NCIOM North Carolina Institute of Medicine
shaping policy for a healthier state

TASK FORCE ON ALZHEIMER'S DISEASE AND RELATED DEMENTIA

DRAFT RECOMMENDATIONS

Oct. edits

Discussion Session 2

Early Detection and Diagnosis

1. **North Carolina Area Health Education Centers (AHEC) programs and associations including, but not limited to, the North Carolina Medical Society, the North Carolina Psychiatric Association, and the North Carolina Nurses Association, should offer and in-service training in the early detection of Alzheimer's and related dementia. Training should include discipline/specialty appropriate validated screening and diagnostic tools, and should be tailored to all populations (discuss in text). Training should focus on:**
    a) Incorporating specific tools that can be incorporated into practice for screening and early detection for all populations, such as that in the Medicare Wellness Visit 2015 updates (discuss in text).
    b) How to meet Medicare annual wellness visit requirements for cognitive assessment using validated tools and a functional approach to assessment.
    c) Benefits of early detection (caregiver support, advance planning, and medication)
    d) Referral resources for additional medical assessment, diagnostic testing and treatment services for those with positive screens
    e) Information about care and available services and supports, including specific additional training or ongoing education for care managers (discuss in text)

Commented [ZAJ1]: These folks don't do the pre-service education---more like SOMs, SON's Community colleges, etc. Always hard to figure out lead agency.

Commented [WU2]: Incorporate new recent one for Medicare Wellness Visit 2015 with tools. Also look at CMS webinar series on diagnosis and management – from Lisa (is this available – transcript or recording?)

Health Professional Training

1. **North Carolina Area Health Education Centers (AHEC) programs, the North Carolina Community Colleges System, organizations that provide care management services, and associations including, but not limited to, the North Carolina Medical Society, North Carolina Nurses Association, North Carolina Academy of Physician Assistants, and the Council for Allied Health in North Carolina should offer continuing education on dementia-specific training for health care providers and home and community based services providers, including but not limited to nurses, certified nursing assistants, outpatient care**

staff, physicians, adult day services staff, behavioral health providers, emergency care providers and staff, emergency medical technicians and other first responders, dentists, clergy and chaplains, etc. Training programs should:

a) Be offered in multiple settings, be provided on an ongoing and recurring basis, include needs of specific vulnerable populations (mention in text), and include opportunities for more intensive trainings when desired and appropriate.
b) Be included for all health care professionals in both pre- and in-service training
c) Include information on palliative care, advanced health directives, and family care planning resources
d) Emphasize aspects of diagnosis and screening, including information on triage-based screening systems and referral-based screening systems (as referenced in recommendation xxx)
e) Use Geriatric Workforce Enhancement Program as a model, promote collaboration of GWEPs statewide around dementia care, and coordinate training with existing geriatric workforce centers
f) Address needs of people with dementia in the creation of emergency/disaster preparedness plans, and increase awareness of specific needs of this population during emergencies/disasters.
g) Include principles of patient and family centered care, as they pertain to people with dementia and their family caregivers

Commented [WU3]: Add info on new federal grant funding – how will this play in? How do we incorporate? – address in text

2. **Health care facilities, including long term care facilities (such as adult care homes, assisted living, and skilled nursing facilities), hospice, home health, and hospitals and management and training entities including nursing home systems, AHEC, North Carolina Community College System, Universities, and trade associations should increase focus on behavioral management training, including expanded training for nursing and front line staff on addressing behavioral challenges in dementia patients.**
    a) Care providers should work to address behavioral expression through individualized and patient and family-centered approach to care and through adjustments to patients' environments
    b) Care providers should work to apply best practices in prioritizing the use of nonpharmacological approaches, including new technological approaches, to behavior management when appropriate (address NC success in this in text – Sharon Wilder and Polly Welsh)

Commented [ZAJ4]: Is this the best term in the field? I

3. **North Carolina academic health education programs supported by NC general funds, in conjunction with the NC Area Health Education Centers Program, should identify and provide methods of incentives for health professionals' entry into geriatric specialization. These methods may include loan forgiveness programs, innovative recruitment models, expansion of Areas of Concentration eligibility, specialty training designations, and additional resources for recruitment of geriatric specialists into health professional shortage areas.** (this rec could also be around study recommendation to identify financial needs for specialization incentives?)

Commented [ZAJ5]: How much will this help? Does the TF want to support this?

4. **The North Carolina Community College System should work with health professional employers and professional associations (including, but not limited to, the Home Care Association, NC HCFA, NC ALA), on establishing guidelines for increased compensation upon completion of geriatric and dementia-specific training modules/certifications within existing health professional training programs (such as CNA training, and RIBN and 2+2 programs).**

Statewide Awareness and Education

1. **Using the resources and toolkits available from the DFA and ACT on Alzheimer's projects, NC Division of Aging and Adult Services (DAAS), together with philanthropic organizations, local Departments of Social Services, Area Agencies on Aging, Association of County Commissioners, and academic institutions should develop a collective impact partnership which will work toward the development and establishment of three to four dementia-capable pilot communities in North Carolina.**
    a) The collective impact partnership should be headed by staff from DAAS, who will oversee collaboration, establish a statewide advisory committee made up of stakeholders, and provide (or support?) technical assistance.
    b) Philanthropic partners should develop a targeted grant process to identify appropriate communities for initial and/or continuing funding
    c) The pilot community projects should lead to the development of a sustainable and replicable model that can be disseminated to additional NC communities and serve as a foundation for dementia capable communities.
    d) The local collective impact pilots will require a full time staff person to champion and organize local efforts. Resources will be required for facilitation, data planning/analysis, and meeting expenses. The estimated budget for each pilot is $125,000.
    e) Pilots should include evaluation processes, including an analysis of the economic impact of creating dementia-capable communities and the potential costs and benefits at the state and local levels

2. **In order to increase awareness and promote education about dementia, organizations including but not limited to DAAS, DPH, DMH/DD/SAS, DMA, DPI, Area Agencies on Aging, Office of Rural Health, local DSS, philanthropic organizations, Chamber of Commerce, businesses/employers, health professional associations, faith-based communities, and advocacy organizations should establish a partnership (and/or build on existing public/private partnerships) to explore the incorporation of dementia information into current programs and social marketing/health promotion materials. Information should include:**
    a) Connection between brain health and other preventable risk factors and health behaviors
    b) Support for early detection and diagnosis, and information about prevention and clinical trial registries
    c) Resources/referrals for home and community based services, health care providers (incl. specialists), caregiver support services, home safety, and long term care

d) Financial planning information, including available insurance coverage for different types of care and advanced care planning, legal protections (including information on fraud, guardianship, Adult Protective Services), care transitions, employee resources
e) Strategies to reduce stigma around Alzheimer's Disease and dementia
f) Resources for underserved populations including individuals with intellectual/developmental disabilities, minority populations, homeless, and rural communities

Safety:

1. **In order to ensure home safety for people with Alzheimer's Disease, organizations/agencies including but not limited to Departments of Social Services, Area Agencies on Aging, primary care providers, adult residential facilities, hospice providers, and home health agencies should work to:**
   a) Enhance and promote falls and injury prevention programs for both people with Alzheimer's and their caregivers (address EBPs in text) , as aligned with the goals of the NC Falls Prevention Coalition
   b) Promote awareness of available home safety assessment services through physical therapy and occupational therapy providers (and financial assistance/reimbursement – is this applicable?) and
   c) Address home safety assessment workforce, reimbursement, and incentives
   d) Explore use of innovative technology in home safety, including web-based monitoring devices, and promotion of existing low-tech solution, innovative technologies to address home safety, and potential return on investment for such technologies (discuss examples in text - many from I/DD)
   e) Utilize training resources on initiating conversations with people with dementia and families about proactive preventive action to reduce fall risk
   f) Increase awareness of gun safety for people with dementia and their families, including information on how to safely remove guns from the home or increase safety within the home.
   g)

2. **To increase safety in the community for people with Alzheimer's Disease, the North Carolina Department of Public Safety (DPS), the Department of Justice, and DAAS should work within the guidelines of the Dementia Friendly America initiative to:**
   a) Expand the utilization of locator devices and promote programs such as Silver Alert
   b) Increase and promote professional training opportunities and explore setting a minimum standard of training for emergency workers (including fire and emergency medical services), law enforcement officers, and other first responders on dementia symptoms, common behaviors (such as wandering), and individual/community safety concerns (build on Act on ALZ and Alz NC modules, Alzheimer's Aware through U.S. Dept. of Justice, expansion of Certified First Responder Dementia Training certification program, GAST, CIT program– address in text)

Commented [WU6]: Talk to Ellen Schneider (MHSA steering committee) and Sue Blaylock (UNC School of Nursing) – what are EBPs in this area? What is cost effective? Work with Falls Prevention Coalition. Reference – NCMJ article from Sept/Oct. 2014

Commented [WU7]: Talk to DPS about dissemination of alerts, use of social media, funding

Commented [NCR8]: GAST training includes dementia. Address in text.

Commented [WU9]: Is there evidence base for training? Look at other states

c) Collaborate with the Dept. of Motor Vehicles Driver Review Branch on outreach work with physician and health professional training groups to promote existing tools that measure cognitive ability and impairment, promote resources for health care providers about safe driving and starting conversations about safe driving with individuals with Alzheimer's Disease and their families, and develop protocols for referring individuals with revoked driver's licenses to community resources and transportation options

Health System Capacity

1. **In order to minimize avoidable treatment, increase patient satisfaction, improve quality of care, and decrease health care costs at the end of life, health care providers, vendors, and payors should promote the potential benefits of appropriate care settings, to include:**
   a. **Information on palliative care through the Palliative Care Initiative, and examine the potential cost impact of expanding Medicaid coverage for hospice and palliative care.**
   b. **Information on additional long term care options, differences between such options**

2. **Health care providers and systems should work with the North Carolina Hospital Association to promote the Dementia Friendly Hospital Initiative (Alzheimer's Association) in North Carolina's hospitals, health care providers, and health systems. Facilities should work to include environmental modifications and practices that enhance continuity of care and patient-centered care (as described in recommendation XX – quality of care). (include info on Mission in text – best practices? Staffing ratios, etc.)**

3. **DAAS, DMA, and DHSR should conduct an assessment of current health system capacity for caring for patients with dementia. The assessment should include dementia specific beds in acute care and psychiatric settings, and also include information on projected status of moratorium on new dementia beds in home health care and other settings.**

Access to Treatment

1. **The Office of Rural Health and Community Care within the North Carolina Department of Health and Human Services should examine and identify funding streams for improved telehealth services for Alzheimer's and dementia patients, with special attention on rural communities. These services should include:**
   a) Remote diagnostic screening capacity and ongoing consultation, medication management, and behavioral management
   b) Home monitoring of ADLs, with local capacity for follow up
   c) Remote resources for caregivers
   d) Additional non-health care services, such as check in calls, etc.

Commented [WU10]: Is there outcomes data on this? Don Taylor work. Address in text

Commented [WU11]: Where is Medicaid reform with regards to hospice/palliative care? Should we address eligibility?

Commented [WU12]: Jeff Spade, NCHA, and Mission/St. Joseph's – emailed Nancy Smith Hunnicutt re: new contact

Commented [WU13]: What is currently happening in tele-geriatric medicine? Are there EBPs/best practices we can cite? What are the cost savings? Evidence of increased access and improved quality? - look at notes from rural health meeting in Silva

Commented [RMG14]: Looks like there are some programs out of Asheville, but most LTC facilities say they are not cost-effective. Does anyone have details? Mission does remote home monitoring through Lifeline http://www.sciencedirect.com/science/article/pii/S1386505615300034

Commented [RMG15]: From Adam: The only tele geri program I know of in NC was Asheville based and closed down. It was to allow after hours assessment of NSG patients to avoid transfer to ED. I think that folks perceived that either docs or nurses were not comfortable in remote assessment and may the transfer of responsibility. I think the question of terl-geri for diagnostics and home monitoring may be different. Should ask Chris Collins.

Commented [RMG16]: Could this be a rec for collaboration with NC Telehealth Network? Is there room for increased funding earmarked for ALZ/dementia? SNF pilot put on hold (through FCC)

Commented [ZAJ17]: This seems like it is more 'dementia system' and less rural. Not sure who should be responsible.

2. **Explore the use of new models of care which use methods of reimbursement to incentivize care for Alzheimer's and dementia patients and reduce wait lists for specialist care.** Models may include accountable care organizations

3. **In order to increase access to medical and community services, DAAS should partner with the NC Department of Transportation to develop a plan for improving door-to-door transportation service, assisted transportation, and other transportation needs for individuals with Alzheimer's Disease and dementia.**

Commented [ZAJ18]: Not sure where these are going.