

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

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- PCS's
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- LTC or other facilities

Audience role in caring for Older Adults with Memory Impairment

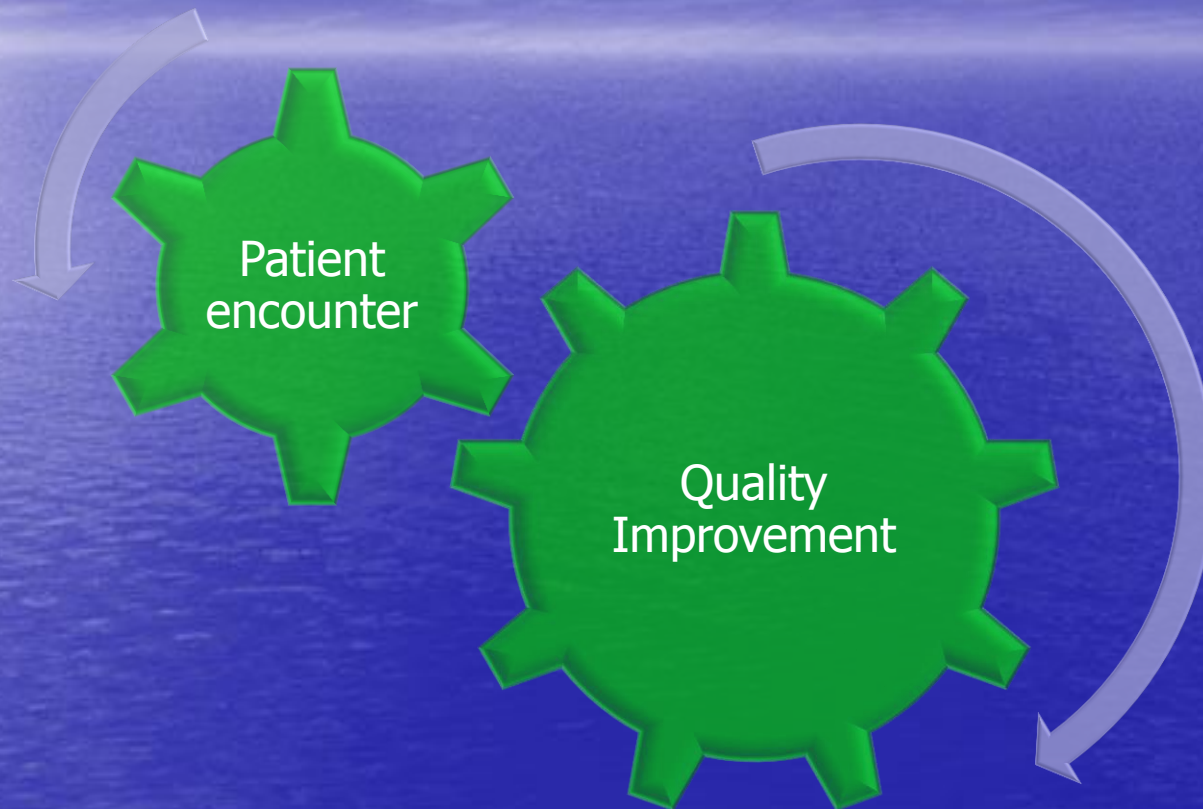
- PCS's
- Other Community based providers
- LTC or other facilities
- Students
- Other disciplines

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



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.

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

$$(3+ = 6+)$$

- 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.
- J Am Geriatr Soc 60:1872-1880,2012

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

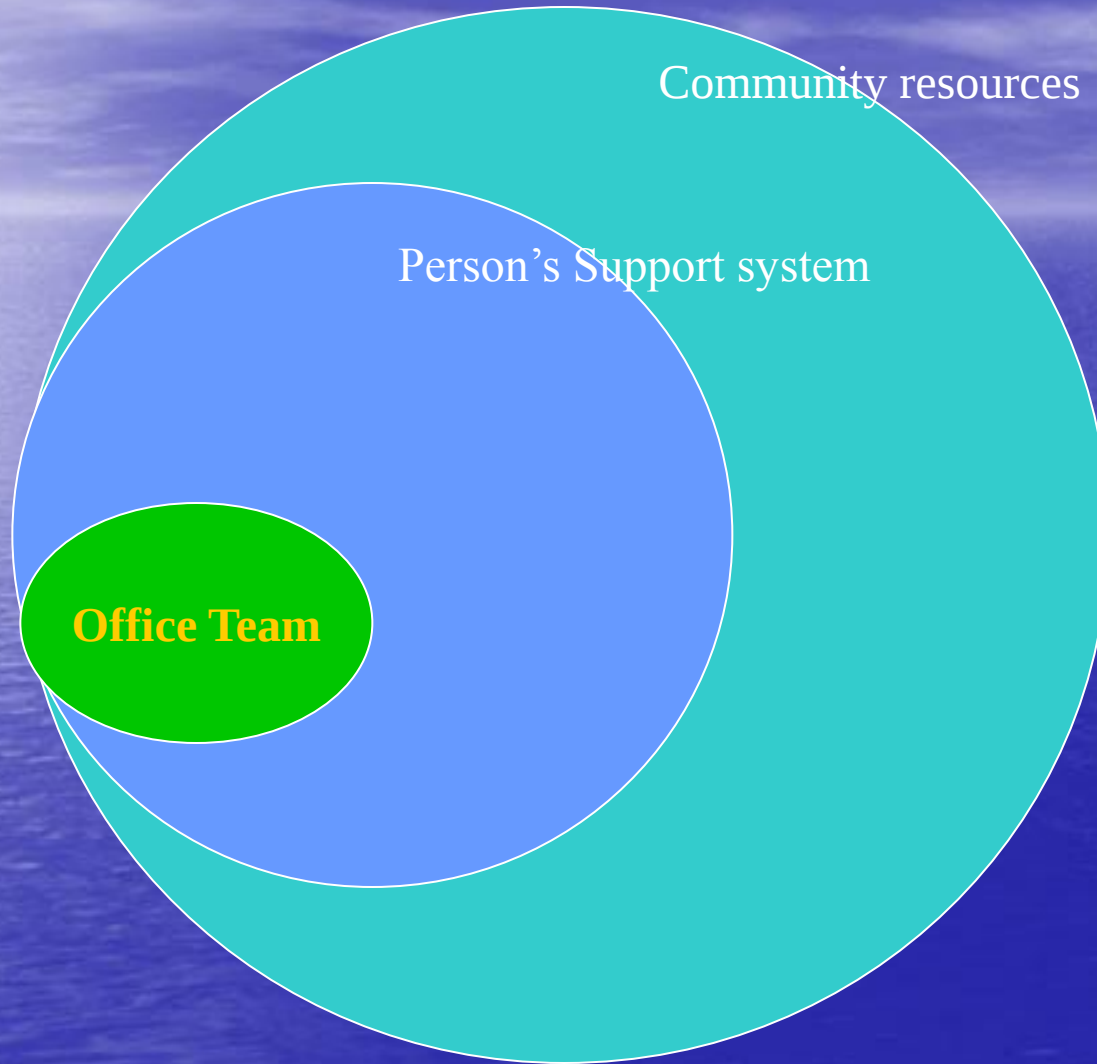
TEAM

- Effective integration of all
- This is a big job.

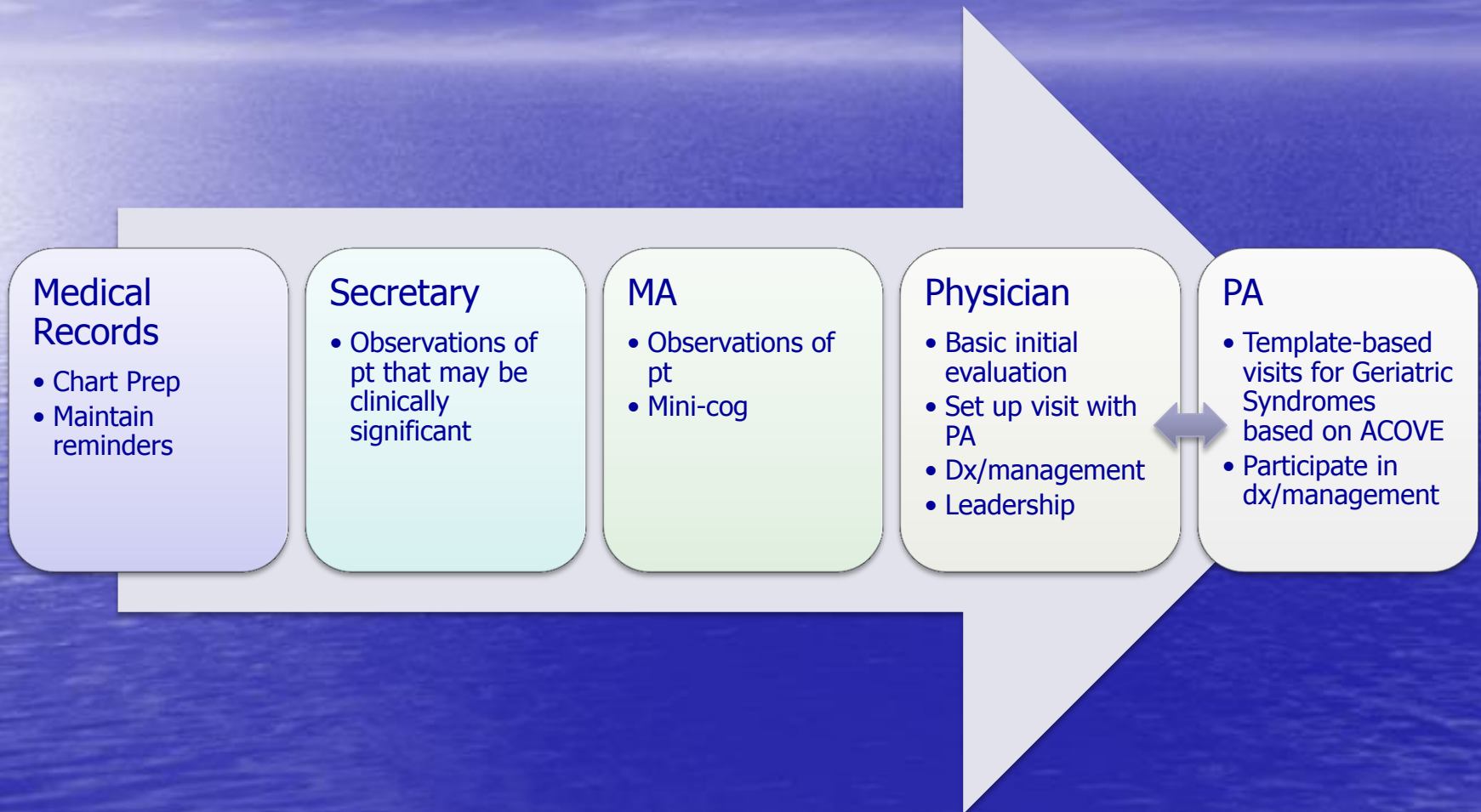
TEAM

- 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.

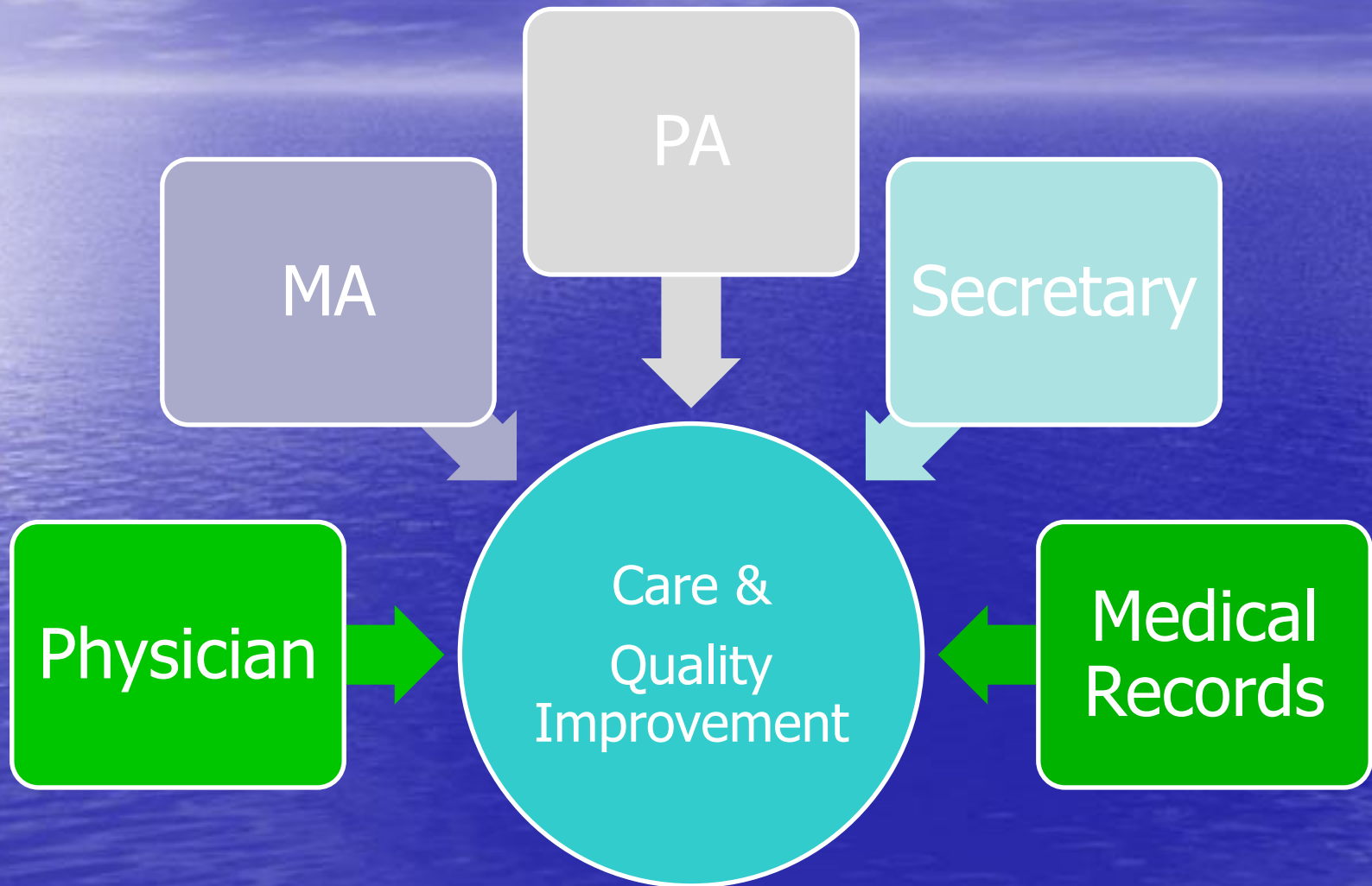
Team in Geriatrics



Office Based Team



Team involved in Care & Q/I



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

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.

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

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)
 - AWW
 - 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.
2001;49:1691-9.

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

Diagnosis

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

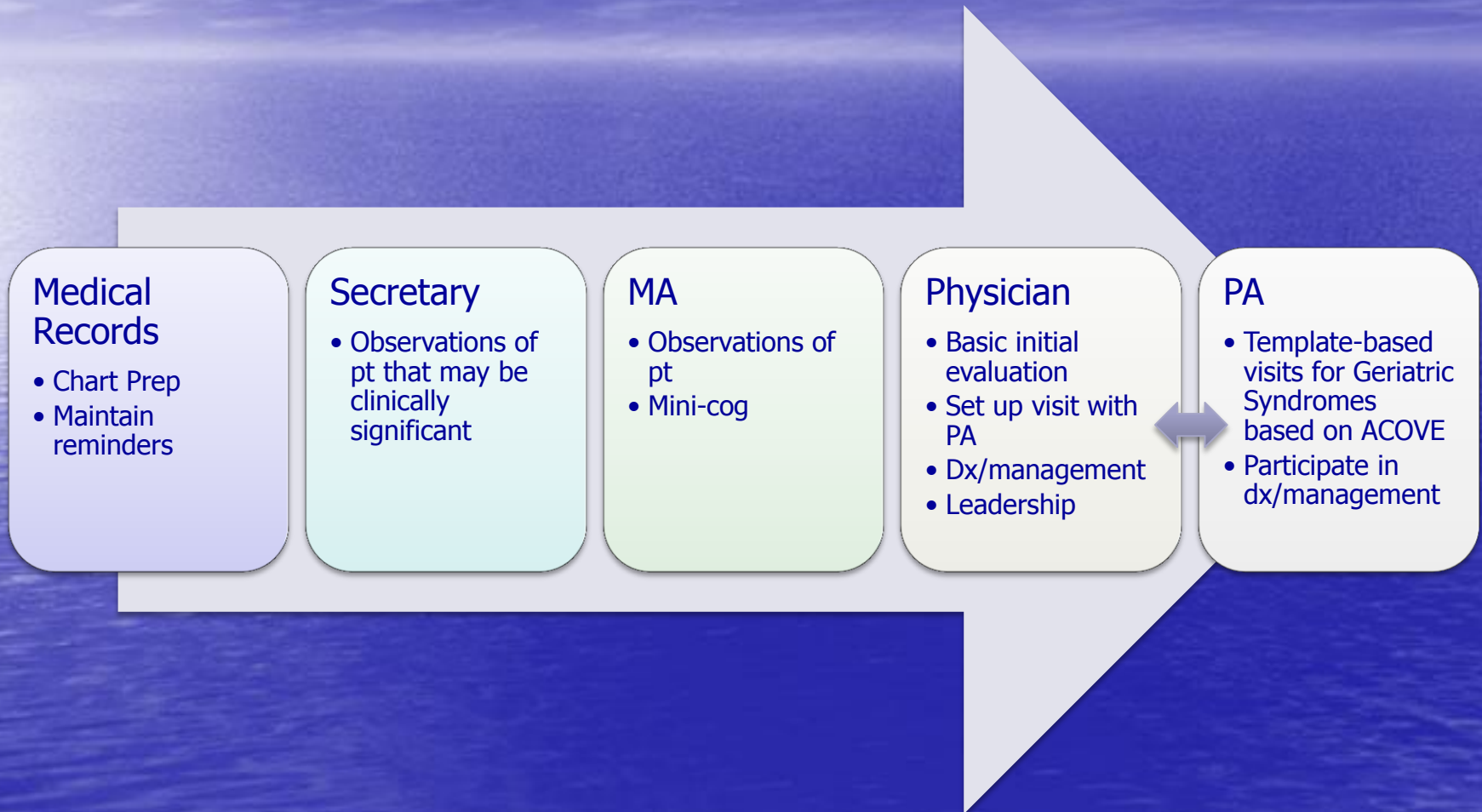
Diagnosis

- 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



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

The background is a solid blue gradient. On the left side, there is a bright, glowing sunburst or lens flare effect that fades into the blue background. The word "Discussion" is centered in the middle of the image.

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