positron emission tomography, RN= Registered Nurse

Healthcare System Model: A brain health specialized team incorporates a BHN

DH BHN Learnings

Opportunities and Successes

- Integration of referral & smartforms into Epic
- Expedited referrals to specialty care
- Stacking of cognitive care and neuropsychological evaluations
- Achieved system buy-in for sustainability & growth
- Community interest through outreach
- Steady increase in referrals



Challenges and Problem-Solving

- Early administrative support burden (scheduling template builds, longitudinal billing models)
- Overlapping roles between BHN and other care team members
- PCP referral educational materials
- Need to bridge cognitive care silos

Twin Goals

Skilled Navigator

+

Easier-to-Navigate Health System

Dartmouth Health

Memorial Healthcare

Creating a Sustainable Brain Health Navigator Model to Improve the Diagnostic Resources for Alzheimer's Disease: The Experience of One Health Care System in Rural Michigan

Poster number 101272

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Family Medicine

Sarah Veith
Family Medicine BHN

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Neuro Operations Manager

Tina Archambault
Neurology BHN

Shaelyn Warren
Neurology BHN

Dr. Leahy has received personal compensation for serving a consultant for Eisai, Lilly, and Biogen. She serves as a scientific advisor for Neurogen Biomarking. The institution of Dr. Leahy has received research support from C2N, Neurogen, Davos Alzheimer's Collaborative and Eisai.

Memorial Healthcare Navigator Model

Independent community hospital serving rural Michigan
Serves rural populations in Michigan with highest concentration in Shiawassee County – sole hospital provider for county residents

Partners:
- King Street Family Medicine
- Memorial Medical Associates (100+ physicians)
- Institute for Neuroscience Memory Care Clinic
- 30+ primary care providers across 8 cities in 3 counties

BHN housed within King Street Family Medicine primary care site, coordinating with Institute for Neuroscience and the neurology post diagnosis BHNs

Specialty: Only neurologic services within 20+ mile radius

Central Michigan Rural Catchment Area

Primary Service Area:
Shiawassee County
Genesee County
Livingston County

Memorial Healthcare Brain Health Navigator Model

🎯Program Overview

Place a registered nurse with understanding of the diagnostic and therapeutic pathway for memory/AD care in a pilot primary care setting. Facilitate appropriate referrals to neurology and provide immediate evaluation and resources when concerns arise.

👥Staffing Evolution

Initially planned for part-time RN already in the office, but quickly realized a dedicated full-time RN focused solely on memory care would better serve patients.

📚Education & Training

RN with primary care experience and complex care billing knowledge.

Two weeks neurology training, MMSE/MoCA certification, custom history templates, & community organization meetings (AA, respite volunteers, county aging council).

⚡High Level Strategy

Increase cognitive screening in primary care, improve referral quality to neurology, and alleviate time and knowledge constraints on primary care physicians.

⚖️Administrative Role

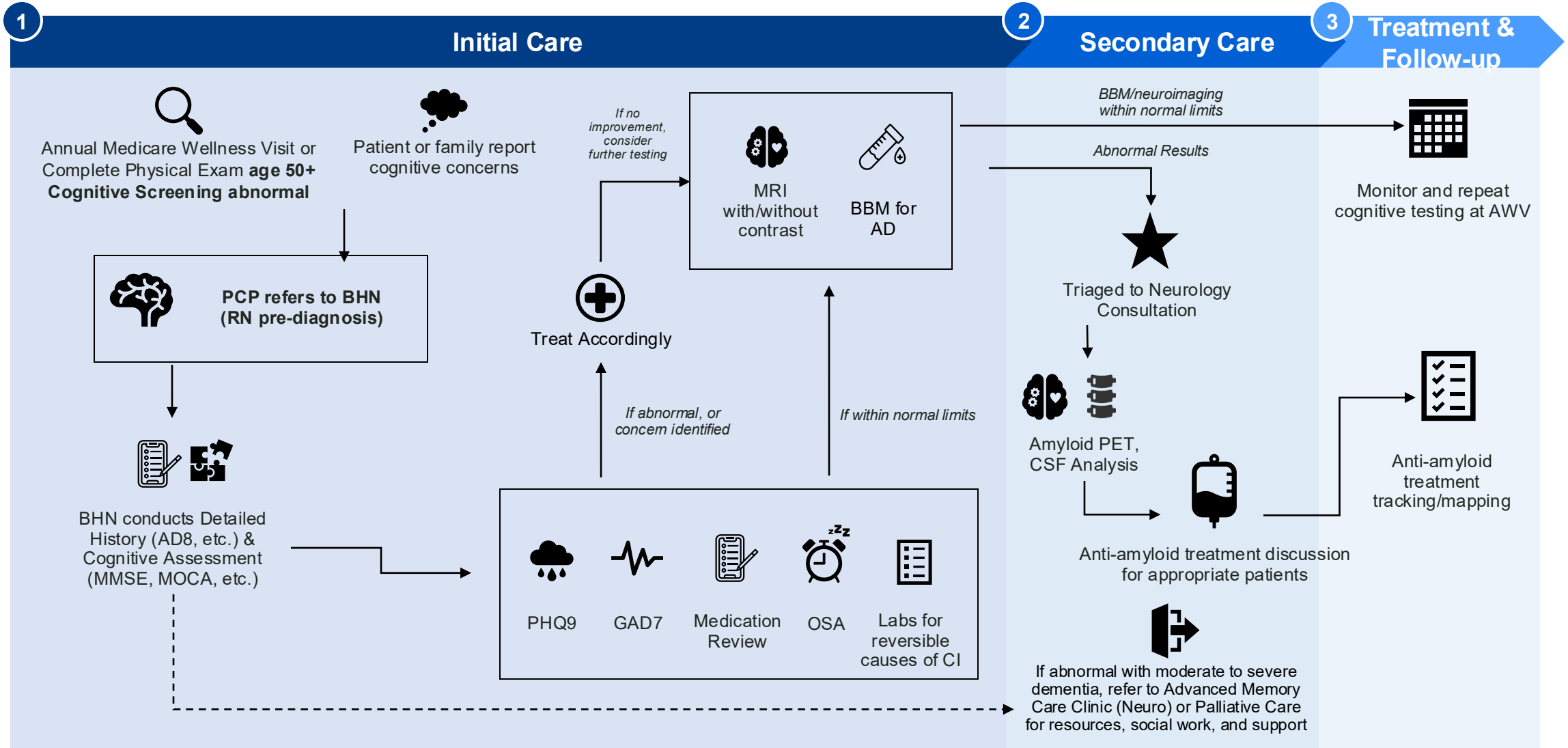
Secured approval for Brain Health Navigator position and obtained support for clinicians' time dedicated to grant implementation.

🏛️Governance Structure

The Brain Health Navigator reports directly to the primary care clinic manager for clear accountability and integration.

Memorial Healthcare BHN Model Care Pathway

Legend
- Standard Pathway
- Optional Pathway



AD= Alzheimer's Disease, AD8= Ascertain Dementia 8, AWV= annual wellness visit, BBM= blood-based biomarker, BHN= Brain Health Navigator, CI= Cognitive Impairment, CSF= cerebrospinal fluid, GAD7= Generalized Anxiety Disorder 7-item Scale, MMSE= Mini-Mental State Examination, MOCA= Montreal Cognitive Assessment, MRI= magnetic resonance imaging, OSA= Obstructive Sleep Apnea, PCP= Primary Care Provider, PET scan= positron emission tomography scan, PHQ9= Patient Health Questionnaire-9, RN= Registered Nurse,

Healthcare System Model: BHN joins an existing department

Memorial Healthcare BHN Learnings

Opportunities and Successes

- Engagement of primary care
- Improved intradepartmental communication
- Increased cognitive screening in primary care
- Triaging of referrals - early to treatment
- Education to primary care leading to interest in expanding cognitive assessment and testing for AD.

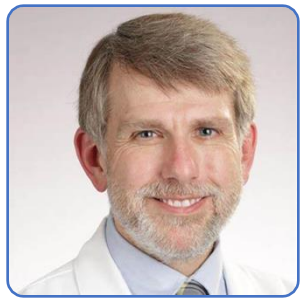
Challenges and Problem-Solving

- Engagement of primary care
- Understanding of BHN vision is based on understanding of quickly changing AD landscape
- Financial sustainability of BHN - intradepartmental budgeting
- Logistics: space, IT/documentation
- Expansion to more clinics in rural setting and travel

Norton Healthcare

Implementation of Brain Health Navigation in a Community Healthcare Setting

Poster number 101274



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Deborah Lockridge, RN BSN CCRC
Norton Healthcare

Disclosures: Research support from Eisai, Lilly and Davos Alzheimer's Collaborative

Norton Healthcare Navigator Model

Largest healthcare system in the region - Louisville, KY metro area

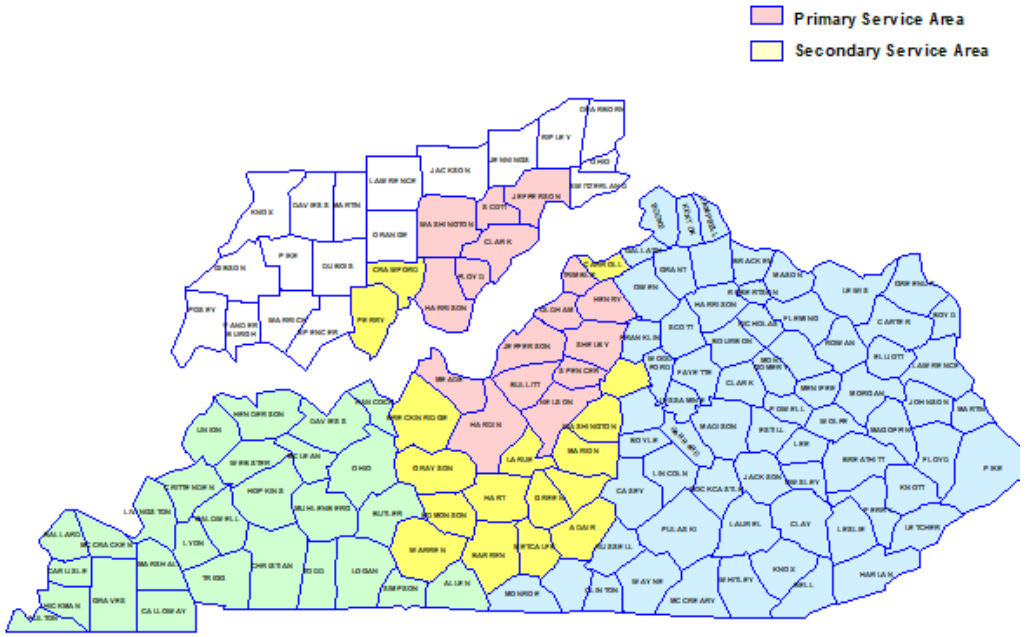
Serves **urban, suburban, and rural populations** across Kentucky and Southern Indiana

BHN housed within **Norton Neuroscience Institute Memory Care Center**

Partners:

Norton Community Medical Associates—Preston (Primary Care)
Norton Medical Group (40 primary care clinics)
Norton Neuroscience Institute Memory Care Center

Systematic screening and navigation through primary care to specialty diagnostics for early and accurate ADRD diagnosis



Geographic Coverage:

- Kentucky and Southern Indiana
- **54% market share** in primary service area
- Jefferson County represents 69.6% of cases

1.5M Population Served

16 Counties Covered

400+ Care Locations

NORTON NEUROSCIENCE INSTITUTE

Norton Healthcare BHN Model Care Pathway

Legend
- Standard Pathway
- Optional Pathway

1 Initial Care (Primary or Secondary Self-Referral)

Symptom Presentation

Initial meeting at primary care or self-referred to memory center. Primary Care can refer directly to memory center

Referral to BHN program can occur at any point within the pathway

Can refer directly to broad navigation services

Detailed History and Exam

Cognitive Testing

Depression Screening

Routine Bloodwork

MRI

Suspected AD

Biomarker testing (including blood-based)

Diagnosis

Initiate treatment plan

If ineligible or declines Anti-amyloid therapy

2 Secondary Care

Provide ongoing care, monitoring, and symptom management

Assessment for anti-amyloid therapies (biomarker testing, CSF or PET, MRI) and offer DMT, if eligible

Suspected AD

Refer to specialty if still in primary care

3 Treatment & Follow-up

Refer to Navigation Services / Infusion Nurse Navigator

Connect to Norton Neuroscience Institute (NNI) resource center, other NNI Memory Center resources, Norton Institute for Health Equity, community resources, etc.

AD= Alzheimer's Disease, BHN= Brain Health Navigator, CSF test= cerebrospinal fluid test, DMT= disease modifying therapy, MRI= magnetic resonance imaging, PET scan= positron emission tomography scan

Healthcare System Model: BHN joins an existing department

Norton Healthcare Brain Health Navigator Model

All our roads lead to the Brain Health Navigator

Focus on ease of referral and use of services

Brain Health Navigator roles:

Care coordination/navigation

Education/support

Interdisciplinary collaboration

Advanced care planning

Liaison between PCP/Specialist and internal/external resources

Supports referrals from both primary and specialty care

Flexibility is emphasized to allow for varied practice patterns

Utilization of billable navigation codes stressed

PIN and PCM codes

Can be billed under primary or specialty care

Norton Healthcare BHN Learnings

- Identify stakeholders (and create team)
- Communicate with stakeholders early and often
  - Identify current gaps in care
  - Identify opportunities to create value
  - Create roles and definitions
  - Establish best processes/pathways
- Determine appropriate billing codes early
  - Understand CMS guidelines for documentation
  - Create processes for billing/coding
- Communicate value to patient/family

Norton Healthcare BHN Learnings

Opportunities and Successes

- Elevated care and increased satisfaction for patients and families
  - Initial feedback has been very positive
- Referral process within EHR
- Improved multi-disciplinary coordination
- Improved early recognition/more efficient evaluation

Challenges and Problem-Solving

- Definition of navigation
  - Evolved through continued discussions
- Obtaining appropriate referrals
  - Improved with better definition of roles and responsibilities
- Revenue generation and sustainability
  - Identification of appropriate navigation codes
  - Development of templates and processes
  - >50 patients enrolled through July 2025 with good claims payment experience

Brain Health at All Stages

Creating a sustainable brain health navigator model to improve the diagnostic journey for Alzheimer's disease

Poster number 101321

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Anne Paul, MBA, MA
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Care Consultant
Alzheimer's Association, Greater Cincinnati

Disclosures

UCB Tau Together Clinical trial
Lilly Foundation Quality Improvement Grant
Eisai BetterDx Grant: DCAs and BBB in primary care
Davos Alzheimer's Collaborative

Partners:

Family Medicine, Internal Medicine, Geriatrics, Neurology

Internal Medicine and Family Practice

19 primary care clinics

85 Physicians, 10 Nurse Practitioners, 1 Physician Assistant

Geriatrics

5 Geriatricians and 1 Social Worker

Memory Care and Brain Health Center

5 UCNS Behavioral Neurologists

2 Nurse Practitioner Specialists

5 Social Workers

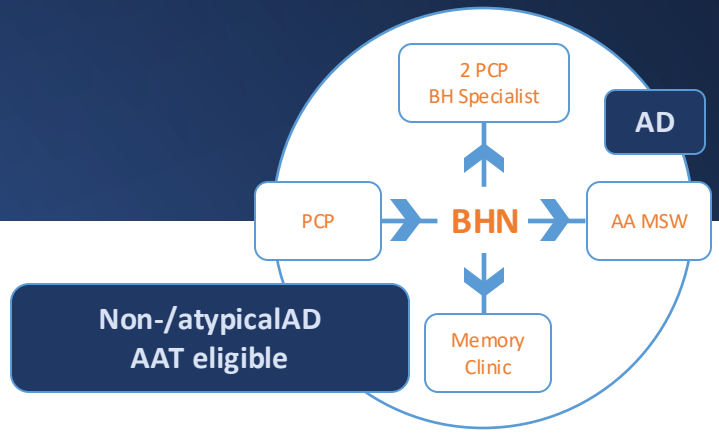
5 Psychometrists

- **>500,000 annually**
- **Greater Cincinnati, Kentucky, Indiana**
- **Urban, Suburban, Rural, Appalachia**

Local culture

- Reliance on AWV, pt/CP report for CI led to <50% of estimated UCH MCI/dementia cases identified
- Multifactorial, modifiable contributors not assessed
- No systematic, culturally appropriate tools
- PCP survey: desire to tx CI in practices but gaps in
- clinical knowledge: clinical syndromes, biomarkers, comorbidities, new therapies
- structural systems: scheduling support, diagnostic tools, and post-diagnosis resources
- PCP residents lacked opportunity to evaluate CI
- Memory clinic access 6-12 months
- Referrals often later in disease
- Desire to identify MCI/early AD dementia for AAT

Model: Enable PCP for AD



- Learning Health System Specialist
- Business adm neurology, IM, family medicine
- Health system billing administrator
- Billing consultant (Davos)
- Epic IT specialist
- PCP in other health systems (Davos)
- Support from neurology chair

Innovation

- Digital cognitive assessment: CognICA
- Epic smart sets for MRI (3T SWAN Icometrix),ptau217, home sleep studies, lab orders
- CDR standard interpretation, flowsheet for longitudinal tracking
- Epic smart set with specific AD diagnosis and staging
- Use of standard tools with data collected in flowsheets: I/ADLs, STOP-BANG/PSQI, NPIQ, CDR
- Attention to vascular, sleep, and medication comorbidities
- Embedded Alzheimer's Association MSW with standard cognitive MSW across departments
- PCP brain health specialist model
- Leveraging expertise: PCP, BH PCP, Neuro, Geriatrics

UC Health BHN Model Care Pathway

1 Initial Care

Patient schedules AWV with PCP

Cognitive Assessment, Neuropsychiatric screening, and PCP Exam

If CognICA "unimpaired", no patient/care partner complaint, no depression, anxiety

Brain Health, Sleep, Vascular risk, ACB reduction, Exercise, MIND diet, Socialization, Awe/humor

If CognICA "impaired"/"at risk" and/or patient or care partner complaint

Or new onset/ exacerbation of chronic depression, irritability, anxiety (PHQ2/GAD7)

Patient/CP schedules cognitive complaint visit

PCP Exam

If acute conditions ruled out

Treat acute condition if identified (TBI, UTI)

Order labs for comorbidities

Cognitive Assessment at BH PCP

BHN obtains consent
Orders ptau 217, MRI, Home sleep study,
Obtains standardized history
Administers NPIQ
Calculates ACB/flags meds
Referral to MSW
Arranges PCP BH visit

Place referral for BHN (RN)

BH MSW calls CP
Standardized history
I/ADL
Immediate needs
Summary for PCP

BH PCP reviews results and completes targeted neuro exam

If:
- *pTau normal or*
- *pTau elevated with atypical history, motor findings, visual hallucinations*

Refer to Memory Care Clinic for further evaluation

If:
- *pTau elevated*
- *Typical history*
- *No motor findings*
- *No visual hallucinations*

Diagnose AD

Clinical dementia rating score (CDR) (0-3)

2 Treatment & Follow-up

BHN and BH SW 2-week check-up; establish regular follow ups

Provide targeted care plan

Refer to Geriatrics for continuing care

Initiate donepezil target 10 mg and consider memantine after 90 days

AAT referral to Memory and AAT education

Continue treatment in BH PCP clinic

AAT Eligible

AAT Ineligible

CDR 2-3

CDR 0.5-1

Treat apnea/sleep hygiene. treat mood/behavior, optimize vascular factors, MIND diet, Exercise, Awe/positive emotions, Socialization

Initiate donepezil

AAT= Anti-amyloid Therapy, ACB= Anticholinergic Cognitive Burden, AD= Alzheimer's Disease, AWV= annual wellness visit, BBM= blood-based biomarker, BH= Brain Health, CognICA= a Digital Cognitive Assessment platform, GAD7= Generalized Anxiety Disorder 7 item screening tool, MRI= magnetic resonance imaging, PCP= Primary Care Provider, PHQ2= Patient Health Questionnaire 2 item depression screening tool,pTau= phosphorylated tau, RN= Registered Nurse, SW= Social Work, TBI=Traumatic Brain Injury, UTI= Urinary Tract Infection

Healthcare System Model: A brain health specialized team incorporates a BHN

University of Cincinnati BHN Learnings

Opportunities and Successes

- **PCP engagement –2 in initial phase**
  - Aligned with IM AWS initiative (APNs, residents, MDs)
  - Use of ptau 217
  - Inclusion of non-neurodegenerative factors (sleep, vascular)
  - Use of standard tools/templates/dx /tx decision tree
  - Specific diagnosis and staging
  - Identified atypical cases and referred to neuro
  - Expedited neuro referral pathway for AAT, atypical/non-AD cases, and skin biopsy for alpha-synuclein
- **Epic tools**
  - BHN and specific neuro referrals for AAT, 2nd opinion, biopsy
  - Smart sets
  - Flowsheets and standard tools
  - Standard templates for BHN, MSW, BH PCP optimized to meet billing requirements
  - Brochure explaining the BHN process, billing issues (co-pay)
  - Initial dashboard to track outcomes
- **Learning Health Systems specialist: key organizer**

Challenges and Problem-Solving

- Making the business case
- Scaling to other 8 BH PCPs and residents
- CognICA (DCA) off-line while being sold; will be back July 15th
- FDG-PET ordered by PCP not covered by insurance
- PCP initiated skin biopsy for alpha-synuclein too time intensive
- PCP distrust of blood- based biomarker for early cognitive change
- Patient/CP advisory group not organized during pilot, starts July 2025
- Sustainability of Alzheimer's Association MSW undetermined

Streamlining the Diagnostic Journey for Alzheimer's Disease: Developing a Brain Health Navigator Role

Poster number 101327

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The Setting: A Comprehensive Academic Medical Center Serving Southern California

Southern California Catchment Area
16 Million People

Los Angeles County
Orange County
Ventura County
Riverside County
San Bernardino County

Partners:
- Department of Family Medicine
- Department of General Internal Medicine
- Department of Neurology - Memory and Aging Center
- USC Alzheimer Disease Research Center

BHN works within the Healthcare Consultation Centre 2 with co-located Family Medicine, Internal Medicine, and Neurology Clinics

Integrated Pathway: Primary Care → BHN/Linus Health Digital Platform → Specialty Diagnostics → Early and Accurate ADRD Diagnosis → Transition to Dementia-Informed Care

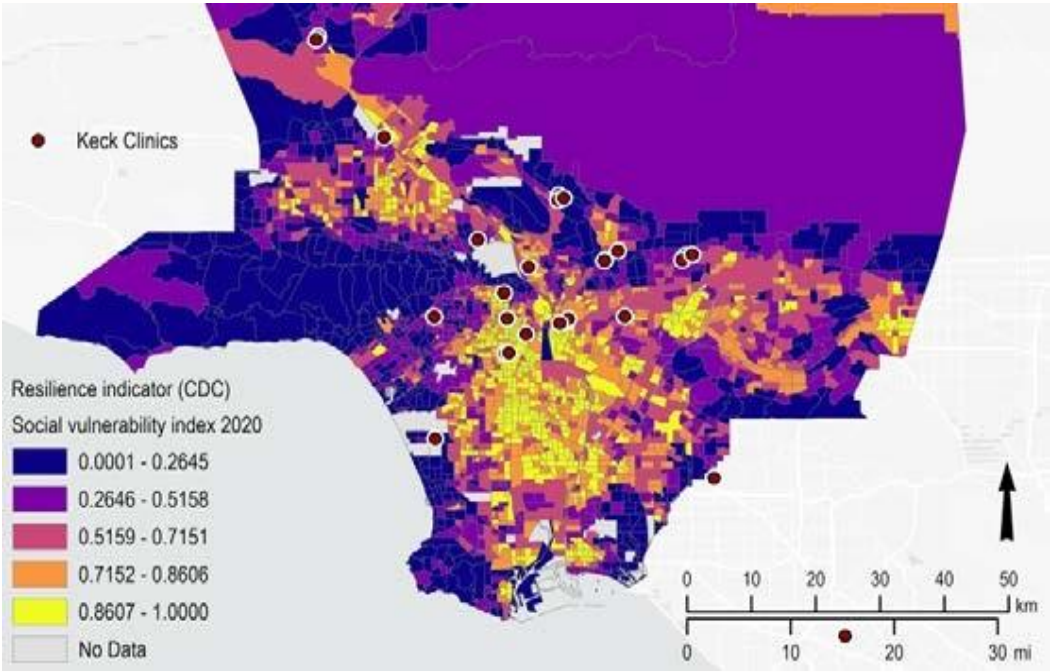


Figure 1 : *Keck clinics are located in diverse communities, with varied social vulnerability index scores. Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability).*

Keck USC Brain Health Navigator Model

The role:

Designed for a non-clinical health care worker, e.g., Health Care Navigator.
Facilitates initial assessment of cognitive concerns on referral from a primary care clinician.
Acts as liaison between patients, caregivers, staff, and primary and specialty clinicians.

The path:

Starts with a concern in primary care (Family Medicine, Internal Medicine)
Referral placed to the BHN for first-stage assessment and coordination of next steps

The goal: To support…

Primary care clinicians with protocolized initial evaluation;
Patients and families with timely attention to emerging cognitive concerns, information and facilitation of diagnostic process;
Memory specialists by pre-screening, ensuring appropriate and timely referrals, and early identification of potential candidates for disease-modifying treatments.

Keck Medicine of USC

Keck Medicine of USC BHN Model Care Pathway

1 Primary Care

Clinician Concern (Internal or Family Medicine)

Patient/Family Concern

Concern identified in Annual Wellness Visit

Referral to Brain Health Navigator (BHN) via Cerner Message

BHN explains visit, consents patient/care partner

2 Primary/Secondary Care

BHN Initial Visit: Assessment

- Digital Cognitive Assessment
- Vision
- Hearing
- Depression (PHQ9)
- Sleep (STOP-BANG)
- Everyday Function (FAQ, ADL)
- Caregiver burden and home safety (checklist)
- High-risk meds (checklist)
- Behavioral symptoms (NPIQ)

BHN Next Steps: Protocol-Based Actions

- Explains findings from initial assessments to patient + care partner
- Sends initial results to PCP with recommendations for further workup, neurology or other referral
- Helps schedule appointments and follow ups, triages questions, retrieves records, documents services provided

ADL= Activities of Daily Living, BHN= Brain Health Navigator, FAQ= Frequently Asked Questions, NPIQ= Neuropsychiatric Inventory Questionnaire, PCP= Primary Care Provider, PHQ9= Patient Health Questionnaire 9 item,

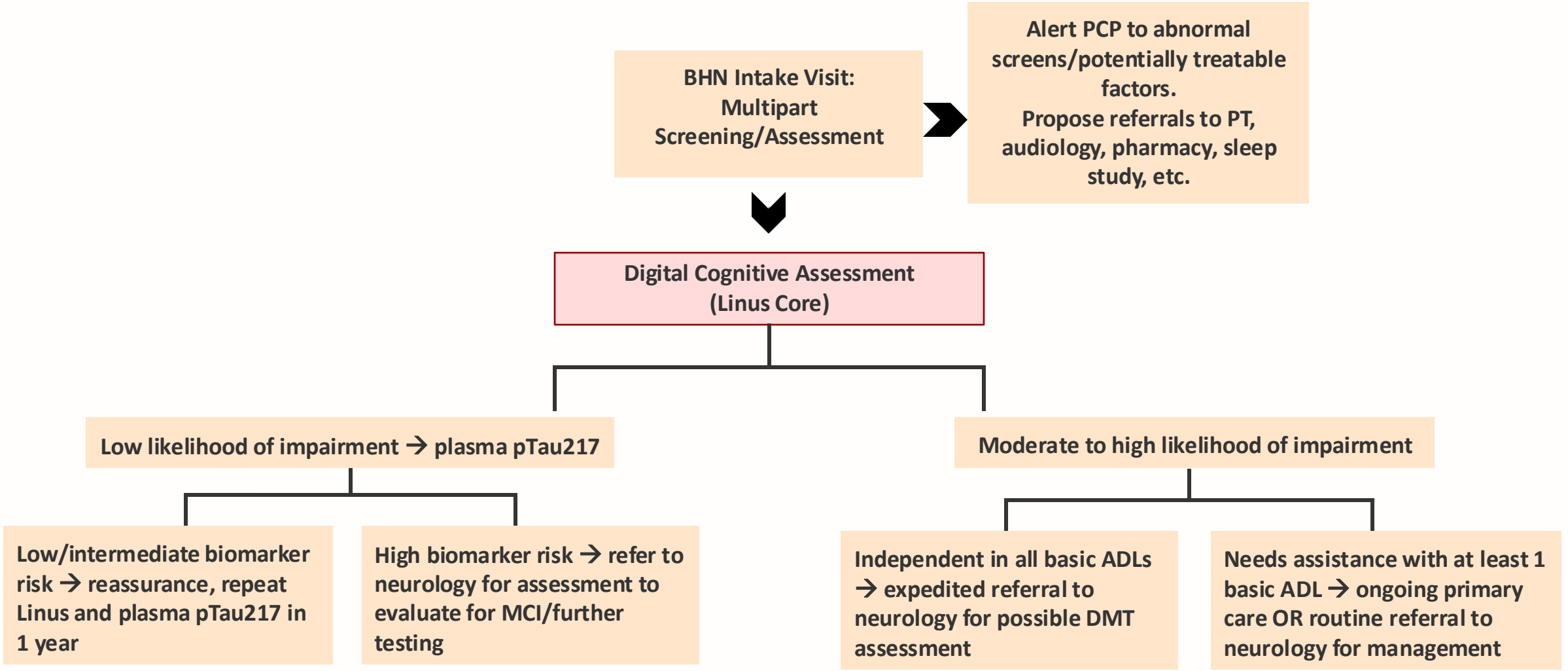
Healthcare System Model: BHN joins an existing department

Tailoring BHN referrals

Possible memory problem identified at clinic visit by patient, family, or PMD (AWV or other), but…

Previously known cause of cognitive impairment: eg, head trauma, ADHD, hepatic encephalopathy	Other major medical problem taking priority (chemo, ESRD on HD, advanced HF)	Obvious moderate or severe dementia	Already in hospice or palliative care	Obvious neurological findings (e.g. parkinsonism, tremor)	None of these 5 situations apply
⌄	⌄	⌄	⌄	⌄	⌄
Continue usual care; defer workup unless recent decline	Postpone/defer workup (or DCA if cognitive impairment will impact treatment)	PCP may consult neurology/ psychiatry for management advice	Defer workup	PCP may refer directly to neurology	**Refer to BHN**

BHN Workflow: Supporting Primary and Specialty Care



Where We Are Now – and Where We Expect to Go

Existing System Assets

- Mature ADRC and cognitive neurology program
- Early adopter of disease-modifying anti-amyloid therapies
- Highly qualified new BHN
- Leadership enthusiasm for DCA (Linus) contract/implementation
- Unified primary care leadership, enriched with new faculty expertise
- Momentum for primary care innovation and age-friendliness
- Active ADRD research across multiple disciplines, schools, and centers

Program Leverage/Opportunities

- Lowers primary care barriers to early diagnosis
- Drives brain health and ADRD education/training
- Promotes new partnerships (departments, faculty, staff, and operations)
- Encourages clinicians' financial literacy
- Addresses ADRD as a population health concern
- Pushes brain health inclusion in health system planning
- Encourages data collection for 'learning health system' action: program refinement, outcome improvement, sustainable funding

Summary and Key Takeaways

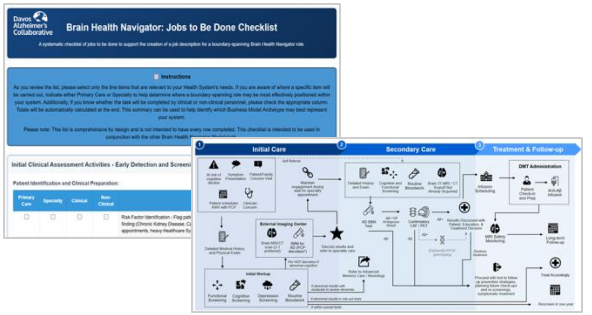
Summary Findings

Training and Education

- There is not a one-size-fits all solution
- A tenacious local champion is still the greatest criteria for success
- Front line staff need to understand and appreciate the value of early detection and accurate diagnosis and embrace the workflow

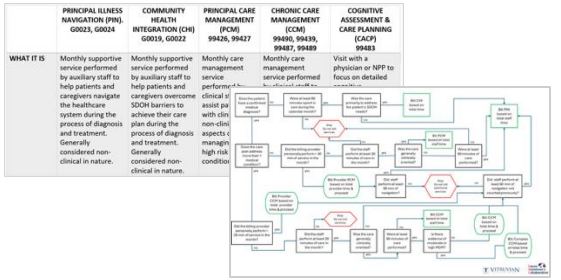
Care Workflows

- Care pathways are critical because they allow for flexible patient identification strategies and help sites identify high-value opportunities for patient retention
- An aligned workflow provides clarity on roles and responsibilities, which is essential for billing



Billing and Business Case

- Healthcare executives prioritize concrete operational benefits over abstract quality improvements, and most ADRD experts are not well-versed in these metrics
- Systemwide scaling requires executive buy-in beyond the initial champion
- Building a business case is essential for sustainability

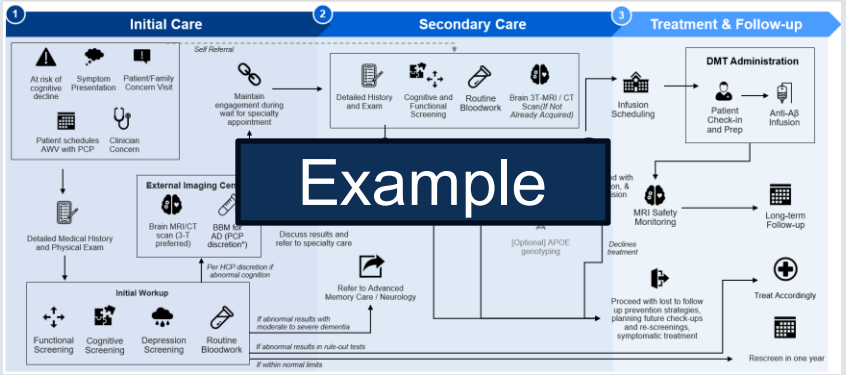


QR Code to BHN Model Toolkit

"It's possible but it's all about the workflow!"

While working with the practices, new archetypes are emerging to support brain health navigation, largely determined by clinical workflow strategies

Evolved archetype characteristics are not a one-size-fits-all approach



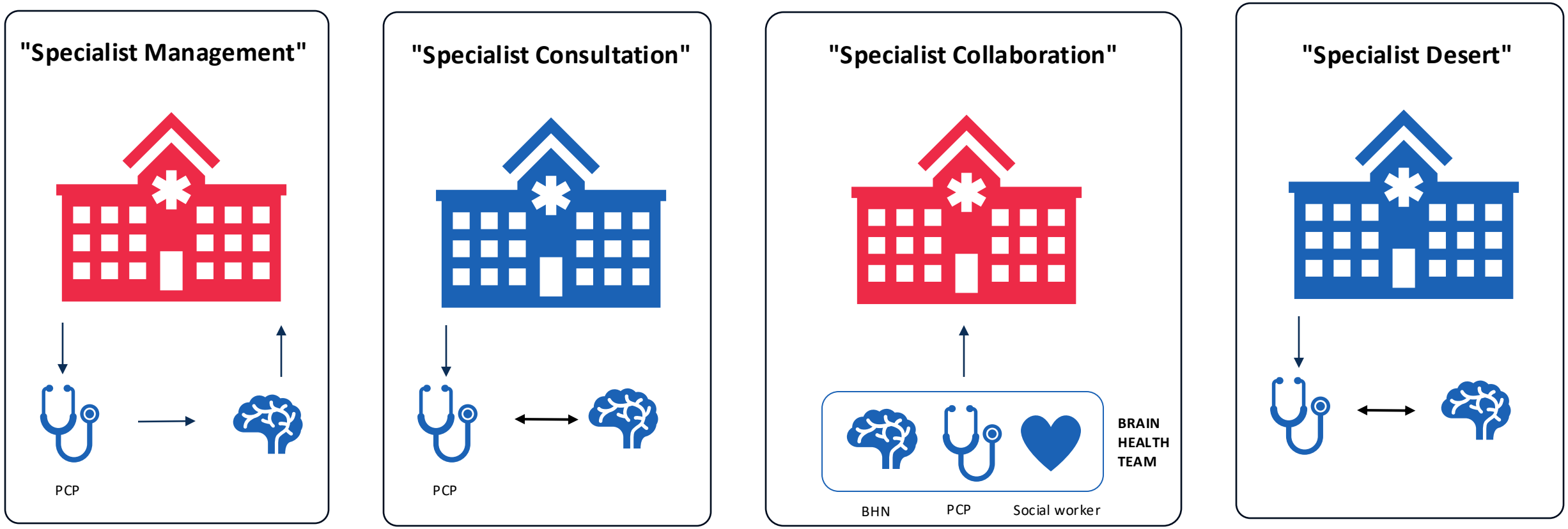
Care pathway

	PRINCIPAL ILLNESS NAVIGATION (PIN). G0023, G0024	COMMUNITY HEALTH INTEGRATION (CHI) G0019, G0022	PRINCIPAL CARE MANAGEMENT (PCM) 99426, 99427	CHRONIC CARE MANAGEMENT (CCM) 99490, 99439, 99487, 99489	COGNITIVE ASSESSMENT & CARE PLANNING (CACP) 99483
WHAT IT IS	Monthly supportive service performed by auxiliary staff to help patients and caregivers navigate the healthcare system during the process of diagnosis and treatment. Generally considered non-clinical in nature.	Monthly supportive service performed by auxiliary staff to help patients and caregivers overcome SDOH barriers to achieve their care plan during the process of diagnosis and treatment. Generally considered non-clinical in nature.	Monthly care management service performed by clinical staff to assist patients with clinical and non-clinical aspects of managing one high risk condition.	Monthly care management service performed by clinical staff to assist patients with clinical and non-clinical aspects of managing their overall health.	Visit with a physician or NPP to focus on detailed cognitive assessment, evaluation and diagnosis of cognitive conditions, and development of a cognition-focused care plan.

Billing codes

The intersection of the care pathway and billing is a better definition of BHN actionability

Pilot care pathways have identified a variety of staffing strategies for BHNs based on billing and existing HCS structures



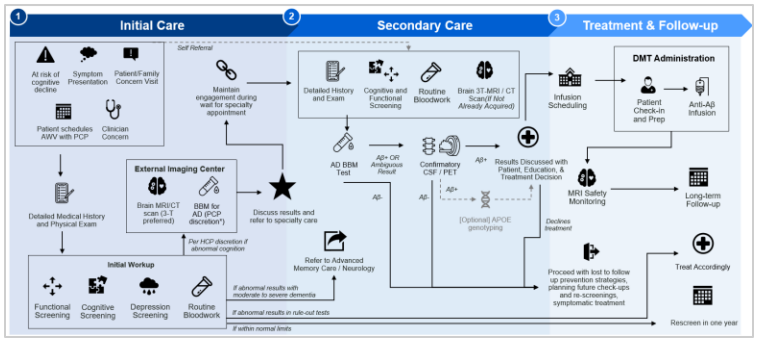
Regardless of clinical workflow strategy, sites identified health care positions that could potentially step into the BHN role, including **social workers, registered nurses, and medical assistants.**

= Brain Health Navigator

Brain Heath Navigator Model Toolkit

The toolkit and all its resources will be open access and available alongside the DAC-SP blueprint for early detection

CARE WORKFLOWS



BILLING & BUSINESS CASE

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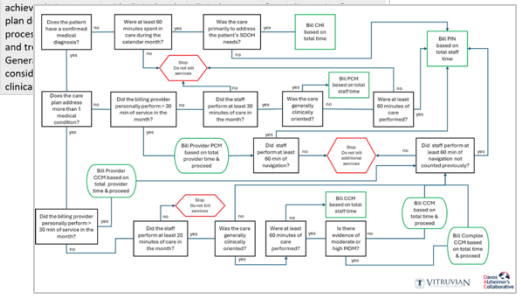
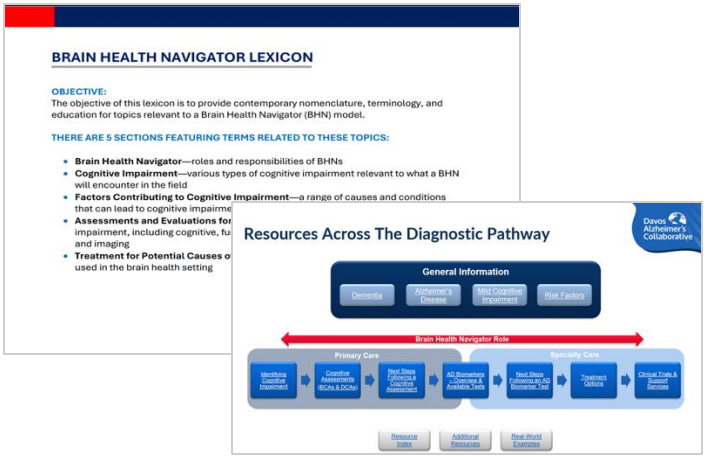


TRAINING & EDUCATION



Durable BHN Model Toolkit Objectives

1. Promote the adoption, dissemination, and sustainment of brain health navigation models in US healthcare settings
2. Create a BHN toolkit containing the resources necessary to design, implement, and sustain a brain health navigation model in primary and/or specialty care settings in US healthcare systems.

Thank You!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- USC (Michael Lee, Elizabeth Joe, Jennifer Marks, Jehni Robinson, Soo Borson, Bonnie Olsen)

Check out the Brain Health Navigator Model Toolkit!

Davos Alzheimer's Collaborative

SCAN HERE

Q&A

Questions should be directed to the diagnostic journey and should be product agnostic. Any questions related to specific products should be directed to company representatives in attendance at their medical booth(s).