2018 ADWG – Compiled Committee Recommendations as of 8/13/18

Guide to using this table: Each committee approached their work differently. Consequently, the recommendations listed below often don't fully reflect the complete nature of the recommendation. It is best to use this table IN CONJUNCTION with the report from each committee. I have provided some assistance within ( ) and flagged those recommendations that are especially in need of the broader description with a *. – Stacy Sjogren

Trends/Disparities	Diagnosis/Treatment/ Prof. Educ.	Public Awareness/Risk Reduction	Cultural Responsiveness	Residential Services
1. Install (report) recommendation tracking system	7. (MDH/Senior Linkage Line should provide more) information for newly diagnosed and their care partners	12. Structured coordination of messaging and awareness campaigns*	18. Identify high-quality dementia care guidelines and measures across care settings. (page 19)	22. Adopt consistent baseline standards of care across all types of long-term care facilities
2. Encourage culturally aware data collection	8. (MN Legislature should provide funding for) state-wide network of regional Community Dementia Resource Centers Concept*	13. Board on Aging should collaborate with stakeholders…(to build a)…centralized hub for MN dementia information and connecting to local resources	19. Explore the effectiveness of new models of care for people with Alzheimer's Disease and related dementias (in their environments in a publicly-funded home care program). (page 19)	23. Review, strengthen, and expand rights of vulnerable adults in long-term care settings.
3. Improve overall quality of (state's) data collection	9. (MN Legislature should direct funding for assessment to help improve) education to primary and direct care providers*	14. (Establish) a work group to break down silos between medical and non-medical systems to increase appropriate referrals and coordinated resource provisions for families*	20. (Improve care planning for Medicare beneficiaries to) ensure that people with Alzheimer's Disease and related dementias experience safe and	24. Require culturally – and LGBTQ – sensitive environments

			effective transitions between care settings and systems (page 20)	
4. Leverage Minnesota All Payer Claims database	10. (MN Dept. of Veterans Affairs should expand mission so that) Veteran's homes offer professional training	15 (Establish) a work group to further define the modifiable risk factors, then explore strategies to increase public understanding and education of the known causes and risk factors for memory impairment.	21. Enable family caregivers to continue to provide care while maintaining their own health and well-being (page 21)	*25. The State will reevaluate the long-term care counseling process*
5. (Include) care giver status on health records	11. (MN Legislature should revise Statute 62J.692 Medical Education and make) targeted increases in MERC Funding (to include nursing homes and home health agencies)	16. Reform health systems in Minnesota to enhance upstream interventions for ADAD and incentivize the treatment of ADAD as a chronic disease		*26 Develop a new licensure framework for assisted living*
6. Synchronize quality indicators		17. State and local health departments (should) assess and enhance their involvement in treating ADAD as a chronic disease, including upstream interventions for modifiable risk factors and public health programming		27 The State will define allowable billing methods and packages for Housing with Services and homecare

Cultural Responsiveness – Guiding Values				
Authenticity: • Accept people where they're at – individual, family, provider, etc. We're all responsible to play an active role in the work of health equity and cultural responsiveness. • Providers and those in positions of power must be open to not only hear and learn about different needs but positively address concerns expressed showing that they have sought and fully heard the voice of the client/patient/caregiver.				
Assets-based approach to equity and diversity: • There are many variations of families and caregiving can look different. A patient isn't one person – it's whatever their family structure is. Consider the needs of families and caregivers who may have different cultural norms and values related to dementia/Alzheimer's, as well as families where the care structure isn't a husband/wife team. • Communities have many different norms around how they view Elder's and Alzheimer's. An equitable solution may mean that different groups need different things, rather than a one-size fits all approach.				

More Considerations

1. **The Diagnosis, Treatment and Professional Education Committee felt the following recommendation candidates are too difficult to achieve or beyond the scope of the State's control (two variables of their assessment process). However, they wanted to share them with the Work Group should there be overlap from other committees that points to possible synergy or solutions.**

   a. Primary Care Compensation   Compensate primary care providers appropriately for education, training, and providing services.

   b. Establish Minimum Levels of Care   Establish a state-mandated minimum level of care and state-wide quality indicators such as the quality indicators by the American Academy of Neurology.

   c. Immediate Referrals Provide immediate referrals to specialists when primary care providers are unable to make a diagnosis if a patient does not "pass" a cognitive screen during a wellness visit or other clinic visit.

   d. Effective Use of Specialists Given the limited number of specialists across our state, judiciously utilize specialists (neurologists, geriatricians, neuropsychologists) for unusual clinical presentations of dementia such as younger onset , MCI, or co-morbid dementias. Stated another way: The Departments of Health and Human Services should promote innovations in payment models for care of those with dementia to permit the limited numbers of specialists/consultants expert in this condition to serve greater numbers of patients who require complex diagnostic or therapeutic approaches.

   e. Patient Registries   Encourage primary care health care homes to create registries of patients with cognitive impairment including measures of quality of care, such as those developed by the American Academy of Neurology.

2. **The Cultural Responsiveness Committee offered information and suggestions to each committee in pages 14-18 of their report. As part of the Work Group's process for aligning and finalizing their recommendations, it would be wise and appropriate to revisit what they shared.**