

Clinicians

- **Level 1 actions (introductory):** activities that provide a starting place to improve care including advancing audience knowledge and self-efficacy in addressing the health topic. These activities may be able to be incorporated into existing workflows.
 - **Note:** These actions are to be encouraging for individuals to begin treating the chosen health topic.
- **Level 2 actions (intermediate):** activities that may require collaboration, new workflows, and resources to accomplish.
- **Level 3 actions (advanced):** activities that may require higher collaboration, resources, funding, and time to accomplish.

Level 1

Risk Reduction & Delaying Progression

- **At routine care visits, identify and address modifiable risk factors for cognitive decline and dementia.** These are important to identify and address across the brain health continuum. See **Appendix C.** for more information.
- **Refer and encourage participation in programs that prevent and treat chronic conditions,** such as:
 - Diabetes Prevention Program (DPP)
 - Self-Monitoring Blood Pressure (SMBP) Programs
 - Older adult exercise programs (e.g. Silver Sneakers)

Detection & Diagnosis

- **Assess cognition (e.g., at a Medicare Annual Wellness Visit or other primary care visit):**
 - When concerns are raised by the patient or family
 - When the patient presents after completing prior community-based assessment (e.g., Health Plan/insurer sponsored in-home evaluation, patient self-obtained blood (biomarker, or genetic) testing, online self assessment,

Informant caregiver communicated concern or Senior living, Home Health, visiting Nurse administered assessment,)

- After an abnormal office-based cognitive brief assessment
- When you observe clinical signs and symptoms, such as missed appointments, medication-management problems (link: [Alzheimer's Association](#))
- **If a cognitive concern is identified, recommend further evaluation. This evaluation is often best performed as a dedicated follow-up appointment. The components of a cognitive evaluation include:**
 - Seeking direct input from the patient/family members/close friends when possible for their observation of cognitive changes. Consider a structured assessment tool to help with this conversation (e.g., AD8) caregiver/family input in conversation
 - Assessing cognitive function (e.g., with MoCA, RUDAS, or SLUMS test)
 - Evaluating for addressable causes and contributors (e.g., B12 deficiency, thyroid disease, medications such as anticholinergics, alcohol use, depression, sleep apnea)
 - Ordering imaging when clinically indicated to rule out intracranial mass, hydrocephalus, or subdural hematoma
- **If diagnosis is uncertain, repeat evaluation in 6-12 months or consider a specialty referral**

Ongoing Care, Support, & Management

- **Keep up to date and engage in continuing education opportunities on modifiable risk factors of dementia and quality improvement in dementia care** (e.g., seek resources through [Project ECHO](#), Memory Hub, ADRC, Alzheimer's Association, etc.).
- **Include the patient and family or other caregivers as part of the care team.** This means proactively asking about, routinely reassessing, and centering care plans around their needs, preferences, and capacity.

- **Identify the patient's goals of care and work to maximize function that meets patient and family needs.** Ask if the patient and family feel confident in their care plan and work to fill any gaps.
- **Incorporate their dementia diagnosis and consideration for the patient's cognitive function into shared decision making for routine medical care** including decisions about safety (e.g., driving, wandering) and/or unnecessary or potentially harmful care (e.g., complicated insulin regimen for managing diabetes)
- **Patient and family education**
 - Educate family about the diagnosis and available treatment, including the natural progression of dementia.
 - Ask about and discuss neuropsychiatric symptoms (e.g., agitation, psychosis) and management strategies using a shared-decision making approach appropriate to the patient. Manage with non-pharmacologic treatments first, consulting with behavioral health clinicians when possible.
- **Identify and address conditions that may worsen symptoms** (e.g., depression, diabetes, hypertension, polypharmacy)
- **Ensure that the patient and family/caregivers know who to contact if symptoms (e.g., pain) develop or worsen**

Level 2

Risk Reduction & Delaying Progression

Detection & Diagnosis

- **When a diagnosis is made, use an interdisciplinary approach to address the following**
 - **Discuss ways to improve safety and quality of life.**
 - Inquire about and document [driving status and safety](#) and home safety/fall risk
 - Assess for sleep quality and sleep disturbance, depression, risk of suicide, and presence of firearms in the house

- Discuss how to mitigate confusion, agitation, aggression, and/or wandering
 - Review and manage medications, and offer tools like pill boxes as appropriate
 - Assessment and guidance around financial management/vulnerability
 - Encourage early advanced care and legal planning, while the individual can meaningfully participate
- **Assess caregiver stress, capacity, and support**
 - Identify the primary caregiver and any other family or friends who are involved in arranging, coordinating, or providing care
 - Help caregivers understand their role and what they need to know to carry out tasks.
 - Assessment should inform the care plan with measurable outcomes for the caregiver; Regularly assess as stress, capacity, and external support can fluctuate.
- **Assess for and address hearing and vision loss** (e.g., readers, hearing aids, voice amplifiers) before cognitive assessment and periodically thereafter, as sensory impairment can complicate diagnosis
- **Advanced Diagnostics and Therapeutics**
 - Blood based biomarkers (BBMs) do not definitively rule out or rule in a diagnosis of Alzheimer's disease. A comprehensive evaluation is needed to make an accurate diagnosis.
 - BBMs may be appropriate for people with a diagnosis of mild cognitive impairment or mild dementia who are otherwise appropriate for and interested in amyloid-targeting therapies, and have the ability to see a neurologist within 4 weeks.
 - Best practice for use of BBMs is in specialty settings to establish eligibility for amyloid targeting therapy; outside of those settings, best practice for use of BBMs is unclear and evolving. See the **Alzheimer's Association Clinical Practice Guidelines** [here](#).
- - Amyloid targeting therapies have been FDA-approved for the treatment of Alzheimer's disease. **The clinical benefit of these therapies is debated, and the risks, costs, and monitoring burdens are significant.** Understand who might be a good candidate for amyloid-targeting therapies when discussing treatment options. The following is a noncomprehensive list of criteria for those that are most likely to benefit:
 - Mild cognitive impairment or the earliest stages of dementia (e.g., minimal interference with high-level IADLs)
 - Low comorbidity; long life expectancy
 - Primary etiology of cognitive impairment is Alzheimer's disease
 - Not on an anticoagulant
 - APOE phenotype is known (e.g., 4/4 is high risk)

- Patient and family understand the benefits and risks of treatment, including cost and medical monitoring requirements (e.g., regular imaging)
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Ongoing Care, Support, & Management

- **Provide a checklist on how to prepare for a potential hospital stay.**
 - Discuss how to plan and prepare for a potential inpatient stay including risks and benefits of a hospitalization and when the patient may want to be hospitalized and when they may not want care in a hospital setting. (link: [Taking a Person with Alzheimer's Disease to the Hospital](#))
- **Advance care planning and palliative care**
 - As soon as possible, have an empathetic, realistic, and patient- and family-centered (e.g., using lower literacy materials if appropriate) advance care planning conversation about preferences, goals, and values for end-of-life care. Include the caregivers and especially the individual designated as the durable power of attorney for health care in the conversation. Talk about the difference between an advance directive and POLST and situations in which each would be acceptable. Document:
 - An advance directive that stipulates specific treatment preferences (if known and applicable to the situation)
 - A durable power of attorney for health care that names a surrogate. Fill out as early in course of cognitive impairment as possible while patient still has legal capacity to do so and to identify back-ups to who would be the immediate durable power of attorney (e.g., alternates to spouse)
 - Ideally, a written personal statement that articulates the patient's values and goals regarding end-of-life care.
 - Physician Orders for Life-Sustaining Treatment (POLST), if appropriate.
 - Discuss advance legal planning and designation of financial decision-maker as part of the conversation
 - Refer to legal or elder-law resources when appropriate
 - Introduce concept of symptom-based palliative care as dementia progresses. Include education around the difference between palliative care and hospice care.

Level 3

Risk Reduction & Delaying Progression

Detection & Diagnosis

Ongoing Care, Support, & Management

- **Discuss preparing for hospitalization and higher levels of care, including:**
 - Possible red flags that may necessitate hospital admission, risks and benefits of hospitalization, and identify when they may not want care in the hospital setting
 - Risk of delirium in the hospital setting, especially after surgery, and ways to mitigate that risk
 - Planning for higher levels of care, possible red flags that indicate more support is needed, and who to contact if a crisis should occur

All Guidelines

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