Dementia and Primary Care

A Structured Team Approach

UNE/MGEC Conference

June 2013

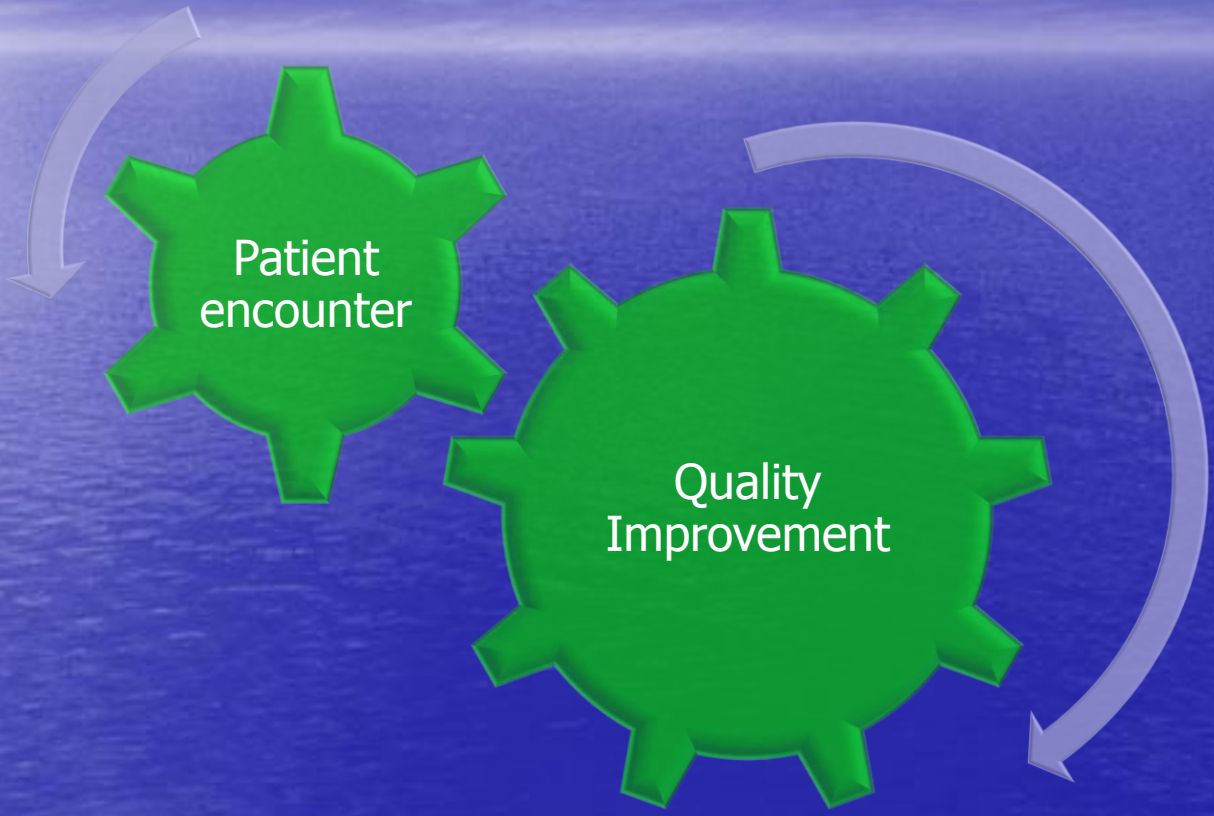
First Proviso

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

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



A bit about me

- Practice of IM in Skowhegan since 1979
- 'Grandfathered' in Geriatrics in 1992
- Primary Focus now is outpatient geriatric care.
  - Practice embedded in an outpatient Adult Medicine Practice.
- Primary interest is How to keep Older Adults functional within the community.
- I am also interested in how to spread Geriatric Principles into Primary Care.

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.

Integrated Program

- I will try not to spend much time on topics otherwise presented here.
  - I will reference when specific topics reflect on our process in my office.

Maine organizations for Health Professionals

- AMDA
- MGS
- DGS

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 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 PROFESSIONAL

Audience role in caring for Older Adults with Memory Impairment

- PCP's

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- Other Providers

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- EMR

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 Geriat 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

- You are already ½ an hour behind schedule.

Structured Team Approach

TEAM

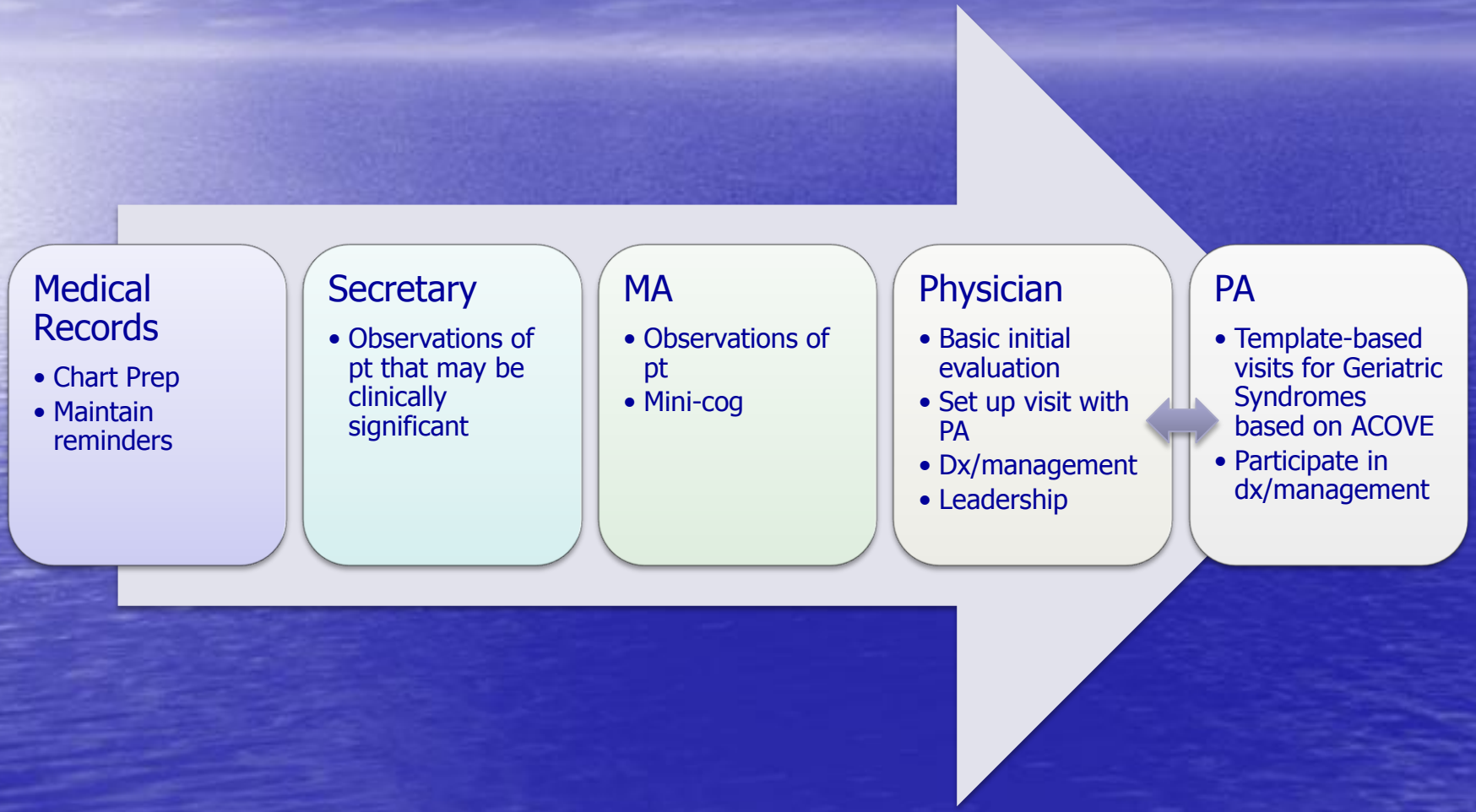
- Effective integration of all
- This is a big job.

TEAM

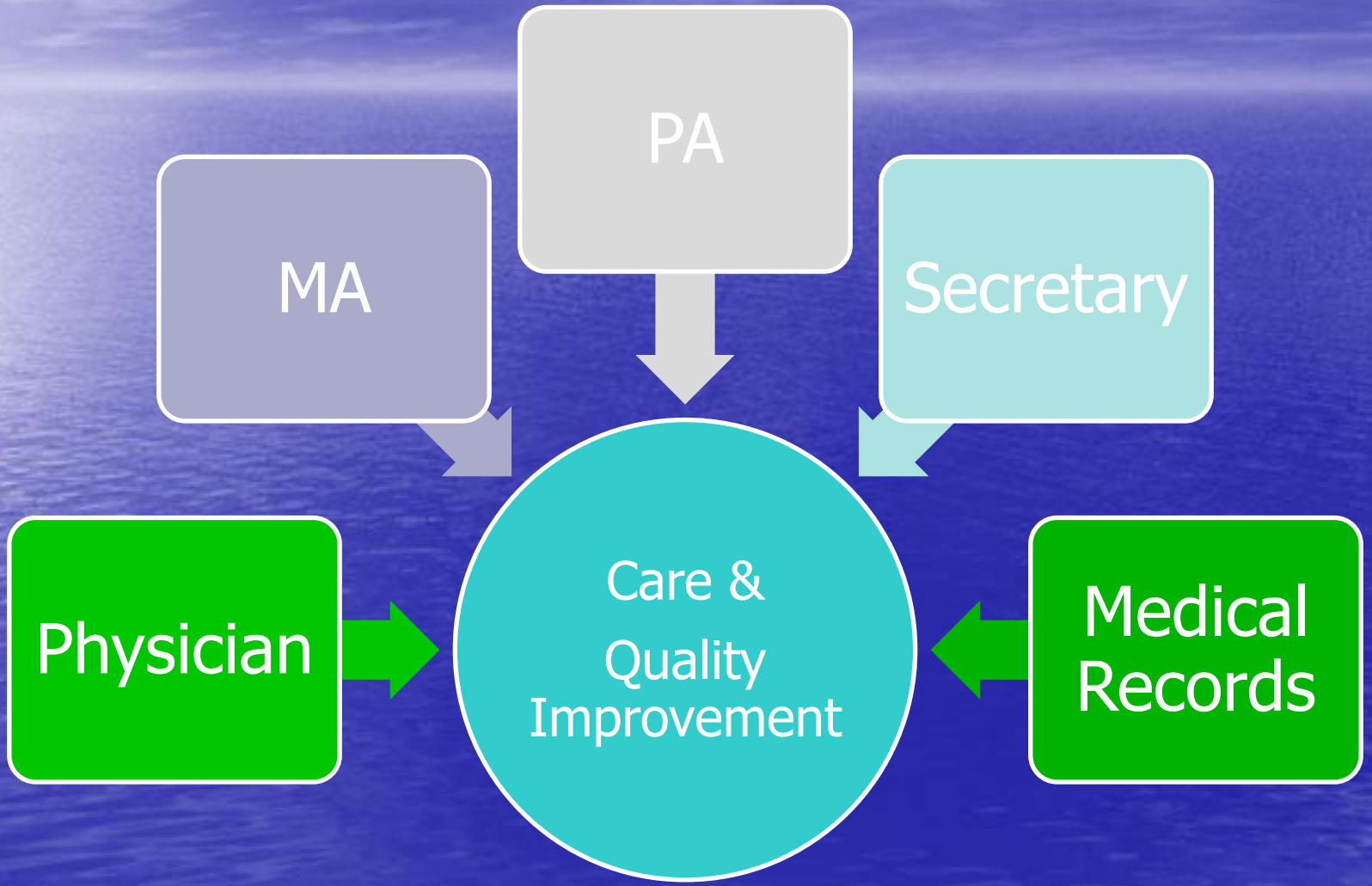
- The team we need extends well beyond the clinician's office.
- Only a small amount of the care of a memory impaired older adult occurs in the office
- The office DOES NOT play the most important role in the individual's care.

Team in Geriatrics

Office Based Team



Team involved in Care & Q/I



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 Geriat 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
  - WIP
- Screening
- Diagnosis
- Management
- Follow up

Screening

Screening

- Who has a structured approach to screening?

Screening

- Who has a structured approach to screening?
- Who could screen?

Screening

- Who has a structured approach to screening?
- Who could screen?
- Should we screen?

Should we screen?

- AGS pre-session symposium
- USPSTF
- AFA (National Memory Screening Day)
- The Internet

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

Why screen

- 80% of public thinks a good idea
- 50-90% PCP's think a good idea
  - BUT TIME (cost)

Why screen

- Patients and caregivers deserve to know
- Study entry
- Prepare
  - Consistency of preferences in patients with MCI
    - Go Wish Cards (Coda Alliance)
    - AGS abstract
  - Law to protect against financial abuse

Why screen

- Management of 6+
  - Compliance
  - Ability to understand
  - Ability to follow through
  - Transitions of care
    - AGS abstract: increased re-hospitalizations with ‘preclinical dementia’

Why screen

- Caregiver support
- Avoid social isolation
- Avoid imprudent judgment

Why not screen

- Misdiagnosis
- Labeling
- LTC Ins
- No treatment for MCI
- Driving
  - Ongoing relationship with provider

Ethics of screening

- Should we obtain informed consent?

Ethics of screening

- Should we obtain informed consent?
- Is it ethical to provide instructions to a patient with memory loss?

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
    - 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
  - Can learn about use of Mini-cog this afternoon

Screening tool

- Functional Evaluation
  - IADL (afternoon session)
  - ADL (afternoon session)
  - VES 13

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.

Diagnosis

There is under diagnosis and over diagnosis

Dementia

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

Diagnosis

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

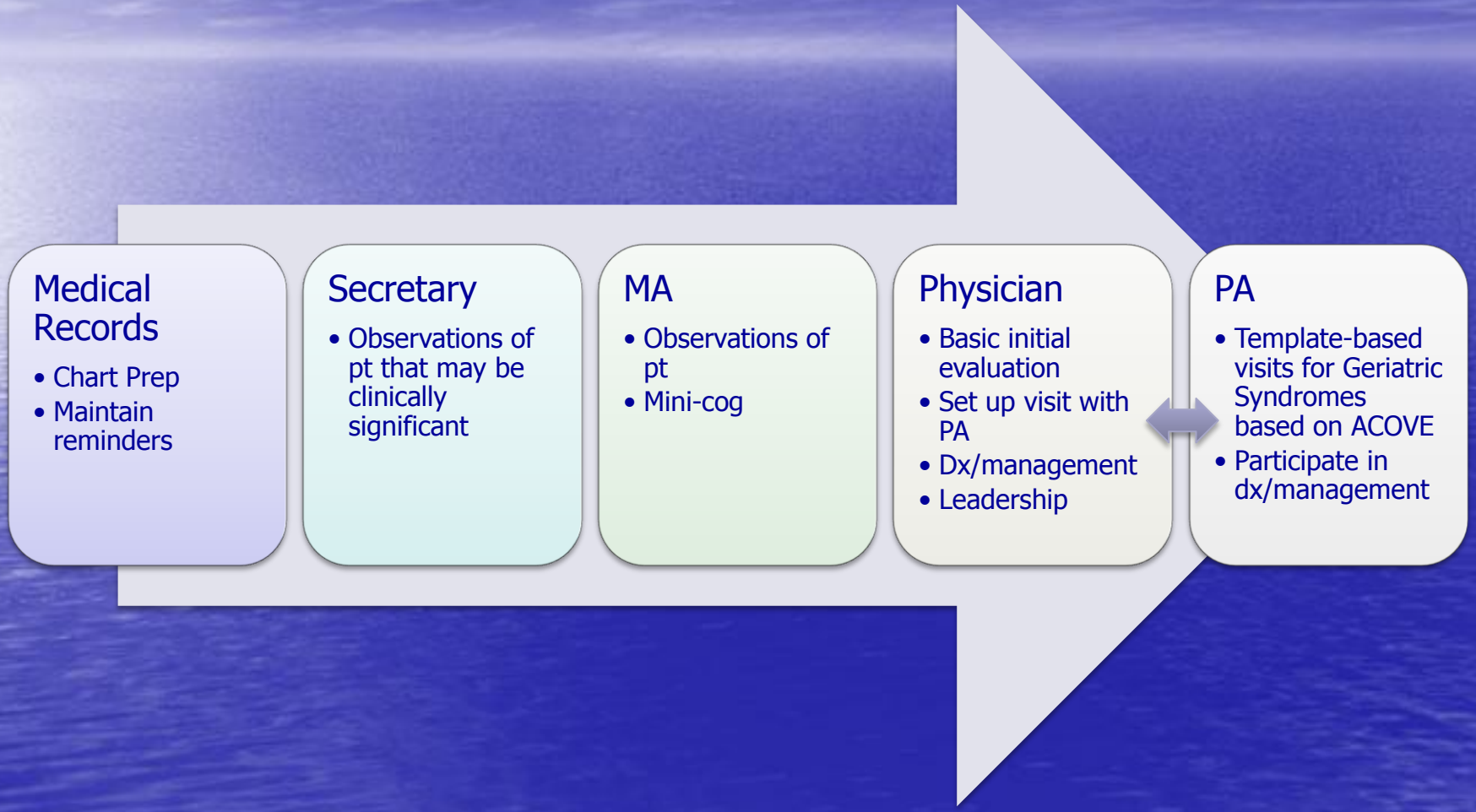
Diagnosis

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

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

Bump in the road

- My PA moved to CA
- Markedly increased my 3rd NAA
- BUT also brought me into more engagement in this process
  - MOCA
  - SLUMS

Management

- Medication
  - Dr. Singer's and Dr. Campbell's talks
  - 2 P's Poly Pharmacy
    - Really PCP 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

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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