Example Implementation Roadmap

DR. ROBERT BREE COLLABORATIVE

Table 1: Recommendations for Optimal Alzheimer's Disease and Other Dementia Care

	Focus Area	Patient Perspective	Operational Details
1	**Diagnosis**	*I or my family members have concerns about memory. My care team talks with me about my concerns and helps me understand the cause of any trouble with thinking ability. I know who to contact in case of urgent questions or situations and have thought about the type of care that I would want at different stages of the disease.*	**Current State:** While some providers may routinely screen for or discuss cognitive issues with patients, in many cases issues with memory and cognition are only addressed if they are brought up by the patient or family member(s). Once brought up by the patient or family member, issues with memory or cognition may be adequately addressed by the provider. In some cases there may be no clinical follow-up. The provider may be unsure as to screening tools, how to utilize the Medicare Annual Wellness Visit, or next steps and may not feel comfortable discussing cognitive issues due to lack of training and lack of a system-wide protocol for addressing cognitive concerns. Primary care providers may diagnose dementia or may refer to a specialist (i.e., neurologist, geriatric psychiatrist) for diagnosis if one is available within the health care system. Specialty consultation may be unavailable. **Intermediate Steps:** Practices work to increase providers' level of comfort and expertise in diagnosing and discussing a dementia diagnosis, increasing understanding that this diagnosis is within the primary care scope of practice. Clear guidelines are available on how to make the diagnosis using validated tools with the expectation that the provider will truthfully discuss the diagnosis with the patient and family and record the diagnosis in the medical record. Practices may pilot screening programs with select populations, reporting on lessons learned before implementing wider screening. Primary care providers involve a neurologist or other specialist as needed for consultation and support or for differential diagnosis. **Optimal Care:** • The patient has an identified primary care provider. • Patient and family members receive coordinated care as part of an interdisciplinary team that has been trained in how to talk about cognitive impairment. This may include support staff in the primary care provider office, specialists such as neurology consultation, and community partners. • Family members or other caregivers are included in conversations and feel supported and heard. • Primary care providers are clear on the value of early detection and feel comfortable truthfully discussing cognitive issues, understanding the uncertainty that can accompany the diagnosis. Mild cognitive impairment (MCI) or dementia is detected at an early stage.

Alzheimers-Dementia-Recommendations-Final-2017.pdf

Implementation Roadmap

Focus Area	Current State	Intermediate Steps	Effective Lung Cancer Screening
Eligibility & Engagement	LCS eligibility and SDM are inconsistent, largely visit-based and not routinely tracked to ensure completion and equity	• Make tobacco history a "vital sign" • Standardize structured tobacco history capture at all points of care. • Use EHR alerts, registries, and panels to proactively identify eligible individuals. • Implement a standard decision aid and team-based SDM workflow. • Implement navigation support • Begin routine stratified reporting of eligibility, SDM visit completion, and uptake (screened/referred)	• Eligibility is automatically identified across systems • SDM is seamless and accessible • Data driven continuous targeted outreach to improve equitable screening rates

Implementation Roadmap

Focus Area	Current State	Intermediate Steps	Effective Lung Cancer Screening
Stigma, Bias, & Equity	Stigma, bias, inequitable access, and inconsistent navigation contribute to lower screening engagement, compounded by gaps in data to inform equity-driven approaches.	• Implement targeted stigma and bias training for patient-facing HCPs with accountability. • Define priority populations, plan targeted outreach, and expand outreach materials to be most relevant. • Expand use of telehealth and mobile CT strategies • Direct quality improvement efforts to improve accurate data capture and identify gaps in care	• Person-centered communication and messaging free of stigma is the norm. • Navigation support is matched to individual-level risk and barriers. • High-quality data enables and directly influences sustained reduction in lung cancer screening and outcome disparities.

Implementation Roadmap

Focus Area	Current State	Intermediate Steps	Effective Lung Cancer Screening
Screening with LDCT	Smoking cessation integration, workflow ownership, and tracking LDCT and follow-up are inconsistent, with no widely adopted LCS performance metrics	• Integrate smoking cessation into every LCS touchpoint. • Designate a clear owner for LCS program operations and population management, and add nodule tracking system • Standardize LDCT protocols, Lung-RADS reporting, and EHR workflows. • Introduce basic LCS metrics into value-based contracts where feasible.	• LCS functions as a standardized within-health-system program with consistent technical quality • Reliable access to guideline-driven follow-up • Payment models reinforce the full screening pathway: identification, SDM, screening, follow-up, and annual screening

Implementation Roadmap

Focus Area	Current State	Intermediate Steps	Best Practice
Results Management	Follow-up after abnormal LDCT findings is inconsistent, with unclear responsibility for results management, no standardized pathways for incidental findings, and no statewide registry to track screening and follow-up.	• Build structured reporting elements in radiology reports utilizing Lung-RADS • Align nodule management protocols with Lung-RADS algorithm. • Assign a clear process owner for abnormal result follow-up and outreach. • Establish connections between systems with access to multidisciplinary teams and patient entry-points	• Timely, reliable follow-up for all abnormal findings with minimal loss to follow-up. • Clear patient communication and navigation from initiation through completion of LCS Continuum. • Multidisciplinary review of concerning findings is universally accessible in house or through established referral and communication pathways