

## DEMENTIA MEASURES GROUP OVERVIEW

### 2016 PQRS OPTIONS FOR MEASURES GROUPS:

#### 2016 PQRS MEASURES IN DEMENTIA MEASURES GROUP:

#47	Care Plan
#134	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
#280	Dementia: Staging of Dementia
#281	Dementia: Cognitive Assessment
#282	Dementia: Functional Status Assessment
#283	Dementia: Neuropsychiatric Symptom Assessment
#284	Dementia: Management of Neuropsychiatric Symptoms
#286	Dementia: Counseling Regarding Safety Concerns
#287	Dementia: Counseling Regarding Risks of Driving
#288	Dementia: Caregiver Education and Support

#### INSTRUCTIONS FOR REPORTING:

- It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group-specific intent G-code has been created for registry only measures groups for use by registries that utilize claims data.

**G8902:** I intend to report the Dementia Measures Group

- Report the patient sample method:  
**20 Patient Sample Method via registries:** 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2016).
- Patient sample criteria for the Dementia Measures Group are all patients regardless of age, with a specific diagnosis of dementia accompanied by a specific patient encounter:

#### **One of the following diagnosis codes indicating Dementia:**

**ICD-10-CM:** A52.17, F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F05, F06.8, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83

#### **Accompanied by:**

**One of the following patient encounter codes:** 90791, 90792, 90832, 90834, 90837, 96116, 96118, 96119, 96120, 96150, 96151, 96152, 96154, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

- To satisfactorily report the Dementia Measures Group requires reporting a numerator option on **all applicable** measures, for each patient within the eligible professional's patient sample, a minimum of once during the reporting period.
- Measure #47 need only be reported on patients 65 years and older.
- Measure #134 need only be reported on patients 12 years and older without an active diagnosis of Depression or a diagnosed Bipolar Disorder.
- Measure #281 need only be reported with one of the following patient encounter codes: 90791, 90792, 90832, 90834, 90837, 96116, 96118, 96119, 96120, 97003, 97004, 99201, 99202, 99203, 99204, 99205,

99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

- Instructions for qualifying numerator option reporting for each of the measures within the Dementia Measures Group are displayed on the next several pages. The following composite Quality Data Code (QDC) has been created for registries that utilize claims data. This QDC may be reported in lieu of individual QDCs when all quality clinical actions for all applicable measures within the group have been performed.

**Composite QDC G8761:** All quality actions for the applicable measures in the Dementia Measures Group have been performed for this patient

- Measure Group Reporting Calculations:

Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each applicable measure within the measures group reported by the eligible professional.

Performance exclusion QDCs are not counted in the performance denominator. If the eligible professional submits all performance exclusion QDCs, the performance rate would be 0/0 (null) and would be considered satisfactorily reporting.

If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening for Osteoporosis for Women Aged 65-85 Years of Age would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 (null) and would be considered satisfactorily reporting.

- **NOTE:** The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures group option.

**\*Measure #47 (NQF 0326): Care Plan -- National Quality Strategy Domain: Communication and Care Coordination**

**DESCRIPTION:**

Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

**NUMERATOR:**

Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

**Numerator Instructions:** If patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, report **1124F**.

**Definition:**

**Documentation that Patient did not Wish or was not able to Name a Surrogate Decision Maker or Provide an Advance Care Plan** – May also include, as appropriate, the following:

- That the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship.

**NUMERATOR NOTE:** *The CPT Category II codes used for this measure indicate: Advance Care Planning was discussed and documented. The act of using the Category II codes on a claim (or equivalent medical record documentation) indicates the provider confirmed that the Advance Care Plan was in the medical record (that is, at the point in time the code was assigned, the Advance Care Plan in the medical record was valid) or that advance care planning was discussed. The codes (or equivalent medical record documentation) are required annually to ensure that the provider either confirms annually that the plan in the medical record is still appropriate or starts a new discussion.*

*The provider does not need to review the Advance Care Plan annually with the patient to meet the numerator criteria; documentation of a previously developed advanced care plan that is still valid in the medical record meets numerator criteria.*

**Numerator Options:**

**Performance Met:**

Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record (**1123F**)

**OR**

**Performance Met:**

Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan (**1124F**)

**OR**

**Performance Not Met:**

Advance care planning not documented, reason not otherwise specified (**1123F with 8P**)

**Measure #134 (NQF 0418): Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan -- National Quality Strategy Domain: Community/Population Health**

**DESCRIPTION:**

Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen

**NUMERATOR:**

Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen

**Numerator Instructions:** The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record. The depression screening must be reviewed and addressed in the office of the provider filing the code on the date of the encounter.

**Definitions:**

**Screening** – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

**Standardized Depression Screening Tool** – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record.

Examples of depression screening tools include but are not limited to:

- **Adolescent Screening Tools (12-17 years)**  
Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), and PRIME MD-PHQ2
- **Adult Screening Tools (18 years and older)**  
Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2

**Follow-Up Plan** – Documented follow-up for a positive depression screening **must** include one or more of the following:

- Additional evaluation for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

**Not Eligible** – A patient is not eligible if one or more of the following conditions are documented:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium
- Patient has an active diagnosis of Depression
- Patient has a diagnosed Bipolar Disorder

**NUMERATOR NOTE:** *The follow-up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening."*

**Numerator Options:**

**Performance Met:**

Screening for clinical depression is documented as being positive AND a follow-up plan is documented (**G8431**)

**OR**

**Performance Met:**

Screening for clinical depression is documented as negative, a follow-up plan is not required (**G8510**)

**OR**

**Other Performance Exclusion:**

Screening for clinical depression not documented, documentation stating the patient is not eligible (**G8433**)

**OR**

**Other Performance Exclusion:**

Screening for clinical depression documented as positive, a follow-up plan not documented, documentation stating the patient is not eligible (**G8940**)

**OR**

**Performance Not Met:**

Clinical depression screening not documented, reason not given (**G8432**)

**OR**

**Performance Not Met:**

Screening for clinical depression documented as positive, follow-up plan not documented, reason not given (**G8511**)

↳ **Measure #280: Dementia: Staging of Dementia -- National Quality Strategy Domain: Effective Clinical Care**

**DESCRIPTION:**

Percentage of patients, regardless of age, with a diagnosis of dementia whose severity of dementia was classified as mild, moderate or severe at least once within a 12 month period

**NUMERATOR:**

Patients whose severity of dementia was classified as mild, moderate or severe at least once within a 12 month period

**Numerator Instructions:** Dementia severity can be assessed using one of a number of available valid and reliable instruments available from the medical literature. Examples include, but are not limited to:

- Global Deterioration Scale (GDS)
- Functional Assessment Staging Tool (FAST)
- Clinical Dementia Rating (CDR)
- Dementia Severity Rating Scale
- Mini-Mental State Examination (MMSE) [Note: While simple and quick to administer, the MMSE is a blunt instrument for staging Alzheimer's disease. The MMSE has not been well validated for non-Alzheimer's dementias.]
- Formal Neuropsychological Evaluation

**Definitions:**

**Mild dementia** - Can be classified quantitatively as MMSE score of > 18, GDS or FAST stage 4, CDR of 1; qualitatively as being likely to have difficulty with balancing a checkbook, preparing a complex meal, or managing a complicated medication schedule. (APA, 2007)

**Moderate dementia** - Can be classified quantitatively as MMSE score of 10–18, GDS or FAST stages 5 and 6, CDR of 2; qualitatively as experiencing difficulties with simpler food preparation, household cleanup, and yard work and requiring assistance with some aspects of self-care (e.g., picking out the proper clothing to wear). (APA, 2007)

**Severe dementia** - Can be classified quantitatively as MMSE score of < 10, GDS or FAST stages 6 and 7, CDR of 3; qualitatively as requiring considerable or total assistance with personal care, such as dressing, bathing, and toileting. (APA, 2007)

**NUMERATOR NOTE:** *The proposed scoring cut-offs listed above are offered only as a guide and are quoted verbatim from the referenced clinical guideline. The scoring and appropriate severity cut-offs for any of these instruments must be interpreted in the context of the patient's age, education, and ethnicity.*

**Numerator Options:**

- |                                |   |
|--------------------------------|---|
| <b><u>Performance Met:</u></b> | Dementia severity classified, mild <b>(1490F)</b>     |
| <b><u>OR</u></b>               |   |
| <b><u>Performance Met:</u></b> | Dementia severity classified, moderate <b>(1491F)</b> |
| <b><u>OR</u></b>               |   |
| <b><u>Performance Met:</u></b> | Dementia severity classified, severe <b>(1493F)</b>   |

**OR**

- |                                    |   |
|------------------------------------|---|
| <b><u>Performance Not Met:</u></b> | Dementia severity not classified, reason not otherwise specified <b>(1490F with 8P)</b> |
|------------------------------------|---|

**▲ Measure #281: Dementia: Cognitive Assessment -- National Quality Strategy Domain: Effective Clinical Care**

**DESCRIPTION:**

Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period

**NUMERATOR:**

Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period

**Numerator Instructions:** Cognition can be assessed by the clinician during the patient's clinical history. Cognition can also be assessed by direct examination of the patient using one of a number of instruments, including several originally developed and validated for screening purposes. This can also include, where appropriate, administration to a knowledgeable informant. Examples include, but are not limited to:

- Blessed Orientation-Memory-Concentration Test (BOMC)
- Montreal Cognitive Assessment (MoCA)
- St. Louis University Mental Status Examination (SLUMS)
- Mini-Mental State Examination (MMSE) [Note: The MMSE has not been well validated for non-Alzheimer's dementias.]
- Short Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)
- Ascertain Dementia 8 (AD8) Questionnaire
- Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) [Note: Validated for use with nursing home patients only]
- Formal neuropsychological evaluation

**Numerator Options:**

<b><u>OR</u></b>	<b><i>Performance Met:</i></b>	Cognition assessed and reviewed ( <b>1494F</b> )
	<b><i>Medical Performance Exclusion:</i></b>	Documentation of medical reason(s) for not assessing cognition (eg, patient with very advanced stage dementia, other medical reason) ( <b>1494F with 1P</b> )
	<b><u>OR</u></b>	
	<b><i>Patient Performance Exclusion:</i></b>	Documentation of patient reason(s) for not assessing cognition ( <b>1494F with 2P</b> )
<b><u>OR</u></b>	<b><i>Performance Not Met:</i></b>	Cognition not assessed and reviewed, reason not otherwise specified ( <b>1494F with 8P</b> )

**Measure #282: Dementia: Functional Status Assessment -- National Quality Strategy Domain: Effective Clinical Care**

**DESCRIPTION:**

Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of functional status is performed and the results reviewed at least once within a 12 month period

**NUMERATOR:**

Patients for whom an assessment of functional status is performed and the results reviewed at least once within a 12 month period

**Numerator Instructions:** Functional status can be assessed by direct examination of the patient or knowledgeable informant. An assessment of functional status should include, at a minimum, an evaluation of the patient's ability to perform instrumental activities of daily living (IADL) and basic activities of daily living (ADL). Functional status can also be assessed using one of a number of available valid and reliable instruments available from the medical literature. Examples include, but are not limited to:

- Lawton IADL Scale
- Barthel ADL Index
- Katz Index of Independence in ADL

**Numerator Options:**

<b><i>Performance Met:</i></b>	Functional status for dementia assessed and results reviewed <b>(1175F)</b>
<b><u>OR</u></b>	
<b><i>Medical Performance Exclusion:</i></b>	Documentation of medical reason(s) for not assessing and reviewing functional status for dementia (eg, patient is severely impaired and caregiver knowledge is limited, other medical reason) <b>(1175F with 1P)</b>
<b><u>OR</u></b>	
<b><i>Performance Not Met:</i></b>	Functional status for dementia not assessed and results not reviewed, reason not otherwise specified <b>(1175F with 8P)</b>



└ **Measure #283: Dementia: Neuropsychiatric Symptom Assessment -- National Quality Strategy**  
**Domain: Effective Clinical Care**

**DESCRIPTION:**

Percentage of patients, regardless of age, with a diagnosis of dementia and for whom an assessment of neuropsychiatric symptoms is performed and results reviewed at least once in a 12 month period

**NUMERATOR:**

Patients for whom an assessment of neuropsychiatric symptoms is performed and results reviewed at least once in a 12 month period

**Numerator Instructions:** Neuropsychiatric symptoms can be assessed by direct examination of the patient or knowledgeable informant.

Examples of reliable and valid instruments that are commonly used in research settings and that can be used to assess behavior include, but are not limited to:

- Dementia Signs and Symptoms (DSS) Scale
- Neuropsychiatric Inventory (NPI)

The assessment of behavioral status may include the assessment of Behavioral and Psychological Symptoms of Dementia (BPSD). For patients residing in nursing homes, it may include an assessment of the behavioral symptom items from the Minimum Data Set (MDS).

The following is a non-exhaustive list of dimensions (based on items included in available validated instruments) that may be evaluated during an assessment of neuropsychiatric symptoms:

*Activity disturbances:*

- agitation
- wandering
- purposeless hyperactivity
- verbal or physical aggressiveness
- resistiveness with care
- apathy
- impulsiveness
- socially inappropriate behaviors
- appetite
- eating disturbances
- sleep problems
- diurnal/sleep-wake cycle disturbances
- repetitive behavior

*Mood disturbances:*

- anxiety
- dysphoria
- euphoria
- irritability
- mood lability/fluctuations

*Thought and perceptual disturbances:*

- having fixed false beliefs (delusions)
- hearing or seeing non-present entities (hallucinations)
- paranoia

**Numerator Options:**

***Performance Met:***

Neuropsychiatric symptoms assessed and results reviewed (**1181F**)

**OR**

***Performance Not Met:***

Neuropsychiatric symptoms not assessed and results not reviewed, reason not otherwise specified (**1181F with 8P**)

**Measure #284: Dementia: Management of Neuropsychiatric Symptoms -- National Quality Strategy Domain: Effective Clinical Care**

**DESCRIPTION:**

Percentage of patients, regardless of age, with a diagnosis of dementia who have one or more neuropsychiatric symptoms who received or were recommended to receive an intervention for neuropsychiatric symptoms within a 12 month period

**NUMERATOR:**

Patients who received or were recommended to receive an intervention for neuropsychiatric symptoms within a 12 month period

<b><u>Numerator Options:</u></b>	
<b><i>Performance Met:</i></b>	One or more neuropsychiatric symptoms ( <b>G8947</b> )
<b><u>AND</u></b>	
	Neuropsychiatric intervention ordered ( <b>4525F</b> )
<b><u>OR</u></b>	
	Neuropsychiatric intervention received ( <b>4526F</b> )
<b><u>OR</u></b>	
<b><i>Other Performance Exclusion:</i></b>	No neuropsychiatric symptoms ( <b>G8948</b> )
<b><u>OR</u></b>	
<b><i>Performance Not Met:</i></b>	One or more neuropsychiatric symptoms ( <b>G8947</b> )
<b><u>AND</u></b>	
	Neuropsychiatric intervention not ordered, reason not otherwise specified ( <b>4525F with 8P</b> )
<b><u>OR</u></b>	
	Neuropsychiatric intervention not received, reason not otherwise specified ( <b>4526F with 8P</b> )

**Measure #286: Dementia: Counseling Regarding Safety Concerns -- National Quality Strategy**  
**Domain: Patient Safety**

**DESCRIPTION:**

Percentage of patients, regardless of age, with a diagnosis of dementia or their caregiver(s) who were counseled or referred for counseling regarding safety concerns within a 12 month period

**NUMERATOR:**

Patients or their caregiver(s) who were counseled or referred for counseling regarding safety concerns within a 12 month period

**Numerator Instructions:** Counseling should include a discussion with the patient and their caregiver(s) regarding one or more of the following common safety concerns and potential risks to the patient. When appropriate, it should also include a recommendation or referral for a home safety evaluation.

*Note: For nursing home patients, different safety concerns might apply.*

A number of organizations have developed educational materials that are recommended to aid implementation of the measure. These materials/tools include:

- Alzheimer's Association Safety Topics. Available on the Alzheimer's Association website.
- Alzheimer's Disease Education and Referral Center's Home Safety for the Alzheimer's Patient. Available on the National Institute on Aging website.

**Definitions:**

**Caregiver(s)** - Person(s) who provide care to those who need supervision or assistance in illness or disability. They may provide the care in the home, in a hospital, or in an institution. Although caregiver(s) include trained medical, nursing, and other health personnel, the concept also refers to parents, spouses, or other family members, friends, members of the clergy, teachers, social workers, fellow patients.

**Safety Concerns** - Safety concerns include, but are not limited to:

- Fall risk
- Gait/balance
- Medication management
- Financial management
- Home safety risks that could arise from cooking or smoking
- Physical aggression posing threat to self, family caregiver, or others
- Wandering
- Access to firearms or other weapons
- Access to potentially dangerous materials
- Being left alone in home or locked in room
- Inability to respond rapidly to crisis/household emergencies
- Driving
- Operation of hazardous equipment
- Suicidality
- Abuse or neglect

**Numerator Options:**

**Performance Met:**

Safety counseling for dementia provided (6101F)

**OR**

**Performance Met:**

Safety counseling for dementia ordered (6102F)

**OR**

***Medical Performance Exclusion:***

Documentation of medical reason(s) for not providing counseling regarding safety concerns (eg, patient in palliative care, other medical reason) **(6101F with 1P)**

**OR**

***Medical Performance Exclusion:***

Documentation of medical reason(s) for not ordering safety counseling (eg, patient in palliative care, other medical reason) **(6102F with 1P)**

**OR**

***Performance Not Met:***

Safety counseling for dementia not provided, reason not otherwise specified **(6101F with 8P)**

**OR**

***Performance Not Met:***

Safety counseling for dementia not ordered, reason not otherwise specified **(6102F with 8P)**

↳ **Measure #287: Dementia: Counseling Regarding Risks of Driving -- National Quality Strategy**  
**Domain: Effective Clinical Care**

**DESCRIPTION:**

Percentage of patients, regardless of age, with a diagnosis of dementia or their caregiver(s) who were counseled regarding the risks of driving and the alternatives to driving at least once within a 12 month period

**NUMERATOR:**

Patients or their caregiver(s) who were counseled regarding the risks of driving and the alternatives to driving at least once within a 12 month period

**Numerator Instructions:** One resource that includes patient and caregiver educational materials that can be used to aid implementation of the measure is the *Physician's Guide to Assessing and Counseling Older Drivers*, developed by the American Medical Association in cooperation with the National Highway Traffic Safety Administration. This document is available on the AMA website.

**Definition:**

**Caregiver(s)** - Person(s) who provide care to those who need supervision or assistance in illness or disability. They may provide the care in the home, in a hospital, or in an institution. Although caregiver(s) include trained medical, nursing, and other health personnel, the concept also refers to parents, spouses, or other family members, friends, members of the clergy, teachers, social workers, fellow patients.

**Numerator Options:**

***Performance Met:***

Counseling provided regarding risks of driving and the alternatives to driving **(6110F)**

**OR**

***Medical Performance Exclusion:***

Documentation of medical reason(s) for not counseling regarding the risks of driving (eg, patient is no longer driving, other medical reason) **(6110F with 1P)**

**OR**

***Performance Not Met:***

Counseling regarding risks of driving and alternatives to driving not performed, reason not otherwise specified **(6110F with 8P)**

**Measure #288: Dementia: Caregiver Education and Support -- National Quality Strategy Domain: Communication and Care Coordination**

**DESCRIPTION:**

Percentage of patients, regardless of age, with a diagnosis of dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND referred to additional resources for support within a 12 month period

**NUMERATOR:**

Patients whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND referred to additional resources for support within a 12 month period

**Numerator Instructions:** There are a number of assessment tools available for the caregiver. These should be considered as an integral component of comprehensive caregiver education and support. The American Medical Association has developed a Caregiver Health Self-assessment Questionnaire to help caregivers analyze their own behavior and health risks and, with their physician's help, make decisions that will benefit both the caregiver and the patient. This questionnaire is available on the AMA website.

**Definitions:**

**Caregiver(s)** – Person(s) who provide care to those who need supervision or assistance in illness or disability. They may provide the care in the home, in a hospital, or in an institution. Although caregiver(s) include trained medical, nursing, and other health personnel, the concept also refers to parents, spouses, or other family members, friends, members of the clergy, teachers, social workers, fellow patients.

**Education** – Education should also include advising the caregiver that he or she is at “increased risk of serious illness (including circulatory and heart conditions and respiratory disease and hypertension), increased physician visits and use of prescription medications, emotional strain, anxiety, and depression.”

**Numerator Options:**

<b><i>Performance Met:</i></b>	Caregiver provided with education and referred to additional resources for support <b>(4322F)</b>
<b><u>OR</u></b>	
<b><i>Medical Performance Exclusion:</i></b>	Documentation of medical reason(s) for not providing the caregiver with education on disease management and health behavior changes or referring to additional sources for support (eg, patient does not have a caregiver, other medical reason) <b>(4322F with 1P)</b>
<b><u>OR</u></b>	
<b><i>Performance Not Met:</i></b>	Caregiver not provided with education and not referred to additional resources for support, reason not otherwise specified <b>(4322F with 8P)</b>

## DEMENTIA MEASURES GROUP RATIONALE AND CLINICAL RECOMMENDATION STATEMENTS

### **MEASURE #47 – CARE PLAN**

#### **RATIONALE:**

It is essential that the patient's wishes regarding medical treatment be established as much as possible prior to incapacity. The Work Group has determined that the measure should remain as specified with no required timeframe based on a review of the literature. Studies have shown that people do change their preferences often with regard to advanced care planning, but it primarily occurs after a major medical event or other health status change. In the stable patient, it would be very difficult to define the correct interval. It was felt by the Work Group that the error rate in simply not having addressed the issue at all is so much more substantial (Teno, 1997) than the risk that an established plan has become outdated that we should not define a specific timeframe at this time. As this measure is tested and reviewed, we will continue to evaluate if and when a specific timeframe should be included.

#### **CLINICAL RECOMMENDATION STATEMENTS:**

Advance directives are designed to respect patient's autonomy and determine his/her wishes about future life-sustaining medical treatment if unable to indicate wishes. Key interventions and treatment decisions to include in advance directives are: resuscitation procedures, mechanical respiration, chemotherapy, radiation therapy, dialysis, simple diagnostic tests, pain control, blood products, transfusions, and intentional deep sedation.

Oral statements

- Conversations with relatives, friends, and clinicians are most common form; should be thoroughly documented in medical record for later reference.
- Properly verified oral statements carry same ethical and legal weight as those recorded in writing.

Instructional advance directives (DNR orders, living wills)

- Written instructions regarding the initiation, continuation, withholding, or withdrawal of particular forms of life-sustaining medical treatment.
- May be revoked or altered at any time by the patient.
- Clinicians who comply with such directives are provided legal immunity for such actions.

Durable power of attorney for health care or health care proxy

- A written document that enables a capable person to appoint someone else to make future medical treatment choices for him or her in the event of decisional incapacity. (AGS)

The National Hospice and Palliative Care Organization provides the Caring Connection web site, which provides resources and information on end-of-life care, including a national repository of state-by-state advance directives.

### **MEASURE #134 - PREVENTIVE CARE AND SCREENING: SCREENING FOR CLINICAL DEPRESSION AND FOLLOW-UP PLAN**

#### **RATIONALE:**

The World Health Organization (WHO), as seen in Pratt & Brody (2008), found that major depression was the leading cause of disability worldwide. Depression causes suffering, decreases quality of life, and causes impairment in social and occupational functioning. It is associated with increased health care costs as well as with higher rates of many chronic medical conditions. Studies have shown that a higher number of depression symptoms are associated with poor health and impaired functioning, whether or not the criteria for a diagnosis of major depression are met. Persons 40-59 years of age had higher rates of depression than any other age group. Persons 12-17, 18-39 and 60 years of age and older had similar rates of depression. Depression was more common in females than in males. Non-Hispanic black persons had higher rates of depression than non-Hispanic white persons. In the 18-39 and 40-59 age groups, those with income below the federal poverty level had higher rates of depression than those with higher income. Among persons 12-17 and 60 years of age and older, rates of depression did not vary significantly by poverty status.



Overall, approximately 80% of persons with depression reported some level of difficulty in functioning because of their depressive symptoms. In addition, 35% of males and 22% of females with depression reported that their depressive symptoms make it very or extremely difficult for them to work, get things done at home, or get along with other people. More than one-half of all persons with mild depressive symptoms also reported some difficulty in daily functioning attributable to their symptoms.

15–20 percent of adults older than age 65 in the United States have experienced depression (Geriatric Mental Health Foundation, 2008). 7 million adults aged 65 years and older are affected by depression (Steinman, 2007). Chronically ill Medicare beneficiaries with accompanying depression have significantly higher health care costs than those with chronic diseases alone (Unützer, 2009). People aged 65 years and older accounted for 16 percent of suicide deaths in 2004 (Centers for Disease Control and Prevention, 2007).

The negative outcomes associated with early onset depression, make it crucial to identify and treat depression in its early stages. As reported in Borner (2010), a study conducted by the World Health Organization (WHO) concluded that in North America, primary care and family physicians are likely to provide the first line of treatment for depressive disorders. Others consistently report a 10% prevalence rate of depression in primary care patients. But studies have shown that primary care physicians fail to recognize up to 50% of depressed patients, purportedly because of time constraints and a lack of brief, sensitive, easy-to administer psychiatric screening instruments. Coyle et al. (2003), suggested that the picture is more grim for adolescents, and that more than 70% of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated. Healthy People 2020 recommends routine screening for mental health problems as a part of primary care for both children and adults (U.S. Department of Health and Human Services, 2014).

Major depressive disorder (MDD) is a debilitating condition that has been increasingly recognized among youth, particularly adolescents. The prevalence of current or recent depression among children is 3% and among adolescents is 6%. The lifetime prevalence of MDD among adolescents may be as high as 20%. Adolescent-onset MDD is associated with an increased risk of death by suicide, suicide attempts, and recurrence of major depression by young adulthood. MDD is also associated with early pregnancy, decreased school performance, and impaired work, social, and family functioning during young adulthood (Williams et al., 2009). Every fifth adolescent may have a history of depression by age 18. The increase in the onset of depression occurs around puberty. According to Zalsman et al., (2006) as reported in Borner et al. (2010), depression ranks among the most commonly reported mental health problems in adolescent girls.

The economic burden of depression is substantial for individuals as well as society. Costs to an individual may include suffering, possible side effects from treatment, fees for mental health and medical visits and medications, time away from work and lost wages, transportation, and reduced quality of personal relationships. Costs to society may include loss of life, reduced productivity (because of both diminished capacity while at work and absenteeism from work), and increased costs of mental health and medical care. In 2000, the United States spent an estimated \$83.1 billion in direct and indirect costs of depression (USPSTF, 2009).

#### **CLINICAL RECOMMENDATION STATEMENTS:**

##### **Adolescent Recommendation (12-18 years)**

The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up (AHRQ, 2010, p.141).

Clinicians and health care systems should try to consistently screen adolescents ages 12-18 for major depressive disorder, but only when systems are in place to ensure accurate diagnosis, careful selection of treatment, and close follow-up (ICSI, 2013, p.16).

##### **Adult Recommendation (18 years and older)**

The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up (AHRQ, 2010, p.136).

A system that has embedded the elements of best practice and has capacity to effectively manage the volume should consider routine screening of all patients, based on the recommendations of the U.S. Preventive Services Task Force (ICSI, 2013, p.7). Clinicians should use a standardized instrument to screen for depression if it is suspected based on risk factors or presentation. Clinicians should assess and treat for depression in patients with some comorbidities. Clinicians should acknowledge the impact of culture and cultural differences on physician and mental health. Clinicians should screen and monitor depression in pregnant and post-partum women (ICSI, 2013, p.4).

### **MEASURE #280 - DEMENTIA: STAGING OF DEMENTIA**

#### **RATIONALE:**

Dementia is characterized by continued and progressive impairment in cognition and function including the evolution of symptoms over time. (APA, 2007)

The treatment varies throughout the disease course. (APA, 2007)

Patients with dementia, therefore, require assessment of disease severity and subsequent treatment specific and appropriate to their current stage of disease. (APA, 2007)

Early stage patients, for example, have special needs and can and should be involved in care planning and referred to community resources. (California Workgroup on Guidelines for Alzheimer's Disease Management, 2008)

Care for late stage patients may focus on improving the quality of life for patients and caregivers, maintaining optimal function and providing maximum comfort. (Third Canadian Consensus Conference on the Diagnosis and Treatment of Dementia, 2008)

#### **CLINICAL RECOMMENDATION STATEMENTS:**

Progressive dementias are generally staged globally according to the level of cognitive and functional impairment, and the same categories may be used to describe the degree of severity of any dementia. However, the staging criteria have not been well validated for non-Alzheimer's dementias. Specific functional staging (FAST staging) has also been developed, is widely used, and can be very useful in tracking the course of Alzheimer's disease and other dementias. The CDR is a commonly used scale to stage dementia severity. The Global Deterioration Scale (GDS) distinguishes three stages in this range. (APA, 2007)

Individuals with "mild" dementia (MMSE score of >18, GDS or FAST stage 4, CDR of 1) are likely to have difficulties with balancing a checkbook, preparing a complex meal, or managing a difficult medication schedule. Those with "moderate" impairment (MMSE score of 10–18, GDS or FAST stages 5 and 6, CDR of 2) also have difficulties with simpler food preparation, household cleanup, and yard work and may require assistance with some aspects of self-care (e.g., picking out the proper clothing to wear). Those whose dementia is "severe" (MMSE score of <10, GDS or FAST stages 6 and 7, CDR of 3) require considerable or total assistance with personal care, such as dressing, bathing, and toileting. Research has shown that measurable cognitive abilities remain throughout the course of severe dementia. In the terminal phase, patients become bed bound, develop contractures, require constant care, and may be susceptible to accidents and infectious diseases, which ultimately prove fatal. (APA, 2007)

### **MEASURE #281 – DEMENTIA: COGNITIVE ASSESSMENT**

#### **RATIONALE:**

Dementia is often characterized by the gradual onset and continuing cognitive decline in one or more domains including memory, executive function, language, judgment, and spatial abilities. (APA, 2007) Cognitive deterioration represents a major source of morbidity and mortality and poses a significant burden on affected individuals and their caregivers. (NIH, 2010) Although cognitive deterioration follows a different course depending on the type of

dementia, significant rates of decline have been reported. For example, one study found that the annual rate of decline for Alzheimer's disease patients was more than four times that of older adults with no cognitive impairment. (Wilson et al., 2010) Nevertheless, measurable cognitive abilities remain throughout the course of dementia. (APA, 2007) Initial and ongoing assessments of cognition are fundamental to the proper management of patients with dementia. These assessments serve as the basis for identifying treatment goals, developing a treatment plan, monitoring the effects of treatment, and modifying treatment as appropriate.

#### **CLINICAL RECOMMENDATION STATEMENTS:**

Ongoing assessment includes periodic monitoring of the development and evolution of cognitive and noncognitive psychiatric symptoms and their response to intervention (Category I). Both cognitive and noncognitive neuropsychiatric and behavioral symptoms of dementia tend to evolve over time, so regular monitoring allows detection of new symptoms and adaptation of treatment strategies to current needs...Cognitive symptoms that almost always require assessment include impairments in memory, executive function, language, judgment, and spatial abilities. It is often helpful to track cognitive status with a structured simple examination. (APA, 2007)

Conduct and document an assessment and monitor changes in cognitive status using a reliable and valid instrument. Cognitive status should be reassessed periodically to identify sudden changes, as well as to monitor the potential beneficial or harmful effects of environmental changes, specific medications, or other interventions. Proper assessment requires the use of a standardized, objective instrument that is relatively easy to use, reliable (with less variability between different assessors), and valid (results that would be similar to gold-standard evaluations). (California Workgroup on Guidelines for Alzheimer's Disease Management, 2008)

#### **MEASURE #282 – DEMENTIA: FUNCTIONAL STATUS ASSESSMENT**

##### **RATIONALE:**

Dementia is characterized by cognitive deficits that cause functional impairment compromising basic and instrumental activities of daily living. Functional decline for dementia patients is progressive and continuous and typically marked by decline in instrumental activities of daily living followed by a slower decline in basic activities of daily living. (Lechowski L et al. *Dement Geriatr Cogn Disord*. 2010;29(1):46-54.) Functional impairment is the main factor negatively impacting quality of life in patients with dementia including reported links to the development of apathy and depression. (Andersen CK, et al. *Health Qual Life Outcomes*. 2004, 2:52., Starkstein SE et al. *Am J Psychiatry*. 2005;162:2086-2093., Boyle PA, et al. *Am J Geriatr Psychiatry*. 2003 Mar-Apr;11(2):214-21.) In addition, decline in basic activities of daily living is an important risk factor for institutionalization and a strong predictor of decreased survival in dementia patients. (Steehan E, et al. *Arch Psychiatr Nurs*. 1997;11, 295-303., Bracco L, et al. *Arch Neurol*. 1994 Dec;51(12):1213-9.) Initial and ongoing assessments of functional status should be conducted to determine baseline level of functioning, monitor changes over time, and to identify strategies to maximize patient's independence.

#### **CLINICAL RECOMMENDATION STATEMENTS:**

A detailed assessment of functional status may also aid the clinician in documenting and tracking changes over time as well as providing guidance to the patient and caregivers. Functional status is typically described in terms of the patient's ability to perform instrumental activities of daily living such as shopping, writing checks, basic housework, and activities of daily living such as dressing, bathing, feeding, transferring, and maintaining continence. These regular assessments of recent cognitive and functional status provide a baseline for assessing the effect of any intervention, and they improve the recognition and treatment of acute problems, such as delirium. (APA, 2007)

Conduct and document an assessment and monitor changes in daily functioning, including feeding, bathing, dressing, mobility, toileting, continence, and ability to manage finances and medications...Functional assessment includes evaluation of physical, psychological, and socioeconomic domains. Physical functioning may focus on basic activities of daily living (ADLs) that include feeding, bathing, dressing, mobility, and toileting. Assessment of instrumental (or intermediate) activities of daily living (IADLs) addresses more advanced self-care activities, such as shopping, cooking, and managing finances and medications. Standardized assessment instruments such as the Barthel or Katz indices can provide information on the patient's capacity for self-care and independent living. Proxies

or patient surrogates can complete a number of these instruments when necessary. The initial assessment of functional abilities is important to determine a baseline to which future functional deficits may be compared. (California Workgroup on Guidelines for Alzheimer's Disease Management, 2008)

## **MEASURE #283 – DEMENTIA: NEUROPSYCHIATRIC SYMPTOM ASSESSMENT**

### **RATIONALE:**

Neuropsychiatric symptoms appear to be common for patients with dementia. In community samples of dementia patients, the prevalence of neuropsychiatric symptoms range from 40-88%. (Lyketsos CG et al. *JAMA*. 2002; 288:1475-1483., Ikeda M et al. *J Neurol Neurosurg Psychiatry*. 2004; 75:146-148., Liu CY et al. *Int Psychogeriatr*. 2007; 19:605-613.) Neuropsychiatric symptoms are also common in long-term care facilities, with prevalence ranges from 80-85%. (Zuidema SU et al. *Int J Geriatr Psychiatry*. 2007; 22:632-638., Kverno KS et al. *J Am Med Dir Assoc*. 2008; 7:509-15.) Neuropsychiatric symptoms of dementia have been associated with accelerated cognitive decline; increased functional impairment; decreased mean survival time; increased co-morbid conditions; increased danger to self; increased danger to others; increased health care service utilization; higher risk for institutionalization; and greater caregiver stress and burden. (Chui HC et al. *Arch Neurol*. 1994; 51:676-681., Weiner MF et al. *Acta Psychiatr Scand*. 2005; 111:367-371., Cummings JL et al. *Neurology*. 1994, 44(12):2308-14. Leger JM et al. *Int Psychogeriatr*. 2002; 14:405-416., Malone ML et al. *J Am Geriatr Soc*. 1993; 41:853-856.,Kunik ME et al. *Gerontologist*. 2003; 43:86-91., Kunik ME et al. *Psychiatr Serv*. 2005; 56:70-75., Steele C et al. *Am J Psychiatry*. 1990; 147:1049-1051., Knopman DS et al. *Neurology*. 1999; 52:718-718., Donaldson C et al. *Int J Geriatr Psychiatry*. 1998; 13:248-256., Miyamoto Y et al. *Int J Geriatr Psychiatry*. 2002; 17:765-773., Snyder L et al. *Am J Alzheimers Dis Other Demen*. 2007; 22:14-19.) An assessment of neuropsychiatric symptoms, therefore, is an important step in the development of a management plan for those with dementia.

### **CLINICAL RECOMMENDATION STATEMENTS:**

It is important for the [clinician] treating a patient with dementia to regularly assess cognitive deficits or behavioral difficulties that potentially pose a danger to the patient or others. (APA, 2007)

Conduct and document an assessment and monitor changes in behavioral symptoms, psychotic symptoms, or depression. (California Workgroup on Guidelines for Alzheimer's Disease Management, 2008)

#### **For mild to moderate Alzheimer's disease**

Assessment of patients with mild to moderate AD [Alzheimer's Disease] should include measures of behavior and other neuropsychiatric symptoms. (Grade B, Level 3) (Third Canadian Consensus Conference on the Diagnosis and Treatment of Dementia, 2008)

#### **For severe Alzheimer's disease**

Assessment should include cognition (eg, MMSE), function, behaviour, medical status, nutrition, safety and caregiver health. (Grade B, Level 3) (Third Canadian Consensus Conference on the Diagnosis and Treatment of Dementia, 2008)

## **MEASURE #284 – DEMENTIA: MANAGEMENT OF NEUROPSYCHIATRIC SYMPTOMS**

### **RATIONALE:**

Neuropsychiatric symptoms appear to be common for patients with dementia. In community samples of dementia patients, the prevalence of neuropsychiatric symptoms range from 40-88%. (Lyketsos CG et al. *JAMA*. 2002; 288:1475-1483., Ikeda M et al. *J Neurol Neurosurg Psychiatry*. 2004; 75:146-148., Liu CY et al. *Int Psychogeriatr*. 2007; 19:605-613.) Neuropsychiatric symptoms are also common in long-term care facilities, with prevalence ranges from 80-85%. (Zuidema SU et al. *Int J Geriatr Psychiatry*. 2007; 22:632-638., Kverno KS et al. *J Am Med Dir Assoc*. 2008; 7:509-15.) Neuropsychiatric symptoms of dementia have been associated with accelerated cognitive decline; increased functional impairment; decreased mean survival time; increased co-morbid conditions; increased danger to self; increased danger to others; increased health care service utilization; higher risk for institutionalization; and greater caregiver stress and burden. (Chui HC et al. *Arch Neurol*. 1994; 51:676-681., Weiner MF et al. *Acta Psychiatr Scand*. 2005; 111:367-371., Cummings JL et al. *Neurology*. 1994, 44(12):2308-14. Leger JM et al. *Int*



*Psychogeriatr.* 2002; 14:405-416., Malone ML et al. *J Am Geriatr Soc.* 1993; 41:853-856.,Kunik ME et al. *Gerontologist.* 2003; 43:86-91., Kunik ME et al. *Psychiatr Serv.* 2005; 56:70-75., Steele C et al. *Am J Psychiatry.* 1990; 147:1049-1051., Knopman DS et al. *Neurology.* 1999; 52:718-718., Donaldson C et al. *Int J Geriatr Psychiatry.* 1998; 13:248-256., Miyamoto Y et al. *Int J Geriatr Psychiatry.* 2002; 17:765-773., Snyder L et al. *Am J Alzheimers Dis Other Demen.* 2007; 22:14-19.) Nonpharmacologic interventions should be considered in all cases and in some will be the mainstay of management. Examples of approaches that may be useful include behavioural management for depression, education programs for caregivers and staff to teach them how to recognize, manage, and sometimes prevent behavioral problems, stress reduction for caregivers, and, for patients living at home, enrollment in adult day programs offering structured activities and social stimulation. The evidence evaluating non-pharmacological interventions varies considerably in quality and amount, but broadly supports an individualized approach that includes one or more such interventions. A management plan that assesses the severity and intrusiveness of problematic behaviors can assist clinicians in determining what pharmacologic or non-pharmacologic interventions might be appropriate. (Lawlor B. *J Clin Psychiatry.* 2004;65(Suppl 11):5-10.) Mild forms of neuropsychiatric symptoms may be alleviated with psychosocial or environmental interventions. For aggressiveness, presentations of psychosis, or agitation, pharmacologic approaches may be more appropriate. (Sink K et al. *JAMA.* 2005;293:596-608.) If pharmacologic approaches are necessary, they should be administered at the lowest effective dose and their use should be reevaluated and their benefit documented on an ongoing basis.

### **CLINICAL RECOMMENDATION STATEMENTS:**

#### **For mild to moderate Alzheimer's disease**

The management of BPSD [Behavioral and Psychological Symptoms of Dementia] should include a careful documentation of behaviours and identification of target symptoms, a search for potential triggers or precipitants, recording of the consequences of the behaviour, an evaluation to rule out treatable or contributory causes, and consideration of the safety of the patient, their caregiver, and others in their environment. (Grade B, Level 3) (Third Canadian Consensus Conference on the Diagnosis and Treatment of Dementia, 2008)

#### **For severe Alzheimer's disease**

The management of BPSD should begin with appropriate assessments, diagnosis, and identification of target symptoms and consideration of safety of the patient, their caregiver and others in their environment. (Grade B, Level 3) (Third Canadian Consensus Conference on the Diagnosis and Treatment of Dementia, 2008)

There are no fully comprehensive consensus guidelines for use of specific non-pharmacological approaches to neuropsychiatric symptoms. Patient heterogeneity, variations in care settings, and the broad range of non-pharmacological interventions having some empirical support impede uniform generalization. However, the following evidence statements serve as the evidence to support the measure and are quoted verbatim from the referenced clinical guidelines.

Nonpharmacologic interventions should be initiated first. Approaches that may be useful for severe Alzheimer disease include behavioural management for depression, and education programs for caregivers and staff to teach them how to recognize behavioural problems and to teach them behaviour-modification techniques. Music therapy and controlled multisensory stimulation (Snoezelen) are useful during treatment sessions, but longer-term benefits have not been demonstrated. (Grade B, Level 1) (Third Canadian Consensus Conference on the Diagnosis and Treatment of Dementia, 2008)

Except for emergency situations, non-pharmacological strategies are the preferred first-line treatment approach for behavioral problems. Medications should be used only as a last resort, if non-pharmacological approaches prove unsuccessful and they are clinically indicated. (California Workgroup on Guidelines for Alzheimer's Disease Management, 2008)

Pharmacologic therapies should be initiated concurrently with nonpharmacologic interventions in the presence of severe depression, psychosis or aggression that puts the patient or others at risk of harm. (Grade B, Level 3) (Third Canadian Consensus Conference on the Diagnosis and Treatment of Dementia, 2008)

## **MEASURE #286 – DEMENTIA: COUNSELING REGARDING SAFETY CONCERNS**

### **RATIONALE:**

The vast majority (87%) of individuals with Alzheimer's disease are cared for at home by family members. (Alz Assoc, 2009) "As the disease progresses however, physical features of the home environment may present as a safety hazard or barrier to performing activities of daily living, particularly at the moderate stage of the disease process." (Gitlin LN et al. *Disabil Rehabil.* 2002, Vol. 24, No. 1-3, Pages 59-71.) Safety concerns should be addressed with patients and their caregivers throughout the course of the disease.

### **CLINICAL RECOMMENDATION STATEMENTS:**

Recommended assessments include evaluation of suicidality, dangerousness to self and others, and the potential for aggression, as well as evaluation of living conditions, safety of the environment, adequacy of supervision, and evidence of neglect or abuse (Category I). [I] Important safety issues in the management of patients with dementia include interventions to decrease the hazards of wandering and recommendations concerning activities such as cooking, driving, hunting, and the operation of hazardous equipment. Caregivers should be referred to available books [and other materials] that provide advice and guidance about maximizing the safety of the environment for patients with dementia...As patients become more impaired, they are likely to require more supervision to remain safe, and safety issues should be addressed as part of every evaluation. Families should be advised about the possibility of accidents due to forgetfulness (eg, fires while cooking), of difficulties coping with household emergencies, and of the possibility of wandering. Family members should also be advised to determine whether the patient is handling finances appropriately and to consider taking over the paying of bills and other responsibilities. At this stage of the disease [ie, moderately impaired patients], nearly all patients should not drive. (APA, 2007)

Safety issues such as driving, fall risk, medication management, environmental hazards, wandering, and access to firearms need to be discussed periodically with the patient and caregiver. Safety concerns typically focus on three risks in particular: falling, wandering, and driving. (California Workgroup on Guidelines for Alzheimer's Disease Management, 2008)

#### **For mild to moderate Alzheimer's disease**

Assess for safety risks (eg, driving, financial management, medication management, home safety risks that could arise from cooking or smoking, potentially dangerous behaviours such as wandering). (Canadian Consensus Conference on Diagnosis and Treatment of Dementia, 2008)

## **MEASURE #287 – DEMENTIA: COUNSELING REGARDING RISKS OF DRIVING**

### **RATIONALE:**

Motor vehicle-related injuries are a leading cause of injury deaths in adults over 65. (AMA Physician's Guide to Assessing and Counseling Older Drivers, 2010) Per mile driven, drivers age 75 and older are involved in significantly more motor vehicle crashes than middle-aged drivers. (AMA Physician's Guide to Assessing and Counseling Older Drivers, 2010) Dementia has a negative impact on driving skills which deteriorate with increasing dementia severity. (AAN, 2010)

Compared with cognitively intact older adults drivers, studies suggest that drivers with dementia have at least a 2-fold greater risk of crashes. (Carr DB et al. *JAMA.* 2010;303(16):1632-1641.) "Physicians can influence their patients' decisions to modify or stop driving. They can also help their patients maintain safe driving skills." (AMA Physician's Guide to Assessing and Counseling Older Drivers, 2010) Clinicians should address the risks of driving in patients with dementia for the safety of the patient and everyone on the road.

### **CLINICAL RECOMMENDATION STATEMENTS:**

A diagnosis of Alzheimer's disease is not, on its own, a sufficient reason to withdraw driving privileges. The determining factor in withdrawing driving privileges should be an individual's driving ability. (Alzheimer's Association, 2001)

All patients and families should be informed that even mild dementia increases the risk of vehicular accidents (Category I). Mildly impaired patients should be advised to limit their driving to safer situations or to stop driving (Category I), and moderately impaired patients should be instructed not to drive (Category I). Advice about driving cessation should also be communicated to family members, as the implementation of the recommendation often falls on them (Category I). Relevant state laws regarding notification should be followed (Category I). (APA, 2007)

For patients with dementia, consider the following characteristics useful for identifying patients at increased risk for unsafe driving: the Clinical Dementia Rating scale (Level A), a caregiver's rating of a patient's driving ability as marginal or unsafe (Level B), a history of crashes or traffic citations (Level C), reduced driving mileage or self-reported situational avoidance (Level C), Mini-Mental State Examination scores of (California Workgroup on Guidelines for Alzheimer's Disease Management, 2008) or less (Level C), and aggressive or impulsive personality characteristics (Level C). Consider the following characteristics not useful for identifying patients at increased risk for unsafe driving: a patient's self-rating of safe driving ability (Level A) and lack of situational avoidance (Level C). There is insufficient evidence to support or refute the benefit of neuropsychological testing, after controlling for the presence and severity of dementia, or interventional strategies for drivers with dementia (Level U). Clinicians may present patients and their caregivers with the data showing that, as a group, patients with mild dementia (CDR of 1) are at a substantially higher risk for unsafe driving and thus should strongly consider discontinuing driving. At the very least, patients and their caregivers should prepare for the eventuality of driving cessation as dementia severity increases. (AAN, 2010)

## **MEASURE #288 – DEMENTIA: CAREGIVER EDUCATION AND SUPPORT**

### **RATIONALE:**

The vast majority (87%) of individuals with Alzheimer's disease are cared for at home by family members. (Alz Assoc, 2009) Chodosh et al. found that greater caregiver knowledge of dementia management was associated with higher care quality. (Chodosh J et al. *J Am Geriatr Soc.* 2007 Aug;55(8):1260-8.) Other studies have indicated that intensive caregiver support in the form of individual and family counseling and on-going telephone counseling results in improved patient health outcomes. (Gaugler JE et al. *J Am Geriatr Soc.* 2005;53:2098–2105., Mittelman MS et al. *Neurology.* 2006;67:1592–1599.) Providing education to caregivers and referring them to additional sources for support is a critically important piece of comprehensive care for patients with dementia.

### **CLINICAL RECOMMENDATION STATEMENTS:**

Important aspects of psychiatric management include educating patients and families about the illness, its treatment, and sources of additional care and support (eg, support groups, respite care, nursing homes, and other long-term-care facilities) and advising patients and their families of the need for financial and legal planning due to the patient's eventual incapacity (eg, power of attorney for medical and financial decisions, an up-to-date will, and the cost of long-term care) (Category I)... The family should be educated regarding basic principles of care, including 1) recognizing declines in capacity and adjusting expectations appropriately, 2) bringing sudden declines in function and the emergence of new symptoms to professional attention, 3) keeping requests and demands relatively simple, 4) deferring requests if the patient becomes overly upset or angered, 5) avoiding overly complex tasks that may lead to frustration, 6) not confronting patients about their deficits, 7) remaining calm, firm, and supportive and providing redirection if the patient becomes upset, 8) being consistent and avoiding unnecessary change, and 9) providing frequent reminders, explanations, and orientation cues... In addition to providing families with information on support groups, there are a number of benefits of referral to the local chapter or national office of the Alzheimer's Association (1-800-272-3900; [Alzheimer's Association Website](#)), the Alzheimer's Disease Education and Referral Center (ADEAR) (1-800-438-4380; [Alzheimer's Disease Education and Referral Center Website](#)), and other support organizations. (APA, 2007).

Studies have shown that education and support for caregivers increases the chances of adherence to treatment recommendations for patients. The PCP should provide information and education about the current stage of the disease process and talk with the patient and family to establish treatment goals. Based on the agreed-upon goals, a discussion regarding the expected effects (positive and negative) of interventions on cognition, mood, and behavior

will ensure that the prescribed treatment strategy is appropriate to family values and culture. (California Workgroup on Guidelines for Alzheimer's Disease Management, 2008)

Seamless resource referral and access to critical services for both patients and caregivers are considered essential. The PCP should encourage the caregiver to participate in educational programs, support groups, respite services, and adult day service programs. The local Alzheimer's Association chapter or other local agency support groups and community resources such as the Caregiver Resources Centers should be recommended. (California Workgroup on Guidelines for Alzheimer's Disease Management, 2008).