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Workgroup Members

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American Association for Geriatric Psychiatry

AHRQ
Agency for Healthcare Research and Quality

AMERICAN ACADEMY OF NEUROLOGY

CDC
Change AGents

GERONTOLOGICAL SOCIETY OF AMERICA

INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES

NIH
National Institute of Neurological Disorders and Stroke

Lilly

LEAD

National Institute on Aging

US Against Alzheimer’s

The way I see it, it is a good article. Thanks for sharing!
Background and Context

• Numerous studies have found gaps and barriers to detection of cognitive impairment and diagnosis of dementia in older primary care patients.
• Increased detection of cognitive impairment is essential for earlier diagnosis of Alzheimer’s disease or related dementia.
• Earlier diagnosis leads to more timely linkage of older adults and families with community-based educational and support services.

Background and Context

• African Americans and Hispanics often experience longer delays than non-Hispanic whites between initial awareness of cognitive impairment and receipt of dementia diagnosis.
• Without concerted action to increase cognitive impairment detection in primary care settings, these barriers and disparities will only grow given epidemiological projections of sharp increases in the number of older Americans with Alzheimer’s disease and related dementia.
GSA Workgroup Charge

• Summarize efforts currently underway by national governmental and related organizations to identify evidence-based assessment tools for detecting cognitive impairment.
• Propose how the Medicare Annual Wellness Visit (AWV) can be used as a springboard for implementing evidence-based cognitive impairment assessment tools on a much more widespread basis by primary care providers (PCPs).

Medicare AWV as Springboard

• Established by the Patient Protection and Affordable Care Act of 2010.
• All Medicare beneficiaries entitled to annual wellness visits where “detection of any cognitive impairment” is a mandated component.
• Opportunity to implement evidence-based cognitive impairment detection assessment tools to fulfill this mandate on a universal basis.
• No specific evidence-based assessment tools were mandated; GSA Workgroup reviewed other efforts to identify such tools as part of its charge.
National Efforts to Provide Guidance on Evidence-Based Assessment Tools

- National Institute on Aging internal working group reviewed 138 published assessment tools for CMS and judged them based on criteria including: < 5 min. to administer; assess memory & >1 other cognitive domains; validated in U.S. community or primary care settings; free of charge with easy access.
- Alzheimer’s Association convened a Workgroup to provide guidance for PCPs on suitable assessment tools and a process for assessment during the Medicare AWV.

GSA Workgroup Actions to Date

- Designed diagram illustrating Medicare beneficiary and family member flow from Medicare AWV through referral to post-diagnosis community resources.
- Developed preliminary recommended actions related to steps along the flow diagram.
- Discussed organizing and convening a national stakeholder Summit in 2015 to help implement recommended actions in primary care settings.
- Drafted report that is presently under final review by Workgroup members.
DRAFT

Flow Diagram to Promote Cognitive Impairment Detection & Earlier Diagnosis of Dementia

Medicare beneficiary visits primary care provider (PCP) with or without family

- Medicare Annual Wellness Visit (AWV)
- Complaints about memory or cognition or clinical signs and symptoms at any PCP visit

Step 1*
If AWV, PCP learns or inquires about memory or cognitive complaints, or observes clinical signs and symptoms

Step 2*
For symptomatic beneficiaries, PCP uses an evidence-based tool to detect cognitive impairment

Step 3
For beneficiaries testing positive, PCP rules out reversible causes; conducts or refers beneficiary for full diagnostic evaluation

Step 4
Upon making diagnosis, PCP or specialist develops a care plan and refers beneficiary & family to community resources

Desired Outcomes
Beneficiary & family-specific health-related outcomes

*Steps 1 and 2 represent the scope of the GSA Workgroup’s original charge

Candidate Assessment Tools
Under Consideration by GSA Workgroup

- Draft list of cognitive impairment detection assessment tools, based on review of NIA internal working group and Alzheimer’s Association Workgroup findings:
  - Ascertain Dementia (AD8)
  - Brief Alzheimer’s Screen
  - GPCOG
  - Memory Impairment Screen
  - Mental Status Questionnaire
  - Mini-Cog
  - Short Blessed Test
  - Short Portable Mental Status Questionnaire
  - Short Test of Mental Status
  - Six-Item Screener
Proposed Stakeholder Summit

• Stakeholders will include:
  – Continuation of the Cognitive Impairment Workgroup to provide oversight and strategic direction
  – PCP professional membership organizations, including physicians, physician assistants, nurse practitioners
  – Relevant specialist physician organizations
  – Medicare insurers, including Medicare Advantage plans
  – Medicare Quality Improvement Organizations
  – Federal agencies represented on the GSA Workgroup and other relevant federal agencies
  – Consumer advocacy organizations represented on the GSA Workgroup and other relevant consumer advocacy organizations

Anticipated GSA Workgroup Report
Release Timetable

• Final review completed and report released by end of December 2014
Questions to Run on...

• How best to fulfill the intended purpose of “screening”
• When should we test? Is there a right time?
  – Annual Wellness Visit?
  – Detection vs screening?
• What is important to assess?
  – Which tests?
  – Which elements?
• How do we translate test findings into better health outcomes?
Detection of Any Cognitive Impairment

Statutorily required element of the AWV, added via rulemaking

Federal Register / Vol. 75, No. 228 / Monday, November 29, 2010 / Rules and Regulations

Health Outcomes: What Matters?

Benefits

- Longer life and improved function/participation
- Longer life with arrested decline
- Significant symptom improvement allowing better function/participation
- Care planning
- Reduced need for burdensome tests and treatments

Undesirable

- Surrogate test result better
- Image looks better
- Doctor feels confident
- Improved disease-specific survival without improved overall survival
- Overuse of tests
- Risk over benefit
Technical Solutions in the Clinical Environment

- Physicians and hospitals are eligible for incentive payments for their meaningful use of certified EHR technology. As of April 2013:
  - more than 291,000 professionals, representing more than 50% of the nation’s eligible professionals, received EHR incentive payments
  - over 3,800 hospitals, representing about 80% of eligible hospitals (including Critical Access Hospitals) received EHR incentive payments

- Certified EHR technology must use certain specified health IT standards

- Health IT standards support health information exchange and reuse

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Examples of Application of Health IT Solutions to Clinical Workflow

**Detection Workflow**: Primary Care Providers may detect cognitive impairment using 1 of 8 Brief Cognitive Tools recommended by CMS and NIH

**Example of HIT Activity**: Identify health IT content standards needed for items in the Brief Cognitive Tools to enable interoperable exchange and re-use of this information in EHRs/health IT applications

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Examples of Application of Health IT Solutions to Clinical Workflow

**Diagnosis Workflow:** Primary Care Providers or Specialists may make a diagnosis of ADRD by conducting a dementia work-up: history, cognitive exam, and laboratory.

**Example of HIT Activity:** Identify health IT content and exchange standards needed for a dementia work-up to enable:
- bi-directional and interoperable exchange of consultation requests and results between PCP and specialist
- re-use of dementia work-up information

**Care Planning Workflow:** Care planning for persons diagnosed with ADRD would:
- engage individual/family members/other care team members
- address all health concerns; individual/family member/caregiver preferences, availability and needed supports; I&R to community supports; and need for advance care planning.

**Example of HIT Activity:** Identify and fill gaps in Health IT standards to allow for the interoperable exchange of care plans and content needed on behalf of persons with ADRD.
Recent Reports

• “Medicare covers routine dementia screening, but experts say evidence of its value is lacking” Michelle Andrews. Washington Post, 05/05/14

• “Medicare Pays For Alzheimer’s Screening, But Do You Want To Know?” Michelle Andrews. NPR (formerly National Public Radio), 05/06/14
  http://www.npr.org/blogs/health/2014/05/06/309834180/medicare-pays-for-alzheimers-screening-but-do-you-want-to-know

• Inaccurate and non-concordant with USPSTF I statement (2014)

How to best timely communicate with providers, beneficiaries and their families about potentially misleading information?
Medicare Annual Wellness Visit
Effective January 1, 2011

Established by Section 4103 of the Affordable Care Act

- Health Risk Assessment
- Medical and family history
- Establish list of current medical providers
- Height, weight, BMI, blood pressure, and other routine measurements deemed appropriate
- Detection of any cognitive impairment
- Screening for depression (first AWV only)
- Review of functional ability and level of safety (first AWV only)
- Provide a written screening schedule for the next 5-10 years and a list of risk factors/conditions for which interventions are underway or recommended
- Provision of personalized health advice and referral, as appropriate
- Any other element as determined by the Secretary through the National Coverage Determination process

Medicare Annual Wellness Visit Patient Assessments

Alzheimer's Association Recommendations

- Mini-Cog™, GPCOG, and MIS
- Continually identified as appropriate for primary care in reviews
  - Administered in 5 minutes or less
  - Psychometrically similar/better than the Mini Mental Status Exam
  - Relatively free of educational, race, and age biases
  - Staff can be trained to administer


GPCOG = General Practitioner Assessment of Cognition
MIS = Memory Impairment Screen
Medicare Annual Wellness Visit
Informant Assessment of Patient

Alzheimer's Association Recommendations

- Informants can help determine if there has been a change in cognition over time
- Short IQCODE, AD8, and GPCOG (informant)
  - Informant structured tools that are appropriate for use during the AWV


AWV Algorithm for Assessment of Cognition

\[A \quad \text{Review HRA, clinical observations, self-reports, responses to queries}\]

- \text{Yes} \Rightarrow \text{Signs/symptoms present} \Rightarrow \text{Informant available to confirm} \Rightarrow \text{Follow-up during subsequent AWV}
- \text{No} \Rightarrow \text{Informant: GPCOG, Mini-Cog™ or MIS}
  - Patient: AD8 or GPCOG or IQCODE
  - Patient and/or Informant scores trigger concerns

\[B \quad \text{Refer or conduct full dementia evaluation (with informant)}\]

- \text{Yes} \Rightarrow \text{Follow-up during subsequent AWV}
- \text{No} \Rightarrow \text{Informant available to confirm} \Rightarrow \text{Follow-up during subsequent AWV}


\[\text{ADB = Eight-item informant interview to differentiate Aging and Dementia; GPCOG = General Practitioner Assessment of Cognition; IQCODE = Informant Questionnaire on Cognitive Decline in the Elderly; MIS = Memory Impairment Screen}\]
Interactive assessment tools help you assess patients and interview informants:

- Annual Wellness Visit (AWV) algorithm
- Recommended assessments for use during the AWV, including the Mini-Cog™, Memory Impairment Screen (MIS) and General Practitioner assessment of Cognition (GPCOG)
- Katz ADL
- Geriatric Depression Scale (GDS)

The Alzheimer’s Disease Pocketcard app presented by: MetLife Foundation

Visit alz.org/hcpapp to learn more or download today.

Detection & Diagnosis: Accurate, Timely, Transparent, Compassionate and Actionable

Dignity, Self-Determination and Advocacy

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Absent Cure, Why Detect?

“Not everything that is faced can be changed, but nothing can be changed until it is faced.”

- James Baldwin

Urgency of Detection and Diagnosis

- Dignity
- Self-determination
- Prepare medically, emotionally, physically, legally
- Be your own advocate
- Reduce stigma and build awareness
- Participate in research
- Avoid misdiagnosis/mistreatment
Dignity

“Love isn’t a state of perfect caring. It is an active noun like struggle. To love someone is to strive to accept that person exactly the way he or she is, right here and now.”

- Fred Rogers  
(The World According to Mister Rogers)

Self-Determination

- Particularly when dealing with a degenerative cognitive disorder, the greatest capacity to participate in or lead decision making will be at the earliest stages of disease
- This heightens capacity and confidence of surrogates to follow the individual’s wishes, typically reducing unintended and harmful outcomes for all
Advocacy

“Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.” Margaret Mead

Advocate for Clinical Care

- Detection and diagnosis
- Referral to supports and services
- Person-centered treatment and care
Framework for Detection and Diagnosis Goals

Goals for detection and diagnosis are related but distinct; each goal must have metrics and milestones.

Detection and diagnosis each must be:
- Accurate
- Timely
- Transparent
- Compassionate
- Action-focused beyond Rx (e.g., referral to supports, clinical trial discussion, etc.)

Advocate for Supports & Services

- Full continuum: pre-symptomatic education through bereavement
- Stigma and awareness
- Access, affordability, quality
- Dementia-capability
- Cultural appropriateness
- Utilization
Advocate for Dementia-Friendly Society

- Integration in policy and practice
- Not mere accommodation
- A shift of values and culture

Advocate for Research

An underwhelming response to an overwhelming problem:
- Immoral
- Irrational
- Unsustainable
- Fixable
Millions Living with Alzheimer’s

Disproportionate Investment

Federal Spending on Dementia

0 5 10 15 20 25 30 35 40 45 50

2014 2050

People with AD
AD Family Carers

NIH Research: $556 Million
Medicare & Medicaid Care: $140 Billion
“Americans whisper the word Alzheimer’s because their government whispers the word Alzheimer’s, and although a whisper is better than silence that the Alzheimer’s community has been facing for decades, it’s still not enough. It needs to be yelled and screamed to the point that it finally gets the attention and the funding that it deserves and needs.”

—Seth Rogen, testifying before Congress on February 26, 2014

Detection, Diagnosis, Documentation and Access to Care and Services

Katie Maslow
Scholar-in-Residence
Institute of Medicine
Washington, DC
Detection, Diagnosis, and Documentation of Cognitive Impairment and Dementia are essential for appropriate medical care, appropriate home and community-based services, & desired outcomes for people with dementia and their families.

**Step 4**
Upon making diagnosis, PCP or specialist develops a care plan and refers beneficiary & family to community resources.

**Desired Outcomes**
Beneficiary & family-specific health-related outcomes

**Bottom Line:**

Medical Care: Primary Care Providers

- Understanding the patient’s medical status and problems
  - People with dementia are often poor historians
  - Need a family member or other informant to assist

- Managing co-existing medical conditions
  - People with dementia often have difficulty understanding, remembering, and complying with treatment recommendations

- Considering the use of Alzheimer’s medications

- Avoiding treatments for the wrong condition

- Counseling about safety issues: driving, falls, wandering and getting lost, guns in the home
Medical Care:
Specialists, ED, and Hospital Care

• **Specialists** who are not aware of the person’s dementia can recommend or provide treatments that worsen the person’s cognitive functioning

• **Emergency Department**
  – In a fast-paced, high-pressure ED, when the person’s dementia is not recognized, unnecessary tests can be ordered and non-optimal decisions about discharge can be made

• **Hospital**
  – When the person’s dementia is not recognized, hospital staff are not able to take steps to reduce the risk of falls, elopement, dehydration, inadequate food intake, new incontinence, and loss of other functional abilities

• Appropriate medical care for people with dementia across health care settings requires detection, diagnosis, and documentation of the condition

• Many sets of guidelines are available to guide medical care, including primary care, for people with dementia*

• The goal is intentional management of care that is adapted to accommodate the person’s cognitive impairment and dementia

• That can’t happen without detection, diagnosis, and documentation

Home and Community-Based Services and Supports

Without detection and diagnosis, people with dementia and their families are not likely to be informed about or referred for:

• Information about the condition
• Evidence-based ‘non-drug’ treatments and care practices that could benefit them
  – 50-60 such treatments and care practices validated in RCTs conducted in the U.S.
  – Additional treatments and care practices validated in RCTs conducted elsewhere
  – New treatments and care practices being developed and tested all the time

There is now insufficient awareness, availability, and use of these treatments and care practices

  – Lack of awareness that there are treatments and care practices that work
  – Lack of availability in many communities
  – Again, without detection and diagnosis, people with dementia are unlikely to be informed or referred

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Home and Community-Based Services and Supports

Without detection and diagnosis, people with dementia and their families are not likely to be informed about or referred to:

• Dementia-capable community services
  – Adult day programs
  – Nursing homes
  – Assisted living facilities

• Innovative programs for the person with dementia
  – Meetup and Mentor
  – Memory Club
  – Physical activity / exercise
  – Social activity / recreation
Questions & Discussion