## STATE ALZHEIMER’S DISEASE PLANS:
CARE AND CASE MANAGEMENT

*Recommendations to improve the individual health care that those with Alzheimer’s disease receive*

<table>
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<tr>
<th>State</th>
<th>Recommendations</th>
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<td>Arkansas</td>
<td>• Commission a study documenting patterns of care and costs of Alzheimer’s disease in Arkansas at the Center for Clinical and Translational Research at the University of Arkansas for Medical Sciences. The study will recommend focal areas and key components of a care management program designed to improve care and reduce avoidable costs associated with Alzheimer’s disease within the state.</td>
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| California| • Advocate for adoption of the concept and characteristics of the "medical home" and "health care home," which provide coordinated, interdisciplinary team-based, person-centered Alzheimer's care.  
• Invest in and promote care management and care coordination.  
• Expand upon care coordination infrastructures that assist families in understanding the diagnosis, how to access services, future challenges, and other issues.  
• Promote the critical importance of establishing meaningful activities across the care continuum that are specifically adapted for the person with Alzheimer's disease. This may include vocational, rehabilitative, social, and recreational activities.  
• Regularly update and disseminate California's evidence-based Guidelines for Alzheimer's Disease Management to continually improve assessment, treatment, care coordination, and follow-up support of the patient.  
• Strengthen primary care practices by dedicating staff support (or by providing access to a Dementia Care Manager) to coordinate care, manage individual cases, and develop formal mechanisms for referral to health care homes and community-based agencies that offer specialized expertise, social supports, and mental health services.  
• Protect and promote the California Alzheimer's Disease Centers as a tertiary referral resource for community physicians to support diagnosis and management of complex cases.  
• Incorporate Alzheimer's educational materials for patients and family caregivers into digital libraries to enable physicians to store and forward information on electronic medical records. |
| Colorado  | • Support federal legislation to provide reimbursement to marriage and family therapists and mental health counselors under Part B of Medicare. |
| Illinois  | • Work with Congress to eliminate barriers (such as the Medicare two-year waiting period) for persons with younger-onset Alzheimer’s disease to receive federal benefits.  
• Equalize public benefits for all persons with Alzheimer’s disease and other dementias whether funding is provided by the Illinois Division of Rehabilitation Services (for those in the program before age 60, including persons with younger-onset Alzheimer’s), the Illinois Department on Aging, the Medicaid program, or some other source.  
• Seek any necessary waivers to consolidate services to persons at any stage of Alzheimer’s disease and at any age, including younger-onset Alzheimer’s.  
• Standardize the service package for every person with Alzheimer’s disease, whether they are younger or older than age 60. |
| Iowa      | • Establish Alzheimer’s disease and other dementias Diagnostic Centers of Excellence strategically throughout the state that would serve as multi-disciplinary centers to serve patients with Alzheimer’s disease and other dementias and their caregivers. The public could initially access information about the Centers through an 800-number manned by a non-profit entity (such as the Alzheimer's Association). The ideal center would provide physician services, social services, nursing services, and a special interest in the care of persons with Alzheimer's disease and other dementias. The state would provide funding to support establishment of new centers. Various organizations focused on patient needs in this area could join forces to ensure efficiency and effectiveness. |
| Kentucky | • Ensure a system of care coordinators and benefit counselors in each of 15 regions.  
• Review the current Kentucky Medicaid program to ensure “dementia friendly” approaches and policies, including by: (1) reviewing the Resource Utilization Groups system to determine values of behavior management and evidence-based interventions; (2) increasing opportunities for self-determination; and (3) identifying challenges to admission and eligibility requirements. |
| Louisiana | • Develop and/or implement, building on existing resources, a dementia-branded toll-free number and website to act as a clearinghouse for programs, services, and educational information serving individuals with Alzheimer’s and other dementias that takes advantage of existing information and referral services, such as Aging and Disability Resource Centers, the Alzheimer’s Association, and the Long-Term Care Options Help Line.  
• Investigate the elimination of the current prohibition against receiving Long-term Personal Care Services and Hospice Services concurrently. |
| Maryland | | Michigan |
| Minnesota | • Ensure that patients with early stage Alzheimer's are given good information about available interventions aimed at improving disease knowledge and management, promoting overall physical and cognitive health, and enhancing quality of life.  
• Once identified, cognitive impairment should become an organizing principle for all other care of the patient, in coordination with their caregivers, supported by a health care home team, with special attention to points-of-care transition.  
• Provide care consistent with the patient's needs, values, and preferences across the spectrum of care and life, including palliative, hospice, and end-of-life care.  
• Develop and sustain care coordination, care planning, education, and support for all persons with Alzheimer's, especially for those with Mild Cognitive Impairment or early dementia, in a culturally-appropriate manner.  
• Create a "disease educator" position for Alzheimer's disease similar to those for other chronic diseases, to work with persons diagnosed with the disease and provide practical disease information and care coordination for those persons and their caregivers.  
• Provide professional care management to persons with Alzheimer's and their families immediately on diagnosis and for the entire course of the disease, and improve the access to information on options and resources across all stages of the disease.  
• Support the health care home and include services in this model that connect persons with Alzheimer's and their families to professional care management immediately upon diagnosis.  
• Provide consistent proactive support from a coordinated team of professionals for the entire course of the disease.  
• Seek funding for high quality dementia-competent care management and team support beyond Medicare reimbursement.  
• Provide easy access to information about options and services across all stages of the disease, with attention to smooth transitions between services and settings as well as automatic transfer of clinically-important information at the time of this transition. |
| Mississippi | • Provide information regarding resources available for care of individuals with Alzheimer's disease and other dementias in the form of a resource guide.  
• Provide information and referral regarding care and services for persons with Alzheimer's disease and other dementias. |
| Missouri | • Identify existing statewide resource databases and evaluate them for inclusion of dementia-related resources.  
• Create a Road Map that includes community organizations such as the Alzheimer's Association and the Area Agencies on Aging network, and that provides unbiased information on care planning and in-person consultations.  
• Develop a strategy for dissemination of the Road Map to consumers, health care professionals, and community partners.  
• Design a structure to review transfers/discharges of persons with Alzheimer's disease and other dementias. |
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| Missouri     | • Support the development of a pilot demonstration project that incorporates dementia specialists as a treatment team member for all individuals with dementia while they are inpatients in hospitals and behavioral health settings.  
• Create a Road Map for care and support that provides quality information on services across the continuum from early diagnosis to end of life. |
| New York     | • Increase case management for families to improve planning for services and access to available services.  
• Partner with primary care providers and dementia care facilities to improve lines of communication within the medical community.  
• Identify patient advocates and case managers (including discharge planners) to ease transitions within and between hospitals, nursing homes, and community-based care.  
• Work with hospice to promote a model of care for late-stage dementia patients who do not meet the current hospice criteria for terminal illness of six months or less.  
• Increase integration of the mental and physical health systems using models such as the one implemented by Flushing Hospital.  
• Promote increased awareness of the availability of hospice and palliative care for Alzheimer's disease patients through all state programs. |
| North Dakota | • Provide care consultations to those diagnosed with Alzheimer's disease and their caregivers, including an assessment of needs, identification of issues and concerns, identification of available resources, development of a plan of care, referrals, support and education about dementia, and follow-up. |
| Oklahoma     | • Establish and fund a statewide information and referral system for those with Alzheimer's disease, their caregivers, and their families to connect with local case management, support services, and information.  
• Implement an automatic reminder on electronic medical records requiring physicians' offices to provide referral to the Alzheimer's Association upon a diagnosis of Alzheimer's disease and other dementias.  
• Recommend that pharmacists include written referral to the Alzheimer's Association upon distribution of memory-care medications. |
| South Carolina | • Create a single point of entry for persons seeking assistance with Alzheimer's-related needs, utilizing a toll free number through the Lieutenant Governor's Office on Aging.  
• Provide appropriate referrals for hospice care for people with Alzheimer's disease and aftercare for the caregivers of persons with Alzheimer's disease and other dementias.  
• Provide case management and person-centered support services to individuals with Alzheimer's disease and other dementias and their caregivers through a local/regional provider network. |
| Tennessee    | • Enhance and strengthen the infrastructure to provide a continuum of care for persons with Alzheimer's disease and other dementias and their caregivers to address the progression of the disease from mild to severe and to allow flexibility to move within the care system depending on the needs of the individuals and their families.  
• Provide case managers to help navigate the system.  
• Provide diagnostic services, treatment, and case management to patients and families throughout Tennessee, especially to rural areas of Tennessee.  
• Provide access to optimal care for more Tennesseans in all parts of the state.  
• Identify a patient's true needs at the point of discharge, assess a caregiver's abilities/limitations, involve the family and their needs in planning, and develop a special check-list/survey for persons with dementia.  
• Partner with the Tennessee Hospital Association to provide a “point person” at each hospital responsible for coordinating support for the person with dementia and his/her family.  
• Provide a continuum of care for geriatric-psych patients who require both inpatient and outpatient care. |
| Texas | • Partner with state, local, and community agencies to disseminate Alzheimer’s education materials to patients and families.  
• Conduct research to identify, evaluate, and deploy effective and efficient methods of providing Alzheimer’s disease educational materials to individuals and families.  
• Explore potential funding sources to support a statewide media campaign on resources available to individuals with Alzheimer's disease and their family caregivers.  
• Establish protocols for state and local agencies and cross training to address needs of individuals and families affected by Alzheimer’s disease and other dementias.  
• Look into the feasibility of using large-scale public presentations, mass media outlets, information kiosks, and associated businesses (both public and private) as a way to increase training and educational opportunities for persons with Alzheimer’s disease and their families.  
• Develop and promote recommendations for key Texas service providers that enhance current distribution practices of Alzheimer's disease/dementia care information and services.  
• Develop recommendations to enhance protocols for distribution of Alzheimer's disease and dementia care information/services.  
• Develop one comprehensive, state sanctioned web-based repository that contains the most current information on prevention, risk factors, disease management, translational research and science, and family caregiver resources. |
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| Utah | • Provide a statewide comprehensive resource database and directory that includes information about the range of medical and other providers, programs, and services related to diagnosis, treatment, and support for persons with dementia.  
• Extend person-centered care in rural Utah with evaluations and consultations for persons with dementia and their family caregivers by dementia specialists and an outpatient geriatric psychiatry consultation program through the Utah Telehealth Network.  
• Partner with health insurance providers to ensure that medically-appropriate dementia services are clearly identified and addressed in coverage statements and covered in policies, including those for younger-onset dementias.  
• Partner with hospitals as part of their public service mission to provide access to high-quality postmortem diagnostic services for individuals with Alzheimer’s disease and related dementias.  
• Encourage family-centered biobanking and linkage with the Utah Population Database so families can develop their own family health history based upon genealogical medical and genetic records.  
• Provide guidance to care managers, advocates, and providers on the Medicare Annual Wellness Visit and its inclusion of detection of cognitive impairment.  
• Encourage care providers to partner with multicultural coalitions as they develop “dementia-friendly services” for ethnically diverse clients and residents across the continuum of care, including adult day care, in-home respite, assisted living, long-term care, and specialized dementia care.  
• Improve primary care practices by linking to dementia care managers who will coordinate care, manage individual cases, and supplement clinical care with resources on supportive services and community-based agencies that offer specialized expertise, social supports, and mental health services.  
• Protect and promote Utah’s Center on Alzheimer’s Care, Imaging and Research as a tertiary referral resource for the state’s physicians to support diagnosis and management of complex cases.  
• Incorporate Alzheimer’s educational materials for patients and family caregivers into digital libraries to enable physicians to store and disseminate such information in connection with electronic medical records.  
• Educate clinicians on the criteria needed to refer and qualify dementia patients for hospice care to ensure that patients receive the full benefit of the medical, health services, and social supports offered at the end of life. |
### Vermont
- Design and standardize care management plans that are outcome focused. Central to this activity will be a priority to develop strength-based care management approaches to address both the clinical and social needs of people with dementia. These plans may be tailored for a variety of care providers, including primary care practitioners, nursing homes, residential care homes, adult day centers, and home health agencies.
- Initiate programs that promote cognitively-stimulating services in homes, nursing homes, residential care homes, assisted living residences, and adult day centers.
- Support access to dementia care for rural and remote regions of Vermont through the development of regional care teams that provide for the evaluation, consultation, specialty care, and outreach through a hub-and-spokes model, such as coordinating services between regional memory centers and Area Agencies on Aging.
- Increase access to geriatric and neuropsychiatric care through telemedicine, video conferencing, and internet-based consultation.
- Improve the coordination and delivery of care by emphasizing strong links and relationships between medical, mental health, and other home and community-based services.
- Work with hospital systems to develop special inpatient programs meeting the needs of people with dementia, for both neuropsychiatric and medical admissions.
- Work with hospital systems to improve hospital-based care management services to assist in care coordination for people with dementia, in ambulatory care, hospital, and community service settings, including home health, rehabilitation, residential, and nursing home settings.
- Work with regional medical centers and community hospitals to improve assessment, referral, and care coordination for people with dementia who are treated in emergency departments. This may include hospital-based care managers and regional care coordinators from dementia specialty clinics (“the hub”) available around the clock.
- Pilot a statewide, virtual or real, resource and referral center for individuals with a new or previous diagnosis of dementia and their family members. This service should provide a single point of entry for information and resources for families and consumers, such as the Vermont Aging and Disability Resource Connections.
- Explore new models of care and support across provider settings that enhance responsiveness to individual needs and preferences of people with dementia and their families.

### Virginia
- Explore changes needed to ensure Medicaid eligibility for younger-onset dementia.
- Support a pilot demonstration project with the appropriate stakeholders to improve transitional care and address the problem of lack of placement and facility discharge for residents exhibiting disruptive behavior.
- Foster university-community partnerships to address community needs and promote mutually beneficial participatory research opportunities.

### West Virginia
- Secure state funding for the Alzheimer’s Association’s 24/7 Helpline.
- Implement “Alzheimer-informed” facility policies and procedures to create a system of “Universal Observation” to identify people with Alzheimer’s disease in health care settings so that people receive optimal inpatient care as well as ambulatory medical services.
- Develop a non-threatening, non-discriminatory system to identify people with Alzheimer’s disease in acute care settings in order to improve safety and quality of care.
- Ensure that program guidelines for the Bureau for Medical Services’ chronic disease health homes state plan amendment reflect the unique needs of people with Alzheimer’s disease.
- Conduct an evidence-based review of transitions of care models for people with Alzheimer’s disease, and then pilot these best practice approaches in West Virginia.