## **Clinical Care Subcommittee**

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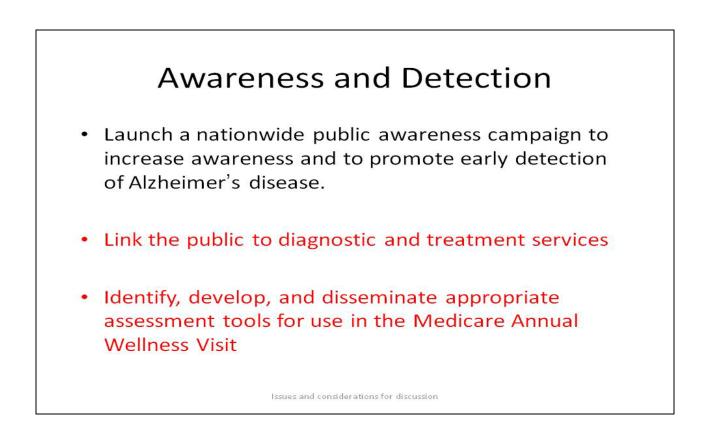
January 17, 2010

Issues and considerations for discussion

#### Process

- Discussion of top level goal and implementation steps
- Full recommendations include a situation analysis, recommendation rationale, responsible agencies and measures of success
- Conference calls on Nov 10 and Jan 12, with email-based discussions
- Informal literature review and consultations with additional experts\
- Merge with federal workgroup product.

# Overall Goal • Individuals with Alzheimer's disease have the disease detected and diagnosed at an early stage, receive care planning, and have access to coordinated and high quality health care throughout the course of the disease.



2 **NOTE**: Any mention of recommendations in these slides was for subcommittee discussion. These slides do not reflect formal Advisory Council recommendations.

#### **Diagnosis and Care Planning**

- Redesign Medicare coverage and physician reimbursement to encourage diagnosis of Alzheimer's disease and to provide care planning to diagnosed individuals and their caregivers.
- · Link the public to diagnostic and treatment services
- Identify, develop, and disseminate appropriate assessment tools for use in the Medicare Annual Wellness Visit
- Enhance assistance for people with AD and their caregivers to plan for care needs.
- Educate physicians about accessing long term care
- Identify / develop and disseminate dementia care guidelines / protocols / pathways.

Issues and considerations for discussion

#### **Quality Indicators**

- Develop quality indicators for the care and treatment of individuals with Alzheimer's.
- Identify / develop dementia care guidelines / protocols / pathways to anchor quality indicators.
- Curricula for workforce / caregivers to support quality of care

#### Medical Home – Primary Care

- Provide improving medical management for individuals with Alzheimer's disease, including management of co-existing medical conditions and coordination with family and community care providers in all settings.(in-home care, longterm care, and inpatient hospital care) through robust, patient centered medical home capacity in primary care.
- Review evidence on effectiveness of care coordination models
- Implement and evaluate care coordination models
- Implement new care models to support care transitions / AD specific toolkit for care transitions
- Identify / develop and disseminate dementia care guidelines / protocols / pathways. Issues and considerations for discussion

#### Care Throughout the Stages: Palliative Care

- Form a blue ribbon panel of experts to recommend models of palliative care for people with advanced dementia, including eligibility criteria and financing mechanisms, to remove barriers to access to palliative care.
- Test, evaluate, and implement these recommendations (e.g. Center for Medicare and Medicaid Innovation (CMMI))

#### Care Throughout the Stages: Caregiver Support

- Improve and expand the National Family Caregiver Support Program and other evidence-based caregiver support models.
- Enhance assistance for people with AD and their caregivers to plan for care needs.

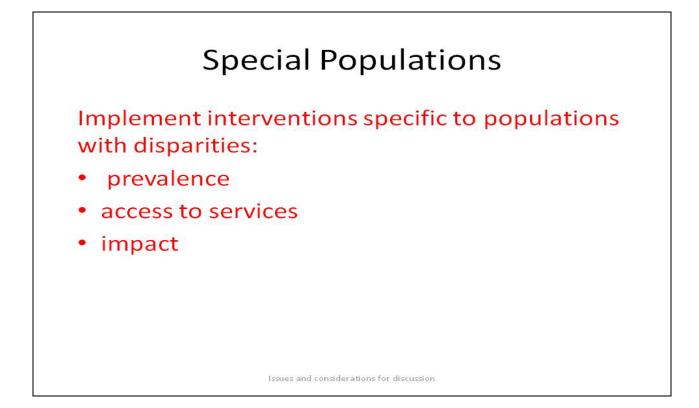
Issues and considerations for discussion

### Hospitalization

- Create a specific grant round of pilot projects through CMMI to reduce potentially preventable ER visits and hospitalizations for individuals with Alzheimer's disease.
- Public-private partnership to develop and evaluate ways to improve hospital care for people with Alzheimer's and other dementias, including training approaches and proposed quality measures.
- Implement and evaluate new care models to support effective care transitions for patients with Alzheimer's disease.
- Develop an AD –specific toolkit on care transitions

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