Dementia and Primary Care

A Structured Team Approach

UNE/MGEC Conference

June 2014
First Proviso

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

• There is a great deal of experience in caring for older 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.
Maine organizations for Health Professionals

- AMDA
- MGS
- DGS
Audience role in caring for Older Adults with Memory Impairment

- PCS’s
Audience role in caring for Older Adults with Memory Impairment

- PCS’s
- Other Community based providers
Audience role in caring for Older Adults with Memory Impairment

- PCS’s
- Other Community based providers
- LTC or other facilities
Audience role in caring for Older Adults with Memory Impairment

- PCS’s
- Other Community based providers
- LTC or other facilities
- Students
- Other disciplines
GOALS
Structured Team Approach

• Keep it simple
• Team
  – Maximize the resources you have
• Structure (measures)
  – ACOVE
  – Roadmap
• Q/I
  – Pick simple projects which will work with the tools you have
  – This is for Q/I not publication
Quality Improvement

Patient encounter

Quality Improvement
Who will provide Dementia Care?

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

Xakellis GC. J Am Board Fam Pract. 2004
Grumbach JAMA 2002
Who will provide Dementia Care?

- Cancer or CHF?

- There are parts of this work that can ONLY BE DONE BY A PRIMARY CARE SPECIALIST
Fundamental Concept of Geriatric Care

- FUNCTION
Medicare Current Beneficiary Survey

• “functional status is a more important predictor of death and functional decline than are specific clinical conditions.”
The Challenge

- Chronic illnesses
- Geriatric syndromes
- Social Issues

- ALL IMPORTANT IN MAINTAINING FUNCTION
Chronic Disease Management in the Elderly
Chronic Disease Management in the Elderly

- Multiple Medical Conditions
- Multiple ‘Quality Indicators’
  - Little research on these metrics in Vulnerable Elderly or people with multiple comorbidities.
- Have significant functional impacts
  - Under treatment
  - Over treatment
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.

The reality is even more complex
- VA study looking at common combinations of 3 CI’s.
- In patients with the 15 most common triplets the mean number of conditions ranged from 6.7-8.5.

Geriatric Syndromes
Geriatric Syndromes

- Common syndromes in older persons
- Often 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
Complexity of an Office Visit

- 3+ - 6+ Chronic Illnesses
- Geriatric Syndromes
- Social Issues
Structured Team Approach
TEAM

• Effective integration of all

• This is a big job.
The team we need extends well beyond the clinician’s office.

Only a small amount of the care of a memory impaired older adult occurs in the office.

The office DOES NOT play the most important role in the individual’s care.
Team in Geriatrics

- Community resources
- Person’s Support system
- Office Team

[Image of a layered diagram with circles indicating the different team components.]
Office Based Team

Medical Records
- Chart Prep
- Maintain reminders

Secretary
- Observations of pt that may be clinically significant

MA
- Observations of pt
- Mini-cog

Physician
- Basic initial evaluation
- Set up visit with PA
- Dx/management
- Leadership

PA
- Template-based visits for Geriatric Syndromes based on ACOVE
- Participate in dx/management
Team involved in Care & Q/I

Physician, PA, Secretary, Medical Records

Care & Quality Improvement
Other Format

• Can do as single provider
  – Multiple visits
  – Weave pieces into other visits using reminder system and flow sheet

• Cancer model
  – Recognize
  – Refer
STRUCTURE

• Key to implementation of standardization
  – Allows measurement for Q/I

• There are no geriatric specific CMS indicators.

• ACOVE
Assessing Care of the Vulnerable Elderly

- Series of indicators of care for vulnerable elderly patients we should all meet.
  - In reality aspirational
- 17 indicators for dementia
- I will reference in this talk as used to develop office based approach.

ACOVE

- Literature references available on the Rand web site

- Tools available at UCLA
  - http://www.geronet.ucla.edu/professionals/patient-care-resources
Comprehensive Roadmap

Referenced by Dr. Singer
Our Practice

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

• Should we screen?
Screening

- Should we screen?
- Who has a structured approach to screening?
WHY SCREEN?
Why screen

- Under diagnosed
  - 30-50% of people with MI are not diagnosed
  - Case finding only picks up 20% of cases identified by screening.
- Variability
  - Our Q/I
    - 6-63% MI in all patients >75 y/o
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.
How we screen

• **Case finding**
  – Team
    • Patient
    • Any one on my office team
    • Caregiver
      – Informant interview (AD8)
    • Concerned others

• **Screen (structure)**
  • AWV
  • All > 75 (prevalence 11% 75-84 y/o)
    – From the Q/I showing the differences
  • Falls
Screening tool

• Mini-cog
  – MA
  – Dr. Singer’s talk
Mini-cog: Scoring

- Dr. Singer’s talk algorithm
- Five point score
  - 0-3 for recall
  - 0 or 2 for clock
    - Numbers in correct order and hands correct
  - 4-5 normal
  - 0-2 abnormal
  - 3???
  - Difficulty drawing the circle ???
Mini-cog as a screen

- Goal is to start down a path so looking for high sensitivity
- Research needs to be tight
- Clinical Medicine is curiosity about the patient in front of you.
Screening tool

• Functional Evaluation
  – IADL
  – VES 13
IADL’s

- Phone
- Shopping
- Food Preparation
- Housekeeping
- Laundry
- Transportation
- Medication Management
- Financial Management
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.*
Diagnosis
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.
Dementia

It is not dementia without new significant functional impairment due to the cognitive impairment.
Diagnosis: Tools

- **MoCA**
  - Well known, high specificity for mild AD, high level of literature support
  - Not in public domain
- **MMSE**
- **AD8**
Diagnosis

- 3 D’s
  - Dr. Singer has addressed
- 3 D’s + 2P’s
- 2 P’s Poly Pharmacy
  - CNS active drugs
  - Anticholinergic medications
Diagnosis

• First Level
  – Normal
  – Normal MSE but concerns
  – MCI
  – Dementia

• Second level
  – SDAT
  – Vascular
  – Lewy body
  – Parkinson
  – Other
Our Practice-Team

- Screen or history raises concerns
- PA template visit
  - See specific Visit #1 for goals of that visit (WIP)
    - History
      - Template
    - MSE
      - MMSE
      - MoCA
    - PE
    - Med review
    - Further workup
Patient Encounter: Prep and Visit

Medical Records
- Chart Prep
- Maintain reminders

Secretary
- Observations of pt that may be clinically significant

MA
- Observations of pt
- Mini-cog

Physician
- Basic initial evaluation
- Set up visit with PA
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- Leadership

PA
- Template-based visits for Geriatric Syndromes based on ACOVE
- Participate in dx/management
Our Practice-Q/I

• Very quickly saw that we were not meeting all the elements we wished to as delineated by ACOVE
• 2 visit approach
• Developed flow sheet
  – Under using as requires extra steps in EMR
    • Assigning more to medical records
Management

- Medication
  - Dr. Singer’s talk
    - 65% use of cognitive enhancing medications in community based patients. (JAGS 61:723-733, 2013)
  - 2 P’s Poly Pharmacy
    - Really PCS issue
      - WHO ELSE IS GOING TO PRIORITIZE AND COORDINATE ALL OF THIS?
    - Beer’s list
      - Anticholinergic medications
      - CNS active medications
Management

• Much more than medication
  – Again reference the checklist
  – Medical illnesses
    • MANAGE TO MAXIMIZE FUNCTION
  – Patient and caregiver resources
  – Connect to community resources
  – Legal issues
    • Competency
  – Driving
Management-Team

• This work in the office is shared between Physician and PA.
  – Communication
  – Flow sheet
Management-Q/I

• Early recognition that we were not routinely connecting with community resources
  – Pamphlet from our AAA
Follow-up

- This is the ‘third side of the coin’.
- We have not standardized our approach
  - MS
  - Function
  - Behaviors
  - Caregiver stress
    - Can not overemphasis this
- Flow sheet really helps
And then

- 80% of chronic care older adults will continue to be provided by PCS’s
- A Structured Team approach
- Refer when you need help
  - Geriatrician/Neurologist/Geriatric Psychiatrist
MEDCAPS

- Grant to the OADS
- Make Maine Dementia Capable
- Broad reach
- Focus on physician practices
  - ACOVE and other indicators
  - CME session
  - Recruit practices interested in Q/I
    - A-Q/I for MOC
  - rrenfrew@rfgh.net
Discussion
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