Medicare Annual Wellness Visit as Springboard to Detection of Cognitive Impairment, Diagnosis, and Post-Diagnosis Support

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Webinar Panel

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Quick Audience Poll

Webinar Agenda

• Introductions
• Background and Context
• Workgroup Report Recommendations
• Centers for Medicare & Medicaid Services Perspective
• Detection, Diagnosis, Documentation, and Access to Care and Services
• Questions and Discussion
Workgroup on Cognitive Impairment Detection and Earlier Diagnosis

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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 more widespread use of evidence-based cognitive assessment tools by primary care providers (PCPs).
Medicare AWV as Springboard

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

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 minutes to administer; assess memory and >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.
- Recommendations report by Workgroup members.

Flow Diagram to Promote Cognitive Impairment Detection and Earlier Diagnosis of Dementia*

*4-Step Process—STEP 1: Kickstart cognition conversation; STEP 2: Assess if symptomatic; STEP 3: Evaluate with full diagnostic workup if cognitive impairment detected; STEP 4: Refer to community resources and clinical trials.

**STEP 1 and STEP 2 represent the GSA Workgroup’s original charge.
Candidate Assessment Tools Under Consideration by GSA Workgroup

- List of cognitive impairment detection assessment tools, based on review of NIA internal working group and Alzheimer’s Association Workgroup findings:

<table>
<thead>
<tr>
<th>Tool</th>
<th>NIA Working Group</th>
<th>Alzheimer’s Association Workgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ascertain Dementia (AD8)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Brief Alzheimer’s Screen</td>
<td>X</td>
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<td>GPCOG for use with the patient</td>
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<td>X</td>
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<tr>
<td>GPCOG for use with an informant</td>
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<tr>
<td>Memory Impairment Screen</td>
<td>X</td>
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<td>Mental Status Questionnaire</td>
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<td>X</td>
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<tr>
<td>Mini-Cog</td>
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<tr>
<td>Short Second Test</td>
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<tr>
<td>Short IQCODE for use with an informant</td>
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<td>X</td>
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<tr>
<td>Short Portable Mental Status Questionnaire</td>
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<tr>
<td>Short Test of Mental Status</td>
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<td></td>
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<tr>
<td>Six-Item Screener</td>
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</tbody>
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Stakeholder Summit

- Stakeholders will include:
  - Continuation of the GSA Cognitive Impairment Detection and Earlier Diagnosis 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.
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
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 [http://www.washingtonpost.com/national/health-science/medicare-covers-routine-dementia-screening-but-experts-say-evidence-of-its-value-is-lacking/2014/05/05/022777d1a519e5a218ec1169b3_story.html]

• “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?

Detection, Diagnosis, Documentation and Access to Care and Services

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Bottom Line:

Detection, Diagnosis, and Documentation of Cognitive Impairment and Dementia are essential for appropriate medical care, appropriate home and community-based services, and desired outcomes for people with dementia and their families.

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 to 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
- Without detection and diagnosis, people with dementia are unlikely to be informed or referred

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
  - Meet up and Mentor
  - Memory Club
  - Physical activity / exercise
  - Social activity / recreation
Thank you!
Questions and Discussion

Emailed to attendees following the webinar:
• Webinar PowerPoint
• GSA Workgroup Recommendations Report
• Webinar recording

Webinar Evaluation

In an effort for continual improvement, we would like to hear your thoughts. Please provide feedback by clicking the survey link at the end of the webinar.

Thank you again and we hope you enjoyed the program!