Complete Summary

GUIDELINE TITLE

Screening for dementia: recommendations and rationale.

BIBLIOGRAPHIC SOURCE(S)

Screening for dementia: recommendation and rationale. Ann Intern Med 2003 Jun 3;138(11):925-6. PubMed

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY

SCOPE

DISEASE/CONDITION(S)

Dementia

GUIDELINE CATEGORY

Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Geriatrics
Internal Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses

Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To summarize the current U.S. Preventive Services Task Force recommendations on screening for dementia and the supporting scientific evidence
- To update the 1996 recommendations contained in the Guide to Clinical Preventive Services, Second Edition

TARGET POPULATION

Older adults seen in primary care, or those in whom cognitive impairment or deterioration is suspected, based on direct observation, patient report, or concerns raised by family members, friends or caretakers

INTERVENTIONS AND PRACTICES CONSIDERED

1. Cognitive screening tests
    - Mini-Mental Status Examination (MMSE)
    - Other cognitive screening tests, such as the Short Portable Mental Status Questionnaire, Clock Drawing Test, Modified MMSE, Mini-Cog, Hopkins Verbal Learning Test, and the 7-minute screen have not been adequately evaluated in primary care settings.
2. Functional tests
    - Functional Activities Questionnaire
    - Informant Questionnaire on Cognitive Decline in the Elderly
    - Instrumental Activities of Daily Living Questionnaire

MAJOR OUTCOMES CONSIDERED

Key Question No. 1: Does screening for dementia in older adults (>60 years) do any of the following:

- improve or worsen patients' cognitive, social, or physical function?
- increase or decrease hospitalizations, institutionalizations, or health care visits?
- prevent or precipitate behavioral problems?
- alleviate or worsen caregivers' stress and coping?
- prevent or precipitate accidents, such as accidental falls or automobile crashes?
- improve or worsen patients' health-related quality of life?

Key Question No. 2: What is the prevalence of undiagnosed dementia in primary care patients? What are the common causes of dementia in primary care patients?

Key Question No. 3: Is there a reliable and valid screening test to detect dementia in primary care populations?

Key Question No. 4: Do pharmacologic interventions of potentially reversible or irreversible dementia improve any of the 6 outcomes noted in Key Question No. 1?

- Such treatments include antiplatelet therapy for vascular dementia, cholinesterase inhibitors for Alzheimer's disease, thyroid treatment for hypothyroidism, and vitamin B12 for vitamin B12 deficiency.

Key Question No. 5: Do nonpharmacologic interventions, such as sensory, environmental, behavioral, or activity-directed programs, improve any of the 6 outcomes noted in Key Question No. 1?

Key Question No. 6: Do caregiver interventions improve any of the 6 outcomes noted in Key Question No. 1?

Key Question No. 7: What are the adverse effects of screening for dementia?

Key Question No. 8: What are the costs and cost-effectiveness of screening for dementia?

Key Question No. 9: What are the adverse effects of dementia therapy?

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Research Triangle Institute (RTI) International-University of North Carolina Evidence-based Practice Center for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

Inclusion/Exclusion Criteria for Admissible Evidence

Inclusion and exclusion criteria were developed for selecting evidence relevant to answer the key questions (see Table 1 in the Systematic Evidence Review). A search was first done for evidence from randomized controlled trials (RCTs) for the efficacy of screening (Key Question No. 1). As no well-conducted RCT of screening was found, the evidence for Key Questions No. 2 through 9 was examined.

For Key Questions No. 2 and 3, systematic reviews, RCTs (Key Question No. 3 only) and cross-sectional prevalence or prospective cohort studies that used an acceptable reference standard in a primary care population comparable to those

typical in the United States were used. Key Questions No. 4 through 6 concerned the efficacy of various treatments (pharmacologic, nonpharmacologic, and caregiver, respectively) and included systematic reviews and RCTs that included participants with mild to moderate dementia verified by an acceptable diagnostic test and that provided information on at least 1 of the 6 outcomes of interest. Longitudinal studies were also included for studies of reversible dementia.

Pharmacologic searches used specific drug names, restricting the pharmacotherapies to those that the U.S. Food and Drug Administration has approved, are available in the US market for off-label use, and are not investigational drugs.

Systematic reviews were used for Key Questions No. 7 and 9, involving harms of screening and treatment. Prospective cohorts and cross-sectional prevalence studies were also included for screening. And RCTs and prospective cohort studies were also used for therapy.

For Key Question 8, regarding the costs and cost-effectiveness of screening and early treatment, a search was conducted for systematic reviews or studies of any research design (preferably RCTs and prospective cohort) that provided information about costs and for cost-effectiveness, cost-utility, and cost-benefit studies of screening.

The inclusion and exclusion criteria were used to develop search terms. A search was first done for well-conducted systematic reviews, including any in the Cochrane Collaboration Database, relevant to the key question. When such reviews were found, the MEDLINE, PsycINFO, and EMBASE databases were searched for studies published since the date of the review. If no systematic review was found, these databases were searched for studies from January 1994 through January 2001. Only studies in the English language concerning humans ages 60 years or older were accepted. All searches began with exploding the terms "dementia" and "Alzheimer's disease," then adding other terms as appropriate.

Study Selection

At least 2 authors independently reviewed the titles and abstracts of the articles identified in the searches and excluded those that did not meet eligibility criteria. If the reviewers disagreed, the article in question was carried forward to the next stage, during which the full article was reviewed, and a final decision made about inclusion or exclusion.

NUMBER OF SOURCE DOCUMENTS

Key Question No. 1: What is the efficacy of screening? = 0

Key Question No. 2: What is the prevalence of undiagnosed dementia in primary care patients? What are the common causes of dementia in primary care patients? = 4

Key Question No. 3: Is there a reliable and valid screening test to detect dementia in primary care populations? = 10

Key Question No. 4: What is the efficacy of pharmacologic interventions? = 30

Key Question No. 5: What is the efficacy of nonpharmacologic interventions? = 6

Key Question No. 6: What is the efficacy of caregiver interventions? = 6

Key Question No. 7: What are the adverse effects of screening for dementia? = 0

Key Question No. 8: What are the costs and cost-effectiveness of screening for dementia? = 0

Key Question No. 9: What are the adverse effects of dementia therapy? = 19

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The U.S. Preventive Services Task Force grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor):

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Research Triangle Institute (RTI) International-University of North Carolina Evidence-based Practice Center for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

Synthesis of the Literature

All senior authors reviewed articles of special interest. Several authors then abstracted data from included articles into predesigned evidence tables (evidence tables appear in Appendix B of the Systematic Evidence Review). Articles were graded using criteria developed by the USPSTF Methods Work Group. Throughout the review, the authors worked closely with the USPSTF liaisons assigned to this topic.

Preparation of the Systematic Evidence Review

The authors presented an initial work plan for the Systematic Evidence Review (SER) including a provisional analytic framework and key questions to the Task Force in December 2000. Interim reports on results of the literature search and early results of the synthesis of information were presented in March 2001 and June 2001. Feedback from these meetings was incorporated into a draft SER. At this point, a broad-based external review of the draft was conducted. The comments of these reviewers were taken into account in developing the final version of the SER, which was presented to the USPSTF in January 2002.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

When the overall quality of the evidence is judged to be good or fair, the U.S. Preventive Services Task Force (USPSTF) proceeds to consider the magnitude of net benefit to be expected from implementation of the preventive service. Determining net benefit requires assessing both the magnitude of benefits and the magnitude of harms and weighing the two.

The USPSTF classifies benefits, harms, and net benefits on a 4-point scale: "substantial," "moderate," "small," and "zero/negative."

"Outcomes tables" (similar to 'balance sheets') are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the topic teams for use at USPSTF meetings, compare the condition specific outcomes

expected for a hypothetical primary care population with and without use of the preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus, outcomes tables allow the USPSTF to examine directly how the preventive services affects benefits for various groups.

When evidence on harms is available, the topic teams assess its quality in a manner like that for benefits and include adverse events in the outcomes tables. When few harms data are available, the USPSTF does not assume that harms are small or nonexistent. It recognizes a responsibility to consider which harms are likely and judge their potential frequency and the severity that might ensue from implementing the service. It uses whatever evidence exists to construct a general confidence interval on the 4-point scale (e.g., substantial, moderate, small, and zero/negative).

Value judgments are involved in using the information in an outcomes table to rate either benefits or harms on the USPSTF´s 4-point scale. Value judgments are also needed to weigh benefits against harms to arrive a rating of net benefit.

In making its determinations of net benefit, the USPSTF strives to consider what it believes are the general values of most people. It does this with greater confidence for certain outcomes (e.g., death) about which there is little disagreement about undesirability, but it recognizes that the degree of risk people are willing to accept to avert other outcomes (e.g., cataracts) can vary considerably. When the USPSTF perceives that preferences among individuals vary greatly, and that these variations are sufficient to make trade-off of benefits and harms a 'close-call', then it will often assign a C recommendation (see the "Recommendation Rating Scheme" field). This recommendation indicates the decision is likely to be sensitive to individual patient preferences.

The USPSTF uses its assessment of the evidence and magnitude of net benefit to make recommendations. The general principles the USPSTF follows in making recommendations are outlined in Table 5 of the companion document cited below. The USPSTF liaisons on the topic team compose the first drafts of the recommendations and rationale statements, which the full panel then reviews and edits. Recommendations are based on formal voting procedures that include explicit rules for determining the views of the majority.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The Task Force grades its recommendations according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

A

The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

B

The USPSTF recommends that clinicians provide [this service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

C

The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

D

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

I

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

COST ANALYSIS

One of the key questions during guideline development was: What are the cost and cost-effectiveness of screening for dementia? However, no studies were found that evaluated the costs of screening for dementia in a primary care setting.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review. Before the U.S. Preventive Services Task Force (USPSTF) makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center and the Agency for Healthcare Research and Quality send a draft systematic evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about

the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments are discussed before the whole USPSTF before final recommendations are confirmed.

Recommendation of Others. Recommendations for screening for dementia from the following groups were discussed: the American Academy of Neurology; the Canadian Task Force on Preventive Health Care; the American Medical Association and the American Academy of Family Physicians.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and the quality of the overall evidence for a service (good, fair, poor). The definitions of these grades can be found at the end of the "Major Recommendations" field.

The USPSTF concludes that the evidence is insufficient to recommend for or against routine screening for dementia in older adults. I recommendation.

The USPSTF found good evidence that some screening tests have good sensitivity but only fair specificity in detecting cognitive impairment and dementia. There is fair to good evidence that several drug therapies have a beneficial effect on cognitive function (equivalent to delaying the natural progression of Alzheimer's disease from 2 to 7 months), but the evidence of their beneficial effects on instrumental activities of daily living is mixed, with the benefit being small, at best. There is insufficient evidence to determine whether the benefits observed in drug trials are generalizable to patients whose disease would be detected by screening in primary care settings. The accuracy of diagnosis, the feasibility of screening and treatment in routine clinical practice, and the potential harms of screening (e.g., labeling effects) are also unknown. The Task Force therefore could not determine whether the benefits of screening for dementia outweigh the harms.

Clinical Considerations

- The Mini-Mental Status Examination (MMSE) is the best-studied instrument for screening for cognitive impairment. When the MMSE is used to screen unselected patients, the predictive value of a positive result is only fair. The accuracy of the MMSE depends upon a person's age and educational level: using an arbitrary cut-point may potentially lead to more false-positives among older people with lower educational levels, and more false-negatives among younger people with higher educational levels. Tests that assess functional limitations rather than cognitive impairment, such as the Functional

Activities Questionnaire, can detect dementia with sensitivity and specificity comparable to that of the MMSE.

- Early recognition of cognitive impairment, in addition to helping make diagnostic and treatment decisions, allows clinicians to anticipate problems the patients may have in understanding and adhering to recommended therapy. This information may also be useful to the patient's caregiver(s) and family member(s) in helping to anticipate and plan for future problems that may develop as a result of progression of cognitive impairment.
- Although current evidence does not support routine screening of patients in whom cognitive impairment is not otherwise suspected, clinicians should assess cognitive function whenever cognitive impairment or deterioration is suspected, based on direct observation, patient report, or concerns raised by family members, friends, or caretakers.

Definitions:

The Task Force grades its recommendations according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

A

The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

B

The USPSTF recommends that clinicians provide [this service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

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The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

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The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

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The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

The Task Force grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor):

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Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

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Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendation is identified in the "Major Recommendations" field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

The USPSTF found good evidence that some screening tests have good sensitivity but only fair specificity in detecting cognitive impairment and dementia. There is fair to good evidence that several drug therapies have a beneficial effect on cognitive function (equivalent to delaying the natural progression of Alzheimer's disease from 2 to 7 months), but the evidence of their beneficial effects on instrumental activities of daily living is mixed, with the benefit being small, at best. There is insufficient evidence to determine whether the benefits observed in drug trials are generalizable to patients whose disease would be detected by screening in primary care settings. The accuracy of diagnosis, the feasibility of screening and treatment in routine clinical practice, and the potential harms of screening (e.g., labeling effects) are also unknown. The Task Force therefore could not determine whether the benefits of screening for dementia outweigh the harms.

POTENTIAL HARMS

Potential Adverse Effects of Screening

The harms of dementia screening have not been systematically examined. Both false-positive and true positive results could have adverse psychological effects on patients, but the U.S. Preventive Services Task Force (USPSTF) found few studies that address these outcomes. In one study of patients undergoing a detailed assessment of mental function, fewer than 5% found the screening itself distressing, intrusive or depressing; no studies were found of patient attitudes towards more limited tests of cognitive function such as the Mini-Mental Status Examination. Once screening identifies an individual with low cognitive function, clinicians have some concern over the disclosure of information to patients regarding their dementia status. The USPSTF found several case reports of suicide in patients with newly diagnosed Alzheimer's disease, but found no evidence of this potential adverse event in screening studies. A diagnosis of dementia could have effects on a patient's autonomy, but the USPSTF found no evidence supporting this concern. More established risks of receiving the diagnosis of dementia are difficulty obtaining medical or life insurance, or acceptance into assisted-living communities.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The U.S. Preventive Services Task Force recommendations are independent of the U.S. government. They do not represent the views of the Agency for Healthcare Research and Quality (AHRQ), the U.S. Department of Health and Human Services, or the U.S. Public Health Service.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients,

competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Neither the resources nor the composition of the U.S. Preventive Services Task Force equip it to address these numerous implementation challenges, but a number of related efforts seek to increase the impact of future U.S. Preventive Services Task Force reports. The U.S. Preventive Services Task Force convened representatives from the various audiences for the Guide "Put Prevention Into Practice. A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach"--clinicians, consumers and policy makers from health plans, national organizations and Congressional staff--about how to modify the content and format of its products to address their needs. With funding from the Robert Wood Johnson Foundation, the U.S. Preventive Services Task Force and Community Guide effort have conducted an audience analysis to further explore implementation needs. The Put Prevention into Practice initiative at the Agency for Healthcare Research and Quality (AHRQ) has developed office tools such as patient booklets, posters, and handheld patient mini-records, and a new implementation guide for state health departments.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its Web site. The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the third edition of the Guide to Clinical Preventive Services. Freed from having to serve as primary repository for all of U.S. Preventive Services Task Force work, the next Guide may be much slimmer than the almost 1000 pages of the second edition.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals and test results are not always centralized.

RELATED QUALITY TOOLS

- Pocket Guide to Good Health for Adults

- A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Screening for dementia: recommendation and rationale. Ann Intern Med 2003 Jun 3;138(11):925-6. PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2003 Jun)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a Federally-appointed panel of independent experts. Conclusions of the U.S. Preventive Services Task Force do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Task Force Members: Alfred O. Berg, MD, MPH (Chair); Janet D. Allan, PhD, RN (Vice-chair); Paul Frame, MD; Charles J. Homer, MD, MPH*; Mark S. Johnson, MD, MPH; Jonathan D. Klein, MD, MPH; Tracy A. Lieu, MD, MPH*; Cynthia D. Mulrow, MD, MSc*; C. Tracy Orleans, PhD; Jeffrey F. Peipert, MD, MPH*; Nola J. Pender, PhD, RN*; Albert L. Siu, MD, MSPH; Steven M. Teutsch, MD, MPH; Carolyn Westhoff, MD, MSc; Steven H. Woolf, MD, MPH

*Members of the Task Force at the time this recommendation was finalized.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task force has an explicit policy concerning conflict of interest. All members and evidence-based practice center (EPC) staff disclose at each meeting if they have an important financial conflict for each topic being discussed. Task Force members and EPC staff with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force. Screening for dementia and other diseases. Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. p. 531-40.

GUIDELINE AVAILABILITY

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Also available from the Annals of Internal Medicine Online and the National Library of Medicine's Health Services/Technology Assessment Text (HSTAT) Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only). (Outside the United States: 1-410-381-3150; Toll-free TDD service; hearing impaired only: 888-586-6340.)

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Boustani M, Peterson B, Hanson L, Harris R, Lohr K. Screening for dementia in primary care: a summary of the evidence for the U.S. Preventive Services Task Force. Ann Intern Med 2003 Jun;138(1):927-37.

  Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site and the Annals of Internal Medicine Online.

- Boustani M, Peterson B, Harris R, et al. Screening for dementia. Systematic evidence review. Rockville (MD); Agency for Healthcare Research and Quality; 2003 Jun. (Systematic evidence review; no. 20).

  Electronic copies: Available from the USPSTF Web site.

Background Articles:

- Woolf SH, Atkins D. The evolving role of prevention in health care: contributions of the U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):13-20.
- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.
- Saha S, Hoerger TJ, Pignone MP, Teutsch SM, Helfand M, Mandelblatt JS. The art and science of incorporating cost effectiveness into evidence-based recommendations for clinical preventive services. Cost Work Group of the Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):36-43.

Electronic copies: Available from the USPSTF Web site.

The following is also available:

- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2001. 189 p. (Pub. No. APPIP01-0001). Electronic copies available from the AHRQ Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

The Preventive Services Selector, an application for Palm Pilots and other PDA's, is also available from the AHRQ Web site.

PATIENT RESOURCES

The following is available:

- The Pocket Guide to Good Health for Adults. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003.

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Copies also available in Spanish from the USPSTF Web site.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

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