Dementia and Primary Care

A Structured Team Approach

UNE/MGEC Conference

March 2013

First Proviso

- I have no actual or potential conflict of interest in relation to this program or presentation.

Goals of this Talk

- Understand complexity of Dementia Care within Primary Care
- Understand availability of Tools and Indicators for Dementia Care
- Understand utility of carving out time for Dementia Specific Care
- Understand role of Team Care for Dementia Care.
- Don't forget: None of this is Easy

COMMENTS

Feedback

A bit about me

- Practice of IM in Skowhegan since 1979
- 'Grandfathered' in Geriatrics in 1992
- 2011 major switch from admin/clinical role to focus on Geriatric care
  - Practice embedded in an outpatient Adult Medicine Practice.
- Primary interest is How to Incorporate Geriatric Principles into Primary Care Practice.

Second Proviso

- There is a great deal of experience in caring for elder adults in this room.
- Although I focus time, reading and thinking on geriatric issues, at the end of the day there is a great deal of judgment involved and we learn from each other.
- Geriatric Syndromes are multifactorial and require a multidisciplinary approach

Who will provide Dementia Care?

- 7,000 Boarded Geriatricians in the US
- 12,000 Neurologists
- 2,500 Geriatric psychiatrists
- 222,000 Primary Care Providers
  - Provide 80% chronic care for the elderly

Xakellis GC. J Am Board Fam Pract. 2004

Grumbach JAMA 2002

The Complexity Issue

Geriatric Syndromes

And

Multiple Chronic Illnesses

What are the Geriatric Syndromes?

Geriatric Syndromes

- Common syndromes in older persons
- Multifactorial in cause
- IMPAIR FUNCTION
- Increase Caregiver Stress
- Increase risk of institutionalization
- Are under treated
- Often travel in tandem

GERIATRIC SYNDROMES

- Memory Impairment
- Falls and Gait Impairment
- Urinary Incontinence
- Delirium
- Sleep Problems
- Polypharmacy
- Elder Mistreatment
- Frailty

ACOVE

- Assessing Care of the Vulnerable Elderly
  - Series of indicators of care for vulnerable elderly patients we should all meet.
  - Considered very basic Quality Indicators

Wenger et al. J Am Geriat Soc 55:S247-S252,2007

ACOVE

- Developed by the AGS, ACP + the Rand corporation
- Directed at the Vulnerable Elderly Subset of the older population.
- Series of If…then statements
  - Evaluate our process of care
  - "IF a VE is new to a primary care practice or inpatient service THEN there should be a documented assessment of cognitive ability and functional status."

ACOVE

- First generated in 1999
- Acove 3 published in 2007 (GRS-7)
- 392 Quality Indicators which cover 26 conditions (chronic medical + geriatric)
- Many require chart review
- Patient outcomes are improved if followed

ACOVE

- Literature references available on the Rand web site
- Tools available at UCLA
  - http://www.geronet.ucla.edu/professionals/patient-care-resources

AGS

- Quality Indicators
- GEM
  - Geriatric Evaluation and Management Tools
    - Available to AGS members
    - Focus on the Vulnerable Elderly

AGS GEM
Dementia

- Addresses the VE subgroup
- Pretty much includes the ACOVE indicators
- A simpler format
- Differences
  - PE: Adds Extra pyramidal signs
  - Labs: + Folate and selective neuroimaging; RPR selective
  - Mgmt: CI for parkinsons and avoids behavioral issues
  - Adds Follow up and AD's

The Complexity Issue

Geriatric Syndromes

And

Multiple Chronic Illnesses

Chronic Disease Management in the Elderly

- Multiple Medical Conditions
- Multiple 'Quality Indicators'
  - Little Research on these metrics in Vulnerable Elderly
- Have significant functional impacts
  - Under treatment
  - Over treatment
- Compete for provider's attention
  - Geriatric Syndromes
  - Social Issues
  - Acute Problems
  - Each Other

AGS initiative "3 or more" (3+)

- Introduced at AGS meeting May 2012
- Over 50% of older adults have 3 or more chronic conditions
- Almost all existing 'guidelines' have single disease focus
- Initiative is to develop guiding principles for the management of the older adult with comorbid conditions.

AGS Expert Panel J Am Geriat Soc 60:1957-1968,2012

AGS Initiative
5 domains

- Patient Preference
- Interpreting the Evidence
- Prognosis
- Treatment Complexity and Feasibility
- Optimizing Therapies and Care Plans

What are these Chronic Illnesses? (3+ = 6+)

- Patterns of Multi-morbidity in Elderly Veterans
  - Looked at clusters of 3 (triplets)
  - Usual Suspects
    - HT
    - Lip
    - CHD
    - DM
    - COPD
    - CVA
    - PVD

J Am Geriatr Soc 60:1872-1880,2012

What are these Chronic Illnesses? (3+ = 6+)

- No Surprise to You or Me
  - In patients with the 15 most common triplets the mean number of conditions ranged from 6.7-8.5.
    - The 3 conditions represented Less than Half the total chronic conditions
- This might explain why this work of providing comprehensive geriatric care can be so hard

ACOVE

- Disease specific management (we do better here)
  - Diabetes
  - CHF
- Geriatric syndromes (We do not do so well here)
  - Common with aging
  - Have significant functional impact

Chronic Disease and Geriatric Specific Care

- Even Academic Geriatricians do not do this well (address the geriatric specific issues)
- The other chronic illnesses compete effectively for the physician's time.

Ganz DA, et Am J Manag Care. 2010;16(12):343-e355.

Challenges in the Office

- We all want to do this right.
- I don’t know about you, but

  WHERE DO WE GET THE TIME?

How do we do this in Primary Care?

- Chronic Illness
- Social Issues
- Geriatric Syndromes

How can we Proceed?

Focus

“ Who is the Geriatric Patient”

Medicare Current Beneficiary Survey

- "functional status is a more important predictor of death and functional decline than are specific clinical conditions."

A word about frailty

- Physiologic instability
  - May lead to a cascade of events due to a physiologic stress
  - May not be obvious until a stress
- Leads to worsening functional incapacity and to loss of independence

Criteria for frailty

- Unintentional weight loss
  - 10# in 1 year
- A sense of exhaustion
- Weakness
  - Grip strength
- Slow walking speed
- Low levels of physical activity

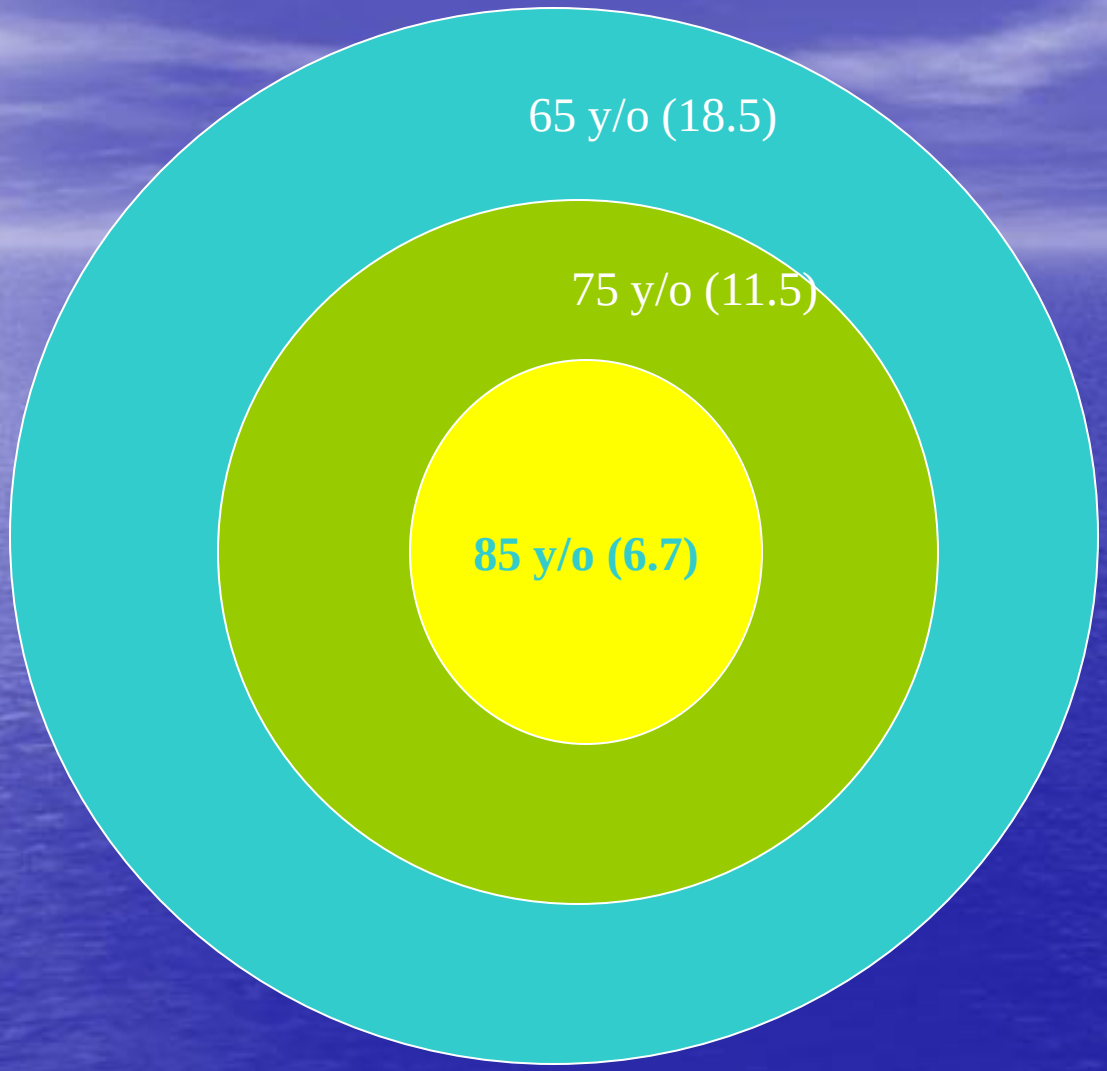
Vulnerable Elderly
Subset of Older Adults

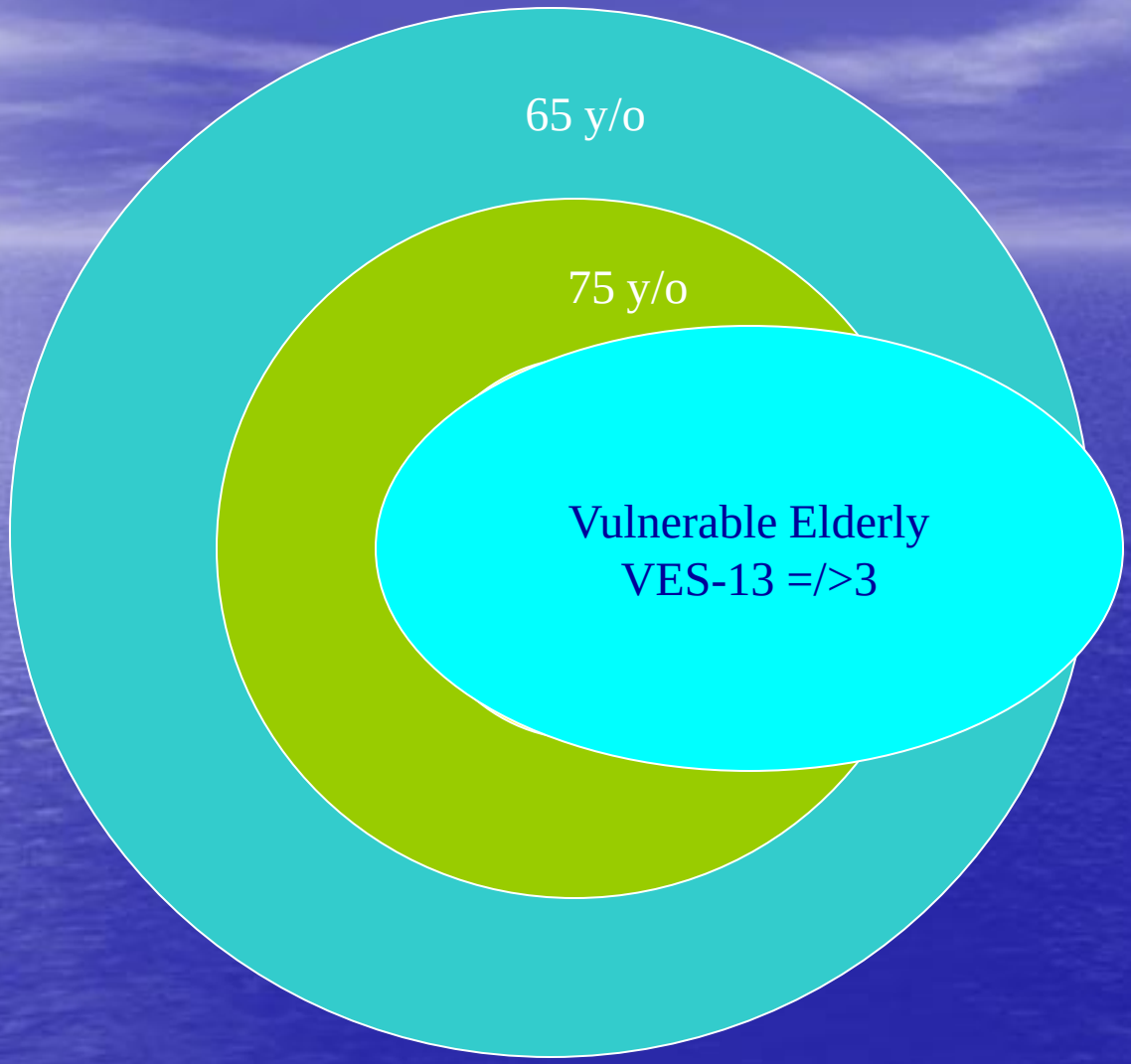
- At increased risk of morbidity and mortality
- Need to be more closely monitored for geriatric syndromes
- Defined through use of simple functional evaluation
  - VES-13
- Associated with a set of quality indicators developed by the Rand Corporation and the AGS.
  - ACOVE (Assessing Care of the Vulnerable Elderly)
  - GEM also refers to Vulnerable Elderly

VES-13

- Age
- Self rated health
- Functional assessment
  - ADLs and IADLs
- Note: No use of disease burden
  - Depends on Functional impairment being the final common pathway.

Journal of the American Geriatric Society. 2001;49:1691-9.


65 y/o (18.5)
75 y/o (11.5)
85 y/o (6.7)


65 y/o
75 y/o
Vulnerable Elderly
VES-13 =/>3

Structure

ACOVE for Dementia

- 17 indicators

ACOVE for Dementia

- IF a VE is new to a practice or inpatient service, THEN there should be a documented assessment of cognitive ability and functional status.

ACOVE for Dementia

- All VE's should be evaluated annually for changes in memory and function.

ACOVE for Dementia

- IF a VE screens positive for dementia, THEN a physician should document an objective cognitive evaluation that tests two or more cognitive domains.

Approaches
Similar to Preventive Services

- Integrate into other work
  - Reminders + Decision support
    - Journal of the American Geriatrics Society, v. 58, no. 2, Feb. 2010, p. 324-329
- Carve out time
  - IPPE
  - AWV
  - Specific visits
- Q/I

TEAM

Team Members

- Patient
- Caregiver(s)
  - Informal
  - Formal
- Community Resources
  - AAA
  - AA
  - AAA
- Providers

Team in Office

- PCP
- Front Office
  - Secretary
  - Medical Records
- Nursing
- PA/NP

Team Function within a Structure

- Academic Geriatric Practice
- NP given specific responsibility for Geriatric Syndromes

- Better performance in relation to ACOVE indicators

Ganz DA, et Am J Manag Care. 2010;16(12):343-e355.

ACOVE and My Practice

- 2011 GRS 7 as study guide for Recertification
  - ACOVE built in to GRS 7
- Became a structure for me to structure my geriatric practice

Team structure and roles

- Medical Records
  - Chart prep
  - Maintain reminders
  - Input on process
- Secretary
  - Observations on patients that may have clinical significance
  - Input on process

Team structure and roles

- MA
  - Observations on patients
  - Mini Cog
  - Q/I
  - Input on process
- PA
  - Template based visits for Geriatric Syndromes based on ACOVE
  - Full participation in diagnosis and management
  - Input on process

Team structure and roles

- Physician
  - Recognition and very basic initial eval
  - Set up visit with PA
  - Full participation in diagnosis and management
  - Input on process
  - Leadership

ACOVE and Templates
Our Practice

- Structure to organize approach
- We do not limit ourselves to this structure
  - Dementia: ACOVE does not address specifics of diagnosis
- Screen, then initial evaluation by PA
- Further management iterative and shared
- Process iterative and shared

Our Practice

- We started with my screening when it seemed appropriate
  - Selective
- Then a single visit with PA
  - History
  - MSE
  - Some information to patient/caregiver

Our Practice

- Communication about diagnosis
  - Sometimes PA, sometimes back to me

Our Practice

- Problems with that approach
  - No standardized screening exam
  - No neuro exam
  - Poor linkage to outside resources
  - No discussion of driving and Advance Directives
- Next step
  - 2 visits.

Indicators and Practice

- Build a structure
- Evaluate success
- Q/I
- Clear decision how far you will take direct responsibility
- Expectations re consultants

ACOVE

- Our checklist
  - WIP
- Screening
- Diagnosis
- Treatment
- Management
- Follow up

Screening in our practice

- AWV
- Otherwise has been a bit random

- Recent decision
  - All over 75 y/o (5-15%)
    - Every 2 years
  - Others when concerned raised
    - Family/caregiver
    - Staff
    - Provider observation
    - Falls

Screening tool

- Mini-cog

Diagnosis

There is under diagnosis and over diagnosis

Dementia

It is not dementia without new significant functional impairment due to the cognitive impairment

Cognitive Exam

- We use MMSE
  - We need to pay for the exam.
  - We need to protect the copyright on the exam
  - Weak on Executive Function
    - Plan/implement/sequence/monitor an action
- MoCA
- FAB (Frontal Assessment Battery) specifically better with Parkinson's and MMSE score >24

Diagnosis

- First Level
  - Normal
  - Normal MMSE but concerns
  - MCI
  - Dementia
- Second level
  - SDAT
  - Vascular
  - Lewy body
  - Parkinson
  - Other

Possible Next steps

- Neuro psych testing
- Consult
  - Neurology
  - MGMC Memory clinic

Management

There is over treatment
(over diagnosis)

Dementia

It is not dementia without new significant functional impairment due to the cognitive impairment

Management

- Medication
- Support
- Behavioral

Management

- Medication
  - Manage medical illnesses
  - Vascular Dementia
    - Lipids, BP,ASA
  - SDAT,Vascular, Lewy Body, Parkinson's
    - CI Rx

Management

- Support
  - Caregiver
    - dementia diagnosis, prognosis and associated behavioral symptoms; home and occupational safety; and community resources.
    - Resource folder
    - Savvy Caregiver Program
    - Stress; potential for abuse
      - 'Does the patient ever yell, push or hit'

Management

Behavioral

- Look for medical issues
  - Pain
  - Constipation
- Behavioral interventions are first and foremost
  - Savvy caregiver
  - Lack of training of paid caregivers
- Medication
  - Discuss and document R+B

Legal

- Will
- PoA
- Driving

Follow-up

- Cognition (serial MMSE/MoCA)
- Function (ADL's/IADL's)
- Behavior
- Care giver stress

Q/I in our Practice

- Problems with our approach
  - No standardized screening exam
  - Poor linkage to outside resources
  - No discussion of driving and Advance Directives (38%)
- Next step
  - 2 visits.
  - Registry for Memory Loss to track AD
  - Practice wide decision to systematically screen

Bumps in the road

- PA moved to California
- NAA 2-3 months
- RR good system for CDM
- How to carve out the time

Discussion

Goals of this Talk

- Understand complexity of Dementia Care within Primary Care
- Understand availability of Tools and Indicators for Dementia Care
- Understand utility of carving out time for Dementia Specific Care
- Understand role of Team Care for Dementia Care.
- Don't forget: None of this is Easy

More ACOVE

ACOVE for Dementia

- IF a VE screens positive for dementia, THEN the physician should review the patient's medications (including over the counter) for any that may be associated with mental status changes.

ACOVE for Dementia

- IF a VE screens positive for dementia and is taking medication that are commonly associated with mental status changes in older people, THEN the physician should discontinue or justify continuing these medications.

ACOVE for Dementia

- IF a VE is newly diagnosed with dementia, THEN a physician should perform a neurologic exam that includes evaluation of gait, motor function and reflexes.

ACOVE for Dementia

- IF a VE is newly diagnosed with dementia, THEN a CBC, TSH, Lytes, LFT's, FBS, BUN serum B12 and RPR should be performed.

ACOVE for Dementia

- IF a VE is newly diagnosed with dementia and has risk factors for HIV, THEN HIV testing should be offered.

ACOVE for Dementia

- IF a VE is newly diagnosed with dementia, THEN he or she should be screened for depression.

ACOVE for Dementia

- IF a VE is newly diagnosed with mild to moderate AD, mild to moderate vascular dementia or Lewy body dementia, THEN there a documented discussion with the patient or caregiver about cholinesterase inhibitor treatment.

ACOVE for Dementia

- IF a VE has mild to moderate vascular or mixed dementia, THEN he or she should receive stoke prophylaxis

ACOVE for Dementia

- IF a VE with dementia has a caregiver, THEN the patient or caregiver should be given information on dementia diagnosis, prognosis and associated behavioral symptoms; home and occupational safety; and community resources.

ACOVE for Dementia

- IF a VE has dementia, THEN he or she should be screened annually for behavioral symptoms of dementia.

ACOVE for Dementia

- IF a VE with dementia has behavioral symptoms, THEN specific target symptoms should be documented and behavioral interventions implemented first or concurrently with pharmacotherapy, or if treating first with pharmacologic interventions, then severe symptoms or safety concerns should be present and documented.

ACOVE for Dementia

- IF a VE with dementia and behavioral symptoms is newly treated with an antipsychotic, THEN there should be a documented risk benefit.

ACOVE for Dementia

- IF a VE has newly diagnosed dementia, THEN (consistent with state law) the patient should be advised not to drive, should be referred to the Dept of Motor Vehicles to test driving ability, or should be referred to a drivers safety course that includes assessment of driving ability.

ACOVE for Dementia

- IF a VE with dementia is physically restrained in the hospital, THEN the target behavioral disturbance or safety concern justifying the use of restraints should be documented in the medical record and communicated to the patient, caregiver or guardian

ACOVE: Driving

- IF a VE has newly diagnosed dementia, THEN (consistent with state law) the patient should be advised not to drive, should be referred to the Dept of Motor Vehicles to test driving ability, or should be referred to a drivers safety course that includes assessment of driving ability.
- Retire from driving