

**VHA DEMENTIA STEERING COMMITTEE RECOMMENDATIONS
FOR DEMENTIA CARE IN THE VHA HEALTH CARE SYSTEM
2016**

The U.S. Department of Veterans Affairs (VA) Veterans Health Administration (VHA) Dementia Steering Committee (DSC) is an interdisciplinary, interoffice committee initially convened in 2006 by the Office of Patient Care Services and logistically supported by the Office of Geriatrics and Extended Care Services. The DSC is charged with synthesizing available best practice information and making recommendations to VHA leadership on key elements of dementia care across the VHA health care system. In 2008, the DSC completed an initial set of recommendations. In 2016, the DSC has reviewed and updated its recommendations.

The attached table contains the DSC 2016 Recommendations for Dementia Care in the VHA Health Care System. There are 67 recommendations, which include 37 recommendations addressed to VHA Clinicians; and 30 recommendations addressed to VHA Central Office (VHACO) Leaders, Veterans Integrated Service Network (VISN) Leaders, and/or VA medical facility (Facility) Leaders.

For the purpose of these recommendations, the term “VHA Clinicians” refers to individual VHA health care clinicians and health care teams, including providers (i.e., physicians, physician assistants, and nurse practitioners) and associated health staff (e.g., nurses, occupational therapists, pharmacists, physical therapists, psychologists, registered dietitians, social workers, speech pathologists). Specific clinician type(s) involved in each recommendation may vary, based on local needs, resources, and models of care.

Of the 37 recommendations to VHA Clinicians, 32 items are labeled “Highly Recommended.” These represent the DSC’s highest level of recommendation for clinical care processes on dementia recognition, diagnosis, and treatment. The DSC based this level of recommendation on its synthesis of evidence-based guidelines combined with Committee members’ clinical experience in the VHA health care system and feedback from VHA clinical and administrative leaders.

There are also two recommendations on Dementia Research and one recommendation on Dementia Education. These recommendations are intentionally worded broadly, to indicate general areas for further activity without limiting the specific avenues that investigators or educators may pursue.

Collectively, the DSC recommendations support the VA Under Secretary for Health’s priorities of improved access to services, increased employee engagement, consistency in best practices, rebuilding the trust of the American public, and building a high-performing network. In addition, the recommendations support the Office of Geriatrics and Extended Care’s strategic priorities of access to needed services, honoring Veteran preferences for a balance of non-institutional and institutional care settings, and providing optimal coordination of care between settings.

NOTE: The DSC recommendations themselves are not VHA policy or mandates. The DSC presents its recommendations for VHACO, VISN, and VA medical facility staff to consider for system-wide or local implementation. Further action may include development of written VHA policies at the national or local level.



VHA DEMENTIA STEERING COMMITTEE RECOMMENDATIONS FOR DEMENTIA CARE IN THE VHA HEALTH CARE SYSTEM FULL LIST

2016 REC #	2016 DSC RECOMMENDATIONS
1	<p><i>Implementation Support</i> VHACO Leaders should provide additional staffing (target GS 9/11) in Office of Geriatrics and Extended Care to support implementation of the VHA Dementia Steering Committee Recommendations.</p>
	CLINICAL CARE
	<i>Dementia Recognition</i>
2	<p><i>Guidance on Dementia Warning Signs</i> VHACO Leaders have provided written guidance to the field regarding use of warning signs to prompt assessment of cognitive function, rather than general screening for dementia in asymptomatic persons. Guidance should be reviewed and updated as needed.</p> <p>Current VHA guidance is available at: <i>VHA NCP Guidance Statement on Screening for Cognitive Impairment (Previous Title: Screening for Dementia), 2016:</i> http://vaww.prevention.va.gov/Screening_for_Cognitive_Impairment.asp <i>NOTE: This is an internal web site that is not available to the public.</i></p> <p><i>VHA NCP Clinician Fact Sheet: Detection of Dementia</i> (2011): http://www.prevention.va.gov/docs/0514_VANCP_Dementia_Fact_F.pdf</p> <p><i>VHA Dementia Warning Signs Report and Toolkit</i> (2011): http://vaww.infoshare.va.gov/sites/geriatrics/national/AH/Forms/AllItems.aspx?RootFolder=%2Fsites%2Fgeriatrics%2Fnational%2FAH%2FDEMENTIA%20MATERIALS%2FDementia%20Warning%20Signs%20Report%20and%20Toolkit%202011&InitialTabId=Ribbon%2EDocument&VisibilityContext=WSSTabPersistence</p>
3	<p><i>Information Technology on Dementia Warning Signs</i> VHACO Leaders support use of information technology to encourage use of dementia warning signs by VHA Clinicians and Veterans/families. These resources will be updated as new information becomes available.</p> <p>Current VHA resources are available at: <i>For VHA Clinicians:</i> http://vaww.infoshare.va.gov/sites/geriatrics/national/AH/Forms/AllItems.aspx?RootFolder=%2Fsites%2Fgeriatrics%2Fnational%2FAH%2FDEMENTIA%20MATERIALS%2FDementia%20Warning%20Signs%20Report%20and%20Toolkit%202011&InitialTabId=Ribbon%2EDocument&VisibilityContext=WSSTabPersistence <i>NOTE: This is an internal web site that is not available to the public.</i></p> <p><i>For Veterans/families:</i> http://www.veteranshealthlibrary.org/, search for "Dementia"; http://www.veteranshealthlibrary.org/Search/SearchResults.pg?SearchPhrase=Dementia&SearchType=keyword&SearchOperator=And</p>
4	<p><i>Use of Dementia Warning Signs</i> Highly Recommended: VHA Clinicians should use dementia warning signs to prompt assessment of cognitive function. If warning signs are present, patients should be evaluated further as in Recommendations #5-10.</p> <p><i>VHA Dementia Warning Signs Report and Toolkit</i> (2011): http://vaww.infoshare.va.gov/sites/geriatrics/national/AH/Forms/AllItems.aspx?RootFolder=%2Fsites%2Fgeriatrics%2Fnational%2FAH%2FDEMENTIA%20MATERIALS%2FDementia%20Warning%20Signs%20Report%20and%20Toolkit%202011&InitialTabId=Ribbon%2EDocument&VisibilityContext=WSSTabPersistence <i>NOTE: This is an internal web site that is not available to the public.</i></p>



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	<i>Dementia Diagnosis</i>
5	<p><i>History</i> Highly Recommended: VHA Clinicians should include the following critical elements of history-taking when investigating or establishing the suspected diagnosis of dementia:</p> <ul style="list-style-type: none"> • A history that elicits the onset and course of signs of cognitive disorder (such as memory loss; difficulty with following instructions or doing complex tasks; misplacing objects; getting lost in familiar surroundings; problems with speech and understanding); • Mood and Behavioral symptoms (by history or by an assessment at the time of the exam, such as agitation, aggression, apathy, disinhibition, impulsivity, inappropriate sexual behavior, resistance to care, repeated vocalizations, sleep-wake cycle changes, wandering); • Functional status (by history or by an assessment at the time of the exam), activities of daily living [ADL], instrumental activities of daily living [IADL], losing ability to manage finances; decline in work, social and interpersonal activities); • Psychiatric disorders (particularly late-life depression; anxiety; posttraumatic stress disorder [PTSD]; and psychosis, including delusions and hallucinations); • Drug and alcohol use; • Medical history, with careful assessment of vascular risks (including history of atherosclerotic vascular disease of coronary, cerebral and peripheral vessels; history of conditions that increase risk for vascular disease: hypertension, diabetes, hyperlipidemia/dyslipidemia & tobacco use disorder); • History of head trauma including traumatic brain injury (TBI)*; • History of sleep disorders; • History of delirium; • Vision and hearing impairment; • History of falls, unsteady gait; • Medication review; • Family history of dementia or other cognitive impairment; • Social history (including social support system, education, literacy, primary language); • Safety assessment (including driving status, access to firearms and/or power tools, kitchen safety [stove/appliances]); • Collateral history (from caregiver or other informant) if possible, to substantiate or supplement information from Veteran. <p>*Assessment as part of history does not necessarily indicate causality for purposes of disability or other benefits determinations.</p>
6	<p><i>Physical Examination</i> Highly Recommended: VHA Clinicians should include the following elements of Physical Examination when investigating or establishing the suspected diagnosis of dementia:</p> <ul style="list-style-type: none"> • General physical examination with particular emphasis on the cardiovascular system; • Neurological examination including mental status examination; • Objective evaluation of cognitive function is required, using a standardized cognitive instrument.
7	<p><i>Routine Laboratory Testing</i> Highly Recommended: VHA Clinicians should include the following Routine Laboratory Testing when investigating or establishing a suspected diagnosis that may be causing or contributing to dementia:</p> <ul style="list-style-type: none"> • Thyroid stimulating hormone; • Complete blood count; • Electrolytes and Calcium; Hepatic panel; • Blood Urea Nitrogen; • Creatinine; • Glucose; • Vitamin B12; • Human Immunodeficiency Virus (with verbal consent documented).



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8	<p>Advanced Diagnostic Testing Highly Recommended: VHA Clinicians should include Advanced Diagnostic Testing, when indicated, to investigate or establish a suspected diagnosis that may be causing or contributing to dementia. When certain risk factors or physical signs are present, Advanced Diagnostic Testing may be needed to exclude any of the following potential diagnoses (including, but not limited to):</p> <ul style="list-style-type: none"> • Syphilis; • Lyme disease; • Heavy Metal or Toxin exposures; • Endocrine disorders; • Prion-related disorders such as Creutzfeldt-Jacob Disease (CJD); • Meningeal carcinomatosis; • Central nervous system vasculitis.
9	<p>Neuropsychological Evaluation* Recommended: VHA Clinicians should consider referral for neuropsychological evaluation* as part of the dementia diagnostic work-up when:</p> <ul style="list-style-type: none"> • Performance on a brief cognitive test is questionable due to level of education (very high or very low), cultural factors (e.g., English as a second language), lack of effort, or inconsistency with reported functional concerns (e.g., brief test results are within normal limits but Veteran and family note everyday functional changes); • Impact of comorbidities (e.g., psychiatric, medical, neurological [including TBI], psychosocial) on cognitive function is unclear; • Clarifying type or severity of neurocognitive disorder is necessary to align appropriate level of therapeutic services and interventions, including family/caregiver education; • Cognitive, emotional, or behavioral presentation is atypical or otherwise complex; • Symptoms are rapidly progressive; • Veteran is <60 years of age. <p>(*Norm referenced cognitive evaluations conducted by neuropsychologists or other appropriately trained doctoral –level psychologists)</p>
10	<p>Brain Imaging a. Highly Recommended: VHA Clinicians should obtain an anatomic image of the brain with either Magnetic Resonance Imaging (MRI) or Computed Tomography (CT) when cognitive decline develops suddenly or is associated with focal neurological deficits that cannot be explained by known, pre-existing pathology.</p> <p>b. Recommended: When investigating or establishing the suspected diagnosis of dementia, VHA Clinicians should obtain a MRI or CT if one has not been obtained since the onset or progression of symptoms.</p>



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11	<p><i>Dementia Specialists</i> Recommended: VISN and Facility Leaders should ensure that at least one site per VISN has at least two Dementia Specialists with specialized training or experience in dementia diagnosis and treatment (including at least one physician [neurologist, geriatrician, and/or psychiatrist] and at least one psychologist [neuropsychologist and/or geropsychologist, with expertise in both cognitive assessment and behavioral interventions.]; or a multidisciplinary Dementia/Memory Disorders Clinic) available to other sites in the VISN directly or through use of telehealth/e-consultation, so that each Facility provides or has access to an appropriate Dementia Specialist for consultation with Primary Care Clinicians under the conditions listed below:</p> <ul style="list-style-type: none"> • cognitive, emotional, or behavioral presentation is atypical or otherwise complex; • rapidly progressive symptoms; • Veteran <60 years of age; • significant behavioral symptoms, such as agitation, aggression, apathy, disinhibition, impulsivity, inappropriate sexual behavior, resistance to care, repeated vocalizations, sleep-wake cycle changes, wandering; • significant comorbid psychiatric disorders (particularly late-life depression, anxiety, post-traumatic stress disorder [PTSD],* psychosis); • history of significant head trauma meeting criteria for TBI;* • accompanying movement disorder. <p>* Targeting history and specialty evaluation do not imply causality for purposes of disability or other benefits determinations.</p>
12	<p><i>Genetic Testing</i> Not Recommended for Routine Use. Genetic testing, including ApoE genotyping, is not recommended for routine evaluation of Veterans with dementia. However, if there is reason to suspect an Alzheimer's Disease gene mutation (e.g., early age at onset and strong family history of dementia), VHA Clinicians should refer the patient to a specialist trained in providing genetic counseling.</p>
13	<p><i>Biomarkers and Advanced Neuroimaging</i> Not Recommended for Routine Use. Cerebrospinal fluid (CSF) biomarkers, positron emission tomography (PET) imaging (for glucose uptake, amyloid, or tau), or other advanced neuroimaging techniques are not recommended for routine evaluation of Veterans with dementia. However, if there is diagnostic uncertainty that will impact prognosis and/or treatment decisions, VHA specialist clinicians with expertise in dementia diagnosis and treatment may consider use of these tests to aid in diagnosis (e.g., ¹⁸F-fluorodeoxyglucose [FDG]-PET to distinguish Alzheimer's disease vs. frontotemporal dementia).</p>
14	<p><i>Cognitive Testing</i> VHACO Leaders should convene a multidisciplinary Workgroup led by VHA psychologists/neuropsychologists to make specific updated recommendations on 1) cognitive test battery(ies) for VHA use in assessment of dementia, 2) brief cognitive instruments, 3) use of tele-neuropsychology in the assessment of dementia, and 4) validated instruments to screen for depression in the context of cognitive impairment.</p>
<i>Dementia Treatment</i>	
15	<p><i>Order Checks for Medications Associated with Mental Status Changes</i> VHACO Leaders should convene a Workgroup to develop an order check process (a process that flags medication orders for patients with a specific diagnosis[es] that deserves further scrutiny by the prescriber) in the electronic medical record for use of medications that may be associated with mental status changes in patients with a diagnosis of dementia or cognitive disorder not otherwise specified. Include the development of order checks for writing a new medication and renewing an old medication.</p>
<i>For Disease Stages: Mild Cognitive Impairment or Other Cognitive Dysfunction Not Meeting Criteria for Dementia; and All Stages of Dementia</i>	
16	<p><i>Medication Monitoring and Adjustment (All care locations)</i> Highly Recommended: VHA Clinicians should review the Veteran's prescription and non-prescription medications and discontinue or document a rationale for continuing any medications known to impact mental status.</p>



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17	<p><i>Depression Screening and Treatment (All care locations)</i> Highly Recommended: VHA Clinicians should screen for depression during the initial dementia evaluation and periodically during follow-up, and should provide treatment for depression or refer to a specialist for treatment as indicated.</p>
18	<p><i>Management of Vascular Risk Factors (All care locations)</i> Highly Recommended: VHA Clinicians should manage vascular risk factors for all patients and consider treatment and prevention strategies for both cardiovascular and cerebrovascular diseases when clinically indicated.</p>
<i>Additional for Disease Stage: Mild Cognitive Impairment or Other Cognitive Dysfunction Not Meeting Criteria for Dementia</i>	
19	<p><i>Advance Care Planning (All care locations)</i> Highly Recommended: VHA Clinicians should encourage the Veteran to identify a surrogate decision maker authorized to make health care decisions in the event that the Veteran loses decision-making capacity in the future. The authorized surrogate may be the Health Care Agent, the legal guardian, or the next-of-kin. The Veteran should also be encouraged to complete a written Advance Directive, such as the Durable Power of Attorney for Health Care. [See <i>VHA Handbook 1004.02, Advance Care Planning and Management of Advance Directives (2013)</i>, http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2967]</p>
20	<p><i>Functional Maintenance (All care locations)</i> Recommended: VHA Clinicians should counsel both the Veteran and caregiver (as appropriate) on the importance of both staying socially, mentally, and physically active.</p>
<i>Additional For Disease Stages: All Stages of Dementia</i>	
21	<p><i>Functional Capacity Identification (All care locations)</i> Highly Recommended: VHA Clinicians should periodically re-assess the functional capacity of a Veteran with dementia. This includes activities of daily living (ADLs), instrumental ADLs (IADLs), safety, and ability to live independently versus need for a supervised setting.</p>
22	<p><i>Functional Maintenance Program (All care locations)</i> Highly Recommended: VHA Clinicians should ensure that an assessment-driven functional maintenance program is developed to address specific strategies of care for a Veteran with dementia. The program should include, but is not limited to, structuring day-to-day activities; ensuring good nutrition and hydration; maintaining physical, cognitive, and social activity; supporting IADL and ADL; and ensuring good sleep hygiene. Referrals should be made to specialty service as appropriate, including but not limited to: rehabilitation, recreation therapy, adult day health care, dietetics, etc.</p>
23	<p><i>Cholinesterase Inhibitors Discussion (All care locations)</i> Highly Recommended: VHA Clinicians should discuss the option of cholinesterase inhibitor treatment with the patient and/or caregiver, if the Veteran has a diagnosis of mild, moderate, or severe Alzheimer's disease (including mixed Alzheimer's plus vascular dementia); Lewy body dementia, or Parkinson's disease with dementia. [Detailed guidance from <i>VA Pharmacy Benefits Management on Acetylcholinesterase inhibitor use is available</i> at http://www.pbm.va.gov/PBM/clinicalguidance/criteriaforuse/Acetylcholinesterase_Inhibitors_Criteria_for_Use_2014_rev_Dec_2015.pdf.]</p>
24	<p><i>Cholinesterase Inhibitors Adjustment (All care locations)</i> Highly Recommended: When cholinesterase inhibitor treatment is initiated, VHA Clinicians should titrate the dose to the therapeutic range, and they should schedule close follow-up to assess for response and adverse effects. Given the lack of evidence for superiority of one agent over another, choice of a specific agent should be based on tolerability, side-effect profile, convenience of use, and cost.</p>
25	<p><i>Cholinesterase Inhibitors and Sleep Disturbances (All care locations)</i> Highly Recommended: VHA Clinicians should consider slower titration of cholinesterase inhibitor therapy if the Veteran with dementia has nightmares from posttraumatic stress disorder or other sleep disturbances, as such medications may cause vivid or abnormal dreams.</p>



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26	<p>Assessment of Dementia-Related Behavioral Symptoms (All care locations) Highly Recommended: VHA Clinicians should ask caregivers about dementia-related behavioral symptoms as part of the history-taking during each follow-up visit. Such symptoms may include, but are not limited to, agitation, aggression, apathy, disinhibition, impulsivity, inappropriate sexual behavior, resistance to care, repeated vocalizations, sleep-wake cycle changes, wandering.</p>
27	<p>Delirium/Distressing Physical Symptoms and Dementia-Related Behavioral Symptoms (All care locations) Highly Recommended: VHA Clinicians should evaluate for possible delirium and/or distressing physical symptoms (e.g., pain, dyspnea, constipation) if a veteran with dementia has behavioral symptoms.</p> <p><i>[Information on delirium for VHA Clinicians is available at http://vaww.va.gov/GERIATRICAL/Delirium_Information_for_VA_Health_Care_Professionals.asp.]</i> <i>NOTE: This is an internal web site that is not available to the public.</i></p> <p><i>Information on delirium for Veterans and families is available at http://www.va.gov/GERIATRICAL/Guide/LongTermCare/Delirium_Veterans.asp</i></p>
28	<p>Non-Pharmacological Interventions for Dementia-Related Behavioral Symptoms (All care locations) Highly Recommended: After delirium has been ruled out, VHA Clinicians should document specific dementia-related behavioral symptoms of concern and initiate non-pharmacological interventions. If pharmacotherapy is considered necessary, non-pharmacological interventions should be instituted concurrently. Examples of non-pharmacological management approaches to treat behavioral symptoms associated with dementia include but are not limited to: caregiver education, support, and problem-solving; behavioral management techniques; engagement in pleasant activities; and environmental interventions (e.g., addressing lighting, noise, temperature).</p>
29	<p>Specialist for Pharmacological Treatment of Dementia-Related Behavioral Symptoms (All care locations) Highly Recommended: VHA Clinicians should refer to or seek consultation from a provider with expertise in pharmacological aspects of dementia care if a Veteran with dementia has disturbing behavioral symptoms that are not responsive to non-pharmacological interventions or pharmacological interventions used to date.</p>
30	<p>Risk-Benefit Discussion for Pharmacological Treatment of Dementia-Related Behavioral Symptoms (All care locations) Highly Recommended: VHA Clinicians should document a risk-benefit discussion, including risk of increased mortality from certain agents, with the Veteran and/or caregiver before initiating pharmacological treatment of dementia-related behavioral symptoms and upon follow-up to re-assess medication efficacy.</p>
<u>Additional for Disease Stage: Mild Dementia</u>	
31	<p>Medication Adherence (Non-institutional settings) Highly Recommended: VHA Clinicians should simplify medication administration directions and use individualized strategies to optimize medication adherence for a Veteran with dementia (e.g., pill boxes and other tools that assist with medication adherence).</p>
<u>Additional For Disease Stages: Mild and Moderate Dementia</u>	
32	<p>Caregiver Assessment (All care settings) Highly Recommended: VHA Clinicians should conduct a caregiver assessment to identify the caregiving resources and needs of the Veteran with dementia. This includes the caregiver's burden, educational and emotional needs, problem solving skills, and access to VA/community resources. Referral to VA Caregiver Support Program should be made as indicated.</p>
33	<p>Support Services (Non-institutional settings) Highly Recommended: VHA Clinicians should discuss support services with the Veteran with dementia and caregiver. Such services include adult day care, homemaker/home health aide, respite care, patient and caregiver support programs, and other VA/community resources.</p>



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34	<p>Firearms (Non-institutional settings) Highly Recommended: VHA Clinicians should counsel the Veteran with dementia and caregiver on firearm safety and encourage restricted access to firearms and ammunition, if the Veteran possesses and/or uses firearms. [See VA Questionnaire, Firearms and Driving http://vaww.va.gov/vaforms/Search_action.asp?FormNo=0435&tkey=&Action=Search; VA Brochure B 10-82 (Revised) Firearms and Dementia http://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=2731; NOTE: This is an internal web site that is not available to the public.]</p>
35	<p>Driving (Non-institutional settings) Highly Recommended: VHA Clinicians should counsel the Veteran with dementia and caregiver on driving safety if the Veteran still drives. VHA Clinicians should follow local policy regarding any mandated reporting of impaired driving. [See VA Questionnaire, Firearms and Driving http://vaww.va.gov/vaforms/Search_action.asp?FormNo=0435&tkey=&Action=Search; VA Brochure B 10-83 Driving and Dementia http://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=1162; VHA National Center for Ethics in Health Care Report on Impaired Driving in Older Adults (2007) http://vaww.ethics.va.gov/pubs/necreports.asp; NOTE: This is an internal web site that is not available to the public.]</p>
36	<p>Advance Care Planning (All care settings) Highly Recommended: VHA Clinicians should encourage the Veteran to identify a surrogate decision maker authorized to make health care decisions on his/her behalf. The authorized surrogate may be the Health Care Agent, the legal guardian, or the next-of-kin. The Veteran should also be encouraged to complete a written Advance Directive, such as the Durable Power of Attorney for Health Care. [See VHA Handbook 1004.02, Advance Care Planning and Management of Advance Directives (2013, http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2967)]</p> <p>VHA Clinicians should also counsel the Veteran and caregiver (and/or surrogate) about likely loss of decision-making capacity, upcoming decisions, and available VA/community resources (e.g., palliative care and hospice care).</p> <p>Discussions regarding the Veteran's values, goals, and preferences for care at various/future stages of illness should be conducted and documented in the patient record.</p>
37	<p>Assessment of Decision-Making Capacity (All care settings) Highly Recommended: VHA Clinicians should assess the decision-making capacity of the Veteran with mild to moderate dementia during care transitions and/or when obtaining consent for treatments or procedures. [See VHA Handbook 1004.01, VHA Informed Consent for Clinical Treatments and Procedures (2009), www.va.gov/vhapublications/viewpublication.asp?pub_id=2055]</p>
38	<p>Financial Management (All care settings) Highly Recommended: VHA Clinicians should encourage the Veteran to complete relevant legal documents before he or she loses capacity to do so, to identify how finances, property, and other assets will be handled when he or she is no longer able to manage them independently. Veterans should be encouraged to discuss their advance financial planning options with their financial institutions and an attorney, if necessary. If the Veteran loses decision-making capacity prior to establishing an advance plan regarding finances, property, and other assets, then VHA Clinicians should encourage the next of kin to discuss options with financial institutions and/or an attorney on how to manage the Veteran's affairs. This may include completion of a financial power of attorney, or, after all less restrictive alternatives have been exhausted, petitioning the court for guardianship/conservatorship. With the completion of proper paperwork, VA can appoint a fiduciary to manage VA funds, and the Social Security Administration can designate a representative payee to manage Social Security funds.</p>
39	<p>Abuse or Neglect (Non-institutional settings) Recommended: VHA Clinicians should be alert to signs of possible neglect (including self-neglect) and/or abuse in their evaluations of a Veteran with dementia who lives in the community. VHA Clinicians should follow local policy regarding any mandated reporting of abuse/neglect.</p>



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	<i>Additional For Disease Stages: Moderate and Severe Dementia</i>
40	<p><i>Memantine Discussion (All care locations)</i> Highly Recommended: For a Veteran diagnosed with moderate or severe Alzheimer's disease, VHA Clinicians should discuss with the Veteran and/or caregiver the use of combination therapy with a cholinesterase inhibitor and memantine. For those who cannot tolerate cholinesterase inhibitor therapy, discussion should focus on the use of monotherapy with memantine. <i>[Detailed guidance from VA Pharmacy Benefits Management on memantine use is available at: http://www.pbm.va.gov/PBM/clinicalguidance/criteriaforuse/Memantine_CFU_2014_INTERnet.doc.]</i></p>
	<i>Additional For Disease Stage: Severe Dementia</i>
41	<p><i>Withdrawal of Pharmacologic Therapy Discussion (All care locations)</i> Highly Recommended: VHA Clinicians should consider withdrawal of cholinesterase inhibitor and/or memantine therapy if a Veteran with dementia deteriorates in functional status to the point that there is dependency in all basic activities of daily living or if meaningful social interactions and quality of life benefits are no longer achievable (e.g. Functional Assessment Staging Test [FAST] Stage 7).</p>
42	<p><i>Supportive Care (All care locations)</i> Highly Recommended: VHA Clinicians should encourage patients with advanced dementia to participate in their activities of daily living (ADLs) to the best of their ability for as long as possible. This includes, but is not limited to, participation in hygiene, nutrition, elimination, fall prevention, positioning and movement, and meaningful activities. The Veteran's preferences regarding sensory stimulation/ environment and level of participation in care should be incorporated into the plan of care to the extent possible.</p>
43	<p><i>Palliative/Hospice Care (All Care Locations)</i> Highly Recommended: VHA Clinicians should employ palliative and/or hospice approaches to optimize quality of remaining life and achieve as comfortable, dignified, and peaceful death as possible, when the Veteran with severe dementia enters the advanced phase of the illness.</p>
CARE COORDINATION	
<i>For VHACO, VISN, and Facility Leaders:</i>	
44	<p><i>Linkage of Care Models</i> VHACO, VISN, and Facility Leaders should ensure linkage of Facility dementia care models with new and ongoing case management and care coordination initiatives, e.g., Caregiver Support Program, Home Tele-health, Patient-Aligned Care Team (PACT). These initiatives will serve as a foundation for case management and care coordination of Veterans with dementia, augmented by dementia-specific competencies and home tele-health technologies where indicated.</p>
<i>Additional For VHACO Leaders:</i>	
45	<p><i>Performance Indicators</i> VHACO Leaders should continue to work with Office of Quality, Safety and Value and others to refine and implement current performance measures of dementia care in various settings and to develop additional measures as needed, including dementia care coordination. Processes used for other chronic illnesses may be applied and/or adapted to develop measures for dementia care.</p>
<i>Additional For VISN and Facility Leaders</i>	
46	<p><i>Support for VISN and Facility Dementia Committees</i> VISN and Facility Leaders should ensure support (e.g., dedicated time, space, other resources) for VISN and Facility Dementia Committees and their activities.</p>
47	<p><i>Female Veterans with Dementia</i> VISN and Facility Leaders should provide treatment services and settings that meet the needs of female as well as male Veterans with dementia to ensure safety, privacy, and dignity across all care settings.</p>



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<i>Additional For VISN Leaders:</i>	
48	<i>Funding for Dementia Care Coordinators</i> VISN Leaders should allocate sufficient funds to Facilities to ensure that Veterans with dementia have their care coordinated through Dementia Case Managers, Dementia Care Coordinators, Case Management Teams, or Home Telehealth Teams and Care Coordinators.
<i>Additional For Facility Leaders:</i>	
49	<i>Dementia Care Coordination Model</i> Facility Leaders should determine the best care coordination model (e.g., generic, dementia-specific, or co-managed) and practice setting (e.g., primary care, geriatrics, mental health, neurology, and/or dementia clinic) for case management and care coordination of Veterans with dementia at their facility.
50	<i>Communication and Collaboration Strategies</i> Facility Leaders should determine optimal communication and collaboration strategies between local primary care team, specialties, and dementia care coordinator(s) at their facility.
51	<i>Local Dementia Protocols</i> Facility Leaders should develop, select, review, and/or revise local dementia-specific protocols at their facility.
52	<i>Dementia Care Coordinator Training</i> Facility Leaders should ensure that Dementia Care Coordinators work closely with facility Caregiver Support Coordinators to ensure that Dementia Care Coordinators receive training regarding VA Caregiver Support Program resources as appropriate.
53	<i>Dementia Sub-Populations</i> Facility Leaders should identify local sub-populations of Veterans with dementia at greatest risk for poor care outcomes and prioritize quality improvement efforts on those groups. Advice from VISN Dementia Specialists should be sought as needed. Examples of sub-populations may include those with medical and/or psychiatric co-morbidities, multiple medications, impaired communication, lack of family or other social support; those from diverse racial/ethnic communities; those in rural, isolated settings; those who are homeless.
ADMINISTRATIVE ISSUES	
<i>VA Dementia Data</i>	
54	<i>Dementia Clinic Stop Code</i> VHACO Leaders should provide guidance to Facilities about correct use of Alzheimer's/Dementia Clinic-related stop codes in order to increase consistency of their use.
55	<i>Dementia Data Needs and Access</i> VHACO Leaders should develop a user-friendly, dynamic dementia reporting tool to be used consistently for official VHA reporting purposes. Tool should be reviewed periodically for any necessary modifications. Data elements should include key information for dementia program planning at the local Facility, VISN, and VHACO levels. The report should establish standardized ways of defining and reporting VHA dementia data (demographics, service use, and costs) using a consistent set of diagnostic codes and business rules.
<i>Estimates of New Cases & Cost Effectiveness</i>	
56	<i>Dementia Projections</i> VHACO Leaders should update VHA dementia projections on a regular basis, using the latest information on prevalence/incidence rates.
57	<i>Dementia Diagnostic Code List</i> VHACO Leaders should maintain a list of dementia diagnostic codes based on inter-professional consensus and promote its consistent use throughout VHA.



2016 REC #	2016 DSC RECOMMENDATIONS
58	<i>Dementia Severity and Health-Related Quality of Life Scales</i> VHACO Leaders should convene a Workgroup to make specific recommendations on (1) a dementia severity scale and (2) a dementia health-related quality of life scale for VHA use.
59	<i>Cost-Effectiveness Analysis Template</i> VHACO Leaders should convene a Workgroup to develop a recommended template for cost-effectiveness analyses of VHA dementia care.
VERA/Cost Incentives/Cost Disincentives	
60	<i>Dementia Co-Morbidity Cost Estimates</i> VHACO Leaders should obtain updated comorbidity cost estimates , including service utilization costs for VHA patients with dementia in comparison with other chronic conditions that VHA treats.
61	<i>VERA Adjustments</i> VHACO Leaders should convene a Workgroup to determine whether adjustments are necessary to the Veterans Equitable Resource Allocation (VERA) Cost Allocation model for VHA patients with dementia.
Workforce Issues	
62	<i>Dementia Workforce</i> VHACO Leaders should determine workforce requirements for VHA professional and support staff to provide dementia care, and should ensure adequate recruitment and retention strategies to attract and maintain a consistent VHA workforce to care for Veterans with dementia.
63	<i>Caregiver Support</i> VHACO Leaders should provide ongoing monitoring of dementia-specific resources available through VA Caregiver Support programs to ensure they are accurate and in compliance with VHA policy guidelines.
VISN Survey Template	
64	<i>VISN Survey</i> VHACO Leaders should convene a Workgroup for further development and implementation of a survey of VISN dementia care practices, including progress and barriers to implementation of VHA Dementia Steering Committee recommendations.
RESEARCH	
65	<i>Dementia Research</i> VHACO Leaders should fund further research on the pathobiology/pathophysiology of dementia; early identification, treatment, prevention; and development and implementation of best practice models for dementia care in the VHA health care system. Suggested topics may include but are not limited to: a) <i>Novel mechanisms that underlie the pathobiology of dementia;</i> b) <i>Genomics/epigenomics;</i> c) <i>Potential risk factors for development of dementia;</i> d) <i>Biomarkers of early or preclinical stages of dementia;</i> e) <i>Effective dementia prevention, recognition, evaluation, prognosis, and/or care; considering co-occurring mental and medical disorders or other factors such as race, culture, or gender;</i> f) <i>Effective management of acute, dementia-related psychiatric or behavioral symptoms;</i> g) <i>Innovative models of care, including use of new technologies;</i> h) <i>End of life care for veterans with severe dementia, including use of palliative and hospice care;</i> i) <i>Cost-effectiveness of standardized processes for dementia recognition, diagnosis, treatment, care coordination, and caregiver support.</i>
66	<i>Dementia Research Partnerships</i> VHACO Leaders should continue to work with other Federal partners to expand dementia research initiatives as outlined in the recommendations from the 2015 Alzheimer's Summit and the 2016 Alzheimer's Disease-Related Disorders (ADRD) Summit, both held by the National Institutes of Health to contribute to the U.S. national Alzheimer's Plan. [See recommendations from these meetings at http://www.nia.nih.gov/research/recommendations-nih-ad-research-summit-2015 ; https://meetings.ninds.nih.gov/Home/Tab1/11958]



2016 REC #	2016 DSC RECOMMENDATIONS
	EDUCATION/TRAINING
67	<p><i>Dementia Education/Training</i></p> <p>VHA Dementia Education and Training Committee should collaborate with VHA Employee Education System to develop further education/training on dementia care best practices for VHA Clinicians. Whenever possible, education interventions for relevant clinician groups (e.g., Geriatrics and Extended Care, Mental Health, Primary Care) should address issues of dementia care. Also, dementia education/training should target audiences in all disciplines, including physicians, associated health staff, and direct care staff including nursing assistants. Training should also include sensitivity to factors such as race, culture, or gender that may affect care needs of veterans with dementia. Suggested topics include but are not limited to: a) <i>Recognition of dementia warning signs and common presentations of dementia</i>; b) <i>Integration of Primary and Specialty Care in the diagnosis and management of dementia</i>; c) <i>Use of non-pharmacological and pharmacological interventions for dementia-related behavioral symptoms</i>; d) <i>Use of palliative care for veterans with advanced dementia, including supportive care approaches to activities of daily living (ADLs)</i>; e) <i>Coordination of dementia care across services, settings, and stages of illness</i>; f) <i>Family caregiver support and collaboration with VA/community resources</i>.</p>

TERMS AND DEFINITIONS

TERM	DEFINITION
Facility	VA medical facility
Highly Recommended	The VHA Dementia Steering Committee’s highest level of recommendation for clinical care processes on dementia recognition, diagnosis, and treatment, based on synthesis of evidence-based guidelines combined with Committee members’ clinical experience in the VHA health care system and feedback from VHA clinical and administrative leaders.
VA	U.S. Department of Veterans Affairs
VHA	Veterans Health Administration
VHACO	Veterans Health Administration Central Office
VHA NCP	VHA National Center for Health Promotion and Disease Prevention
VHA Clinicians	Individual VHA health care clinicians and health care teams, including providers (i.e., physicians, physician assistants, and nurse practitioners) and associated health staff (e.g., nurses, occupational therapists, pharmacists, physical therapists, psychologists, registered dietitians, social workers, speech pathologists). Specific clinician type(s) involved in each recommendation may vary, based on local needs, resources, and models of care.
VISN	Veterans Integrated Service Network