

2016 Clinical Care Recommendations

Clinical Care Recommendations

- 1. Increase early detection and diagnosis by encouraging and promoting cognitive assessment; and confirm measurement strategies to track progress within 2 years.**

Immediate

- a. Encourage clinicians to implement the Gerontological Society of America's (GSA) Workgroup on Cognitive Impairment Detection and Earlier Diagnosis' four-step process; the steps include: 1) "Kickstart the cognition conversation;" 2) "Assess if symptomatic;" 3) "Evaluate with full diagnostic workup if cognitive impairment detected;" and, 4) "Refer to community resources and clinical trials, depending on the diagnosis." [HHS and CMS]

- b. Promote early detection and diagnosis: support continuing education efforts that improve healthcare providers' ability to recognize early signs of dementia, including Alzheimer's disease, and to offer counseling to individuals and their care partners. Sessions should enhance healthcare provider awareness and understanding of the Medicare Annual Wellness Visit and knowledge of validated cognitive assessment tools, through local and state conferences. [HRSA, HHS, States]

- c. Determine if and how the Medicare Annual Wellness Visit can be used to measure the rate of screening for cognitive impairment. Also, determine if and how other measures, such as items within the Physician Quality Reporting System, could be used to track progress regarding the rate of screening for cognitive impairment.
- d. Measure and publicly report data on Alzheimer's disease and related dementias diagnostic levels nationally and by state, released within six months of year end. [CMS]

Longer-Term

- e. Expand Diagnosis Disclosure, Improve Assessment and Care Planning, and Enhance Care Coordination: Develop and implement educational campaigns directed towards a) persons at risk for dementia and their family and caregivers and b) clinicians capable of conducting cognitive screening assessments. For the education of clinicians, include information about best practices for how to conduct the cognition conversation such that the diagnosis is understood, how to conduct conversations about care planning, and how to enhance care coordination through referrals to community resources. For the education of persons at risk for dementia and their family and caregivers, include information about what to expect after cognitive screening. [HHS, CMS]

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- II. Enhance care planning and care coordination by increasing the use of person-centered and caregiver goals, and improving measurement within 3 years.**

Immediate

- a. Identify standards of care that reflects delivery of a comprehensive assessment to establish the diagnosis of dementia, identification of contributing factors, identification of support needs, and formulation of a care plan.
- b. Develop and implement a plan to improve measurement capability so that the perspectives and goals of persons with ADRD, their families and caregivers are known.

Longer-Term

- c. Incorporate best practices from the CMS Financial Alignment Initiative, including guidance provided in “three-way contracts” between CMS, states and health plans to improve care coordination for dementia. One example is the Dementia Cal MediConnect program which implemented care manager training and technical assistance in response to California’s three-way contract specifying that each health plan must have a dementia care specialist.

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- III. Increase the number of communities working to become Dementia Friendly by 50% within 1 year**

Immediate

- a. Encourage efforts to foster Dementia Friendly Communities. As an example, tools and resources used in Minnesota have been replicated through a privately funded collaboration called Dementia Friendly America; under this initiative all U.S. communities have access through a website (www.dfamerica.org) to free tools, resources, best practices and technical assistance to support them in working to become dementia friendly.

Incorporate examples such as this into an update of the November 2011 Dementia Capability Toolkit and the September 2014 report, “Dementia-Capable States and Communities: the Basics;” and/or promote expanded use of the Toolkit and report.

Longer-Term

- b. Promote the Dementia Friendly Community approach as an organizing vehicle to implement state Alzheimer’s disease plans. A public/private collaborative approach should provide funding that is designed to specifically support communities/states with seed money to foster the coordination of community efforts and support technical assistance through a centralized hub and/or state lead entity. In 2016 this collaborative should fund at least 20 communities (via an RFP process) and a technical assistance hub. The communities chosen should reflect differences in cultural groups, size of community, and rural and urban locales.

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IV. Convene a national dementia care and services research summit

- Build on existing work to identify research priorities related to improving early detection and diagnosis, providing care and services to persons with dementia and family caregivers, and providing recommendations as to standards of care, best practices and priorities. [HHS, National Organizations]