

STATE ALZHEIMER'S DISEASE PLANS: CARE AND CASE MANAGEMENT

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

Alabama	
Alaska	<ul style="list-style-type: none"> • Ensure there is “no-wrong door” to access Alzheimer’s and other dementia resources across various media, diagnostic settings and government agencies. • Engage hospital and skilled nursing facility social workers, case managers and discharge planners to increase referrals to the Alzheimer’s Resource of Alaska and other community resources. • Engage Alaska’s Federally Qualified Health Centers to increase referrals to the Alzheimer’s Resource Agency and other community resources. • Educate the public and health care providers about hospice and end of life care. • Improve service coordination particularly at points of hospital intake and discharge to ensure individuals receive appropriate care in the right setting. • Support the implementation of the Patient Centered Medical Home, which promotes a stronger linkage between behavioral health and primary care. • Expand the capacity to conduct medical evaluations of individuals in their home. • Explore using Federal Qualified Health Centers to meet the needs for dementia care in their communities. • Identify evidence-based national models to address cultural differences within care settings for people with Alzheimer’s and other dementias and their caregivers. • Link individuals with Alzheimer’s and other dementias to services and care settings that are consistent with their cultural values and beliefs. • Research and evaluate the impact of the Patient Centered Medical Home model on those with Alzheimer’s and other dementias. • Establish and define levels of acuity based on both functional and behavioral needs. • Eliminate unnecessary admissions to Alaska Psychiatric Institute (API) through increased utilization of the Complex Behavioral Collaborative (CBC) for people with Alzheimer’s and other dementias.
Arizona	<ul style="list-style-type: none"> • Expand diverse care management infrastructures that assist families in accepting and understanding the diagnosis, how to access services, identifying and overcoming future challenges and other concerns. • Promote safe and effective transitions between care settings and systems. • Partner with health insurance providers to recommend that medically appropriate dementia services are clearly identified and addressed in coverage statements and covered in policies, including those for younger-onset dementia. • Promote the Arizona Alzheimer’s Consortium as a tertiary referral resource for the state’s physicians to support diagnosis and management of complex cases. • Incorporate Alzheimer’s educational materials for people with dementia 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 people with dementia for hospice care to ensure that patients receive full benefit of the medical, health services, and social supports offered at end of life. • Improve care practices by linking people living with Alzheimer’s disease and related disorders to dementia care managers to 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.

Arkansas	<ul style="list-style-type: none"> • 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. • Improve access to quality care and services through the expansion of dementia care and behavioral health services and the integration of those services into primary care settings.
California	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Support federal legislation to provide reimbursement to marriage and family therapists and mental health counselors under Part B of Medicare.
Connecticut	<ul style="list-style-type: none"> • Disseminate informational packets to be distributed at doctors' offices, pharmacies, senior centers and other locations for individuals diagnosed with Alzheimer's disease and caregivers. • Explore federal funding for research and demonstrations on care practices. Support Connecticut's existing initiatives such as the State Innovation Model and Medicare and Medicaid Enrollees Integrated Care Demonstration. Encourage focused efforts on individuals with dementia. • Standardize the immediate provider response following an Alzheimer's/dementia diagnosis. This should include: (1) unless clinically contraindicated, clinicians should inform individuals of their diagnosis; (2) referral to the Alzheimer's Association Helpline for immediate triage of needs and resources nationally and in the state; (3) immediately begin assisting the individual to identify a support person and invite them to the next follow-up visit (adhering to HIPAA requirements); and (4) all individuals should be educated about clinical trials and given the option to participate. • Ensure coordination and connection to support services, including: (1) a provision of simple organized information, a checklist of necessary steps, and referrals to the Alzheimer's Association, Area Agencies on Aging, and other community organizations for guidance with accessing services and support; (2) the identification of a care coordinator to counsel a newly affected family through the care process; (3) support using models of integrated care to connect social workers, counselors, and lawyers under a comprehensive unified dementia support system; and (4) charge an agency to review all current statewide dementia resources and ensure that the resources remain organized and easily accessible. • Support development of adequate assessment tools, community-based services and supports, and program eligibility for individuals with Down syndrome and dementia, high-risk minority populations, and people with younger-onset dementia. Encourage promotion and public awareness of centers that offer evaluation, treatment, and support for these special populations.

Connecticut (cont.)	<ul style="list-style-type: none"> • Develop an independent care manager registry through the Department of Consumer Protection. • Encourage use of and reimbursement for tele-monitoring and other new technologies to aid in monitoring health status by consumers and others – and provide support to caregivers.
Delaware	<ul style="list-style-type: none"> • Perform a service needs assessment, at each stage of the disease that includes caregivers as well as persons with Alzheimer's disease and other dementias. • Disseminate evidence-based guidelines for Alzheimer's disease management to primary care providers to improve early diagnostic evaluation, treatment, care coordination, and follow-up support of patients. • Identify Alzheimer's-related service and educational challenges faced in locations with large numbers of older individuals residing in rural areas, including access to emergency psychiatric care, and recommend targeted actions to effectively address these challenges.
District of Columbia	<ul style="list-style-type: none"> • Provide mental health services to persons with cognitive challenges and caregivers, including but not limited to individual counseling, crisis counseling, family therapy, group therapy, support groups, and individual therapy. • Create Alzheimer's disease support groups through collaboration with government and private entities within the District of Columbia with the intent of constructing and facilitating peer support groups for persons affected by Alzheimer's disease and other dementias. • Collaborate with government and community partners to identify a means of providing an information line or 24/7 Alzheimer's disease support helpline for the general public, particularly caregivers and health care providers. • Incorporate electronic links within supported District of Columbia web sites to ensure that reliable information from District of Columbia agencies is disseminated.
Florida	
Georgia	<ul style="list-style-type: none"> • Develop a plan to have the diagnosis of dementia routinely recorded in medical records. • Provide care coordination to people with dementia and their caregivers upon diagnosis to improve access to information on options and resources • Develop strategies to improve care and communication among workers, patients, and family caregivers. • Utilize approaches used by the disability community in its approach to person-first/person-centered care. • Assure that an appropriate discharge plan is developed for each patient being discharged from a hospital, skilled nursing facility, or emergency room. The plan should be made in collaboration with the individual and family, the physician, and the provider. • Assure that all discharge planners in hospitals, skilled nursing facilities, and emergency rooms have access to region-specific resources, including websites and written literature. • Ensure that discharge planners provide families with access to resource information before discharge occurs. Information should include the number for the regional Aging and Disability Resource Connection (ADRC) and the Alzheimer's Association, Georgia Chapter to assist with long-term care planning. • Support care transition programs that help patients move from one health setting to another. • Identify means (payer sources, administrative policies) for obtaining neuropsychological, psychiatric, and occupational therapy evaluations needed to plan adequately for an individual's transition from an institution (hospital, skilled nursing facility) to the community. • Conduct an evidence-based review of transitions of care models for people with Alzheimer's disease, and then conduct pilot projects. • Develop a dementia-capable website and portal to allow family members and those with early-onset dementia to navigate and make health care decisions related to all services and care.
Hawaii	<ul style="list-style-type: none"> • Create a one-stop resource for access to information and referral. • Ensure that people with Alzheimer's and other dementias experience safe and effective transitions between care settings and systems, including by putting into practice models of hospital safety and care transitions as well as research and pilot programs on avoiding unnecessary hospital readmissions and emergency room use.

Hawaii (cont.)	<ul style="list-style-type: none"> • Advance coordinated and integrated health and long-term services and supports for individuals living with Alzheimer's and other dementias through coordinated care options. • Improve care for populations in Hawaii who are disproportionately affected by Alzheimer's and other dementias, and for populations facing care challenges.
Idaho	<ul style="list-style-type: none"> • Promote and/or develop a community-based "resource counselor" or "care coach" program using trained lay people to shepherd newcomers through the landscape of Alzheimer's.
Illinois	<ul style="list-style-type: none"> • 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.
Indiana	<ul style="list-style-type: none"> • Increase utilization of available Alzheimer's services. • Improve the statewide care coordination system for Alzheimer's disease and other dementias. • Ensure reimbursement for care planning and care coordination. • Enhance care coordination for Alzheimer's disease and other dementias.
Iowa	<ul style="list-style-type: none"> • Establish Alzheimer's and other dementias Diagnostic Centers of Excellence throughout the state that would serve as multi-disciplinary centers to serve patients with Alzheimer's 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 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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.
Maine	<ul style="list-style-type: none"> • Develop strategies to coordinate care across health care settings through early recognition and management of Alzheimer's and other dementias that include raising awareness of common medical conditions and disparities that elevate risk for Alzheimer's and exacerbate its effects. • Expand use of the Patient Centered Medical Home health care model as a means to integrate and coordinate dementia care within primary care practices. Connect with each practice's Community Care Team in order to connect people with community resources that will assist them through all phases of the disease. • Establish a protocol regarding referrals from Patient Centered Medical Home practices and primary care providers to community agencies such as Area Agencies on Aging and the Alzheimer's Association. • Support access to dementia care for rural and remote regions of Maine through the development of regional care teams that provide for the evaluation, consultation, specialty care, and outreach through a hub and spokes model.

<p>Maine (cont.)</p>	<ul style="list-style-type: none"> • Improve the coordination and delivery of care by emphasizing strong links and relationships between medical, mental health, other home- and community-based services, long-term care facilities, emergency medical services, and other health care agencies. This should include working with regional medical centers and community hospitals to improve assessment, referral, and care coordination for people with dementia who are treated in emergency departments. • Work with hospital systems to enhance inpatient programs to become fully dementia-capable for both neuropsychiatric and medical admissions and to improve hospital-based care management services to assist in care coordination for people with dementia, in ambulatory care, hospital, and community settings, including home health, rehabilitation, residential, and nursing homes. • Educate hospitals about the special needs of patients with dementia to inform hospital policies and procedures so that hospitals are both well prepared to serve people with dementia and to ensure effective transitions back into the community. • Support care transitioning programs that help patients move from one health care setting to another. • Support, fund, and explore existing or emerging MaineCare programs that would strengthen and better enable care coordination and management so as to encourage the use of cost- and quality-effective home- and community-based services. • Ensure that Alzheimer's disease and other dementias are identified as one of the chronic conditions in the Affordable Care Act and other funding sources' criteria that are used to identify people eligible for services, including home health services. • Work with state partners and other stakeholders to preserve the elements of Medicaid essential to those living with Alzheimer's disease and their families and evaluate the use of Medicaid and Medicare waivers that would strengthen care coordination and management so as to reduce the use of more expensive facility-based long-term care services when cost efficient home- and community-based services are appropriate. • Support and fund care transitioning programs that help patients move from one health care setting to another.
<p>Maryland</p>	
<p>Massachusetts</p>	<ul style="list-style-type: none"> • Oversee the dissemination of information regarding available services. • Work with private and public partners to produce and disseminate multi-lingual and multicultural information regarding availability and eligibility criteria for all dementia-related state supported and private services and educate the newly diagnosed and their families on next steps and services. Ensure that this information is available to those with sight and hearing impairments. • Work with the Alzheimer's Association and other community partners to deliver community-based and online education programs for people with early-stage Alzheimer's. • Develop strategies to coordinate care across health care settings through early recognition and management of Alzheimer's, and awareness of common medical conditions and health disparities that elevate risk for Alzheimer's and exacerbate its effects, including a process to document any cost savings created through implementation of those strategies. • Support use of emerging health care models (such as the Commonwealth's Medical Homes Initiative and initiatives promoting best use of Electronic Health Records, Accountable Care Organizations, systems, etc.) as a means to integrate and coordinate dementia care within primary care practices and in community health centers with growing populations of older adults.
<p>Michigan</p>	
<p>Minnesota</p>	<ul style="list-style-type: none"> • 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.

Minnesota (cont.)	<ul style="list-style-type: none"> • 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	
Missouri	<ul style="list-style-type: none"> • Identify existing statewide resource databases and evaluate them for inclusion of dementia-related resources. • Create a Road Map that includes community organizations, 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. • Support development of a demonstration project incorporating dementia specialists as treatment team members while individuals 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.
Montana	<ul style="list-style-type: none"> • Encourage physicians and direct care providers to establish an interdisciplinary plan of care at diagnosis to follow the individual throughout the disease process, led by a navigator who will act as the family's primary contact for medical and social questions. • Recruit and train Alzheimer's and other dementias navigators to be directly involved in the care of individuals with Alzheimer's and other dementias using the Navigator Flowchart as a guide. Navigators will help individuals with dementia and their caregivers determine the most appropriate and least restrictive setting for individuals throughout the progression of the disease. • Promote the recognition and inclusion of a designated caregiver by all care providers involved in an individual's care, including primary care providers, hospitals, nursing homes, assisted living facilities, respite care centers, and community-based service providers to ensure coordinated care in all settings. • Establish protocols to prevent avoidable transitions to restrictive settings by meeting an individual's needs at their current setting.
Nebraska	<ul style="list-style-type: none"> • Direct Nebraskans to the Alzheimer's Disease Education and Resource Center (ADEAR) sponsored by the National Institute on Aging through Nebraska's Aging and Disability Resource Centers (ADRCs), Area Agencies on Aging and Nebraska Health and Human Services and other relevant websites.
Nevada	<ul style="list-style-type: none"> • Establish and fund a statewide information and referral system for those with Alzheimer's and other dementias, their caregivers, and their families to enable them to connect with local case management and support services. • Address affordability of services for persons with Alzheimer's disease and other dementias by implementing sliding fee scales and other cost-sharing mechanisms.

Nevada (cont.)	<ul style="list-style-type: none"> • Establish hospital transitional care programs that include information on community resources for caregivers and persons with dementia. • Investigate federal funding opportunities through Medicare Innovations or Centers for Medicare and Medicaid Services to develop a transitions planning program or to avoid the hospital setting altogether (for example, a mobile dementia team approach). • Develop partnerships with other organizations that are also affected by Alzheimer's disease and other dementias – such as diabetes, stroke, and heart organizations – to help promote information about services and care for those who have symptoms of dementia.
New Hampshire	<ul style="list-style-type: none"> • Develop strategies to coordinate care across health care settings through early recognition and management of Alzheimer's, and awareness of common medical conditions and health disparities that elevate risk for Alzheimer's and exacerbate its effects, including a process to document any cost savings created through implementation of those strategies.
New Jersey	<ul style="list-style-type: none"> • Support use of emerging health care models such as the Accountable Care Organizations as a means to integrate and coordinate dementia care within primary care practices and in community health centers with growing populations of older adults. • Foster the creation of innovative initiatives like the Statewide Clinical Outreach Program for the Elderly (S-COPE), a program that targets older adults in a long-term care setting who may suffer from mental illness and dementia. • Build strong partnerships with the health care community and develop avenues for reaching physicians and others in health care on best practices and emerging issues in the treatment and support for individuals with Alzheimer's disease. • Promote the use of the dementia care practice recommendations developed by the Alzheimer's Association and other groups to make providers more aware of them and to encourage utilization.
New Mexico	
New York	<ul style="list-style-type: none"> • Increase case management for families to improve planning for services and access to 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.
New York (cont.)	<ul style="list-style-type: none"> • 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 Carolina	<ul style="list-style-type: none"> • Explore new models of care that use methods of reimbursement to incentivize the provision of care for people with Alzheimer's disease and other dementias and reduce wait lists for specialist care. • Prioritize the incorporation of person-centered care into the care planning process, care management, organizational policies, and ongoing care by health care providers and at health care facilities, including hospitals, long-term care facilities, and in-home care settings. • Implement new models of care that enhance person-centeredness, care coordination, and integration through communication, care management, and medication management for people with Alzheimer's disease and other dementias. Medicaid should include such models in health plan contracts, and the Dual Eligibles Working Group should prioritize recommendations on the application of care coordination models to coverage for the dual eligible population. • Expand the Dementia Friendly Hospital initiative under which facilities should work to include environmental modifications and practices that enhance continuity of care and person-centered care.
North Dakota	<ul style="list-style-type: none"> • 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, and follow-up.

Oklahoma	<ul style="list-style-type: none"> • 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 or other dementia. • Recommend that pharmacists include written referral to the Alzheimer's Association upon distribution of memory-care medications.
Oregon	<ul style="list-style-type: none"> • Develop and maintain a statewide list on the central Alzheimer's website of health care providers who serve those with dementia, including providers in primary care, geriatrics, psychiatry, and neurology. • Establish a stakeholder work group to determine how to protect residents of Assisted Living Facilities and Residential Care Facilities that terminate their Medicaid contracts from being negatively impacted by the contract termination.
Pennsylvania	<ul style="list-style-type: none"> • Develop improved modalities of information-sharing regarding treatment and risk reduction options, including evidence-based practices, for all Pennsylvanians, providers, public health workers, and agencies. • Review and maximize utilization of existing financial resources to ensure that individuals with Alzheimer's and other dementias receive care in the most appropriate and cost-efficient setting. • Encourage the appropriate use of palliative care to enable individuals to age in place. • Develop referral processes to encourage use of private geriatric care management for individuals whose means exceed eligibility levels for public case management services. • Research reimbursement availability for care coordination activities including team-based approaches within primary care. • Extend the best practices infrastructure currently used by PACE/PACENET to provide information and assistance regarding all programs and services. • Encourage implementation of electronic health records. • Complete prescription utilization review and intervention for PACE enrollees with Alzheimer's and other dementias. • Incorporate assessment of needs of those with Alzheimer's and other dementias into the Area Agencies on Aging planning process.
Puerto Rico	
Rhode Island	<ul style="list-style-type: none"> • Expand access to case management and care coordination services in both public and private programs. • Expand public and commercial coverage of telehealth technologies to assist in managing chronic illness diagnoses such as Alzheimer's disease. • Encourage ongoing collaboration to address needs and challenges associated with the prison population living with Alzheimer's disease. • Standardize the Continuity of Care document used to transmit patient summaries between hospitals and nursing homes and other care providers; set and communicate standards for electronic submission to ensure uniform transmission. • Improve medication reconciliation for dementia patients at transitions of care. • Develop a list of geriatric specialists in medicine, neurology, and psychiatry and make it widely available on the Rhode Island Alzheimer's disease website. • Forge connections between the regional POINT offices and the Alzheimer's Association to encourage information-sharing regarding identified needs, questions, and requests for services and to disseminate local information about Alzheimer's Association programming. • Develop a "process map" as a joint project between the POINT and the Alzheimer's Association to guide families with a recent diagnosis to address the following, in a manner that is accessible and culturally appropriate: (1) the stages of the disease and what should be expected in each of them; (2) the important planning needs to consider; and (3) the commonly-used services (e.g. adult day programs, senior centers, transportation, meals, caregiver supports).

Rhode Island (cont.)	<ul style="list-style-type: none"> • Seek out a way to connect individuals and their families dealing with a recent diagnosis of Alzheimer's disease or another dementia with a package of information that includes the "process map" and the basic information that will help them become familiar with the available resources. • Explore ways to increase public awareness of the importance of early access through the POINT to Options Counseling. • Develop and disseminate culturally competent materials to assist families with end-of-life care and planning decisions.
South Carolina	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 patient needs at the point of discharge, assess a caregiver's abilities/limitations, involve the family and its needs in planning, and develop a 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	<ul style="list-style-type: none"> • 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.
Utah	<ul style="list-style-type: none"> • 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. • 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. • 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.

<p>Utah (cont.)</p>	<ul style="list-style-type: none"> • 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. • 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 cases, and supplement 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/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.
<p>Vermont</p>	<ul style="list-style-type: none"> • Design and standardize care management plans that are outcome focused. Make a priority to develop strength-based care management approaches to address both the clinical and social needs of people with dementia. Plans may be tailored for a variety of providers, including primary care, 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. • 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 diagnosis of dementia and their family members. This service should provide a single point of entry for information and resources, 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	<ul style="list-style-type: none"> • Explore changes needed to ensure Medicaid eligibility for younger-onset dementia. • Support a pilot project with appropriate stakeholders to improve transitional care and address the 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.
Washington	<ul style="list-style-type: none"> • Promote implementation of evidence-based health promotion programs for people with cognitive impairment and dementia and their caregivers, such as Enhance Fitness, Chronic Disease Self-Management Program (CDSMP), Reducing Disability in Alzheimer's Disease, Program to Encourage Active, Rewarding Lives for Seniors, and STAR-C dementia behavior consultation. • Identify and promote existing models of care coordination services for individuals living in the community and their family caregivers, such as Health Homes, geriatric care managers, and Alzheimer's Association Care Navigators. • Educate and facilitate integration of a "dementia care framework" that targets patients with multiple chronic conditions into existing and emerging initiatives and practices. • Encourage parity in coverage options in all health insurance plans with regard to diagnosis and ongoing support/treatment of persons with dementia. • Convene a workgroup to identify and seek funding to support best practice dementia capable models that minimize care transitions, including emergency room visits, hospital admissions and readmissions. • Advocate for the development of, and promote use of, billing codes and reimbursement for care that improves the health and lives of older adults (e.g., care coordination, patient planning and counseling around care, safety and end of life, etc.) • Educate the clinical community on the impact and management of dementia and co-occurring chronic conditions. Once identified, cognitive impairment and dementia should become an organizing principle for all other care of the patient. • Increase awareness of care coordination and clinic-based health navigation and its potential to improve communication and transitions of care for individuals with dementia.
West Virginia	<ul style="list-style-type: none"> • 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.
Wisconsin	<ul style="list-style-type: none"> • Expand the Dementia Care Specialist Program in Aging and Disability Resource Centers (ADRC) to promote community awareness and access to services. • Strengthen Department of Health Services and ADRC information and referral resources to facilitate access to dementia care resources in the community, including by (1) updating information in resource databases; (2) redesigning the Department's dementia web page to make it more user-friendly; and (3) engaging in outreach regarding assistance an ADRC can provide to those with Alzheimer's and other dementias. • Create a registry of trained professional caregivers and other professionals.

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