

Health Delivery System-Primary Care

- **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

- **Provide brain health education at every annual wellness visit** anchored in the Dementia Action Collaborative's [**"Keep Your Brain Healthy"**](#) resource

Detection & Diagnosis

- **Connect patient and family/caregivers to appropriate local and/or state/national sources of care and support, including explicitly for family/caregivers.** See resources in Appendix B.

Ongoing Care, Support, & Management

- **Identify a care team member's role to assess caregiver distress, fatigue, capacity, knowledge, and skills as a core component of each visit.**
- **Provide a checklist on preparing for hospitalization, inclusive of:**
 - Essential documents and information gathered (e.g., medication list/containers, insurance cards and identification, recent medical records, advance directives, living will, power of attorney, and/or do-not-resuscitate (DNR) orders)
 - Creating a packed 'hospital bag' with comfort items, comfortable clothing/bathrobe, personal care items, etc.

- A written list/tips for staff around possible behaviors and how to calm your family member
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Level 2

Risk Reduction & Delaying Progression

- **Incorporate brain health** (e.g., “heart health is also brain health”) **into existing chronic condition programs**, such as Diabetes Prevention Programs (DPP) and Self-Monitoring Blood Pressure (SMBP) programs

Detection & Diagnosis

- **Design clinic workflows to support assessment of cognition and separate appointments for cognitive evaluation**
- **Make a checklist/reference tool for use by the healthcare team during a visit when a diagnosis is made**, inclusive of:
 - Discussing ways to improve safety and quality of life.
 - Assess caregiver stress, capacity, and support
- **Ensure clinicians are trained to communicate dementia diagnoses through a dignified, culturally responsive approach** (see [Alzheimer’s Association’s Principles for a Dignified Diagnosis](#))
- **Ensure office staff, community partners, and others part of the care team understand how to communicate** with someone with memory loss through dementia communication strategies.
- **Support early detection through clinician and staff training**, including how to discuss uncertainty in diagnosis. Refer to the [Dementia Action Collaborative \(DAC\)](#) for guidance.
- **Partner with specialty care** for referral and consultation for cognitive evaluation
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Ongoing Care, Support, & Management

- **Develop and provide a template for advance care planning conversations for healthcare teams.**

Level 3

Dedicate quality improvement teams/resources to measuring and improving care for people living with cognitive impairment and their families/caregivers. Explicitly measure caregiver and patient-reported outcomes as part of improvement work.

Risk Reduction & Delaying Progression

- **Develop a system to identify adults at higher risk of cognitive impairment or dementia** through identification of documented risk factors (e.g., hypertension, diabetes, dyslipidemia, hearing loss, depression, smoking, obesity, prior TBI, etc) starting at midlife (e.g., age 45-50+)
 - Use this system to flag the health record before annual wellness and chronic condition management visits to provide brain health education and resources

Detection & Diagnosis

- **Flag empaneled patients who may be demonstrating high risk for cognitive impairment** and alert the assigned primary care team before a visit.

Ongoing Care, Support, & Management

- **Offer dementia care management services either through your care team or a community service clinician** (e.g., home health, geriatric care managers, enhanced outpatient management) **to all patients and families diagnosed with dementia**
 - Discuss when additional in-home support or a higher level of care may be needed if care cannot be safely managed, considering caregiver capacity, finances and insurance, medical needs, and available residential, paid caregiver, and community resources.

All Guidelines

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