Dementia and Primary Care

A Structured Team Approach

UNE/MGEC Conference

October 2013

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

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- Other Community based providers

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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

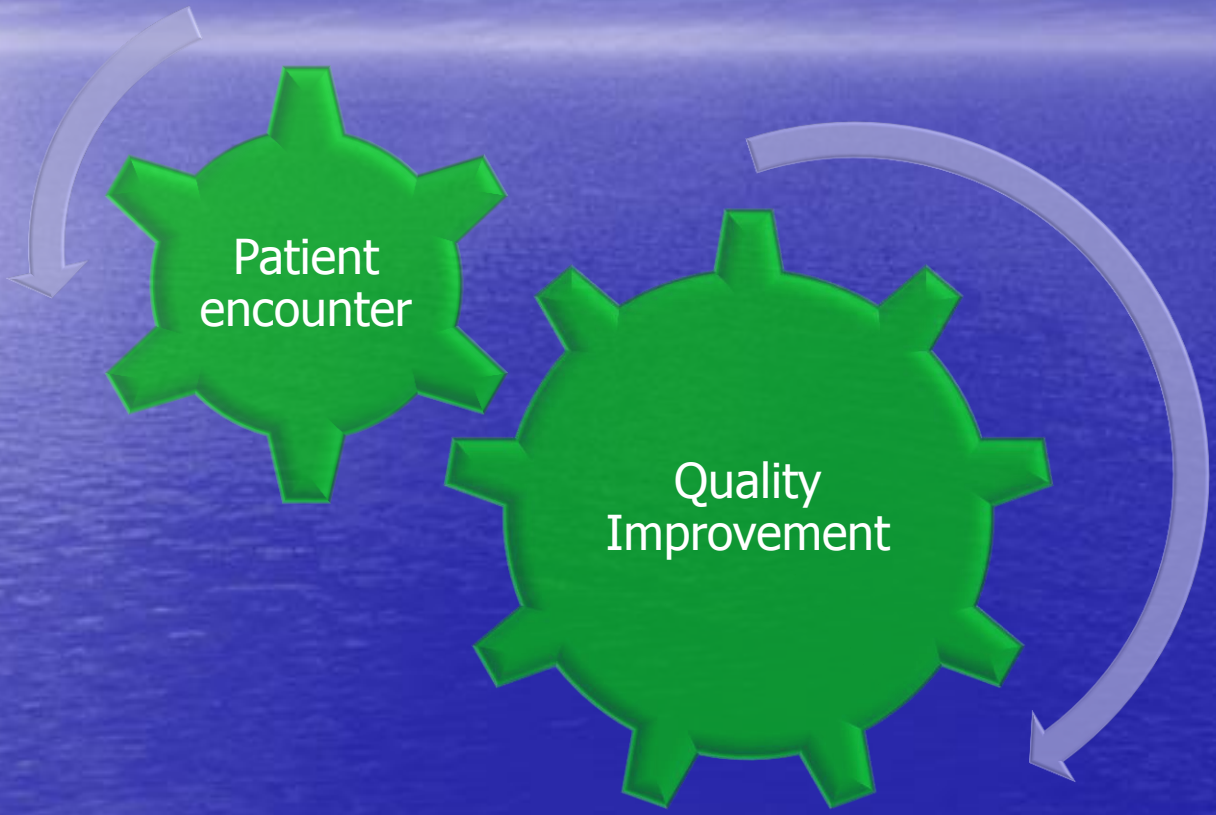
Audience role in caring for Older Adults with Memory Impairment

- Provide care or services for older adults with memory problems
- EMR
- PCMH

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 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

Structured Team Approach

TEAM

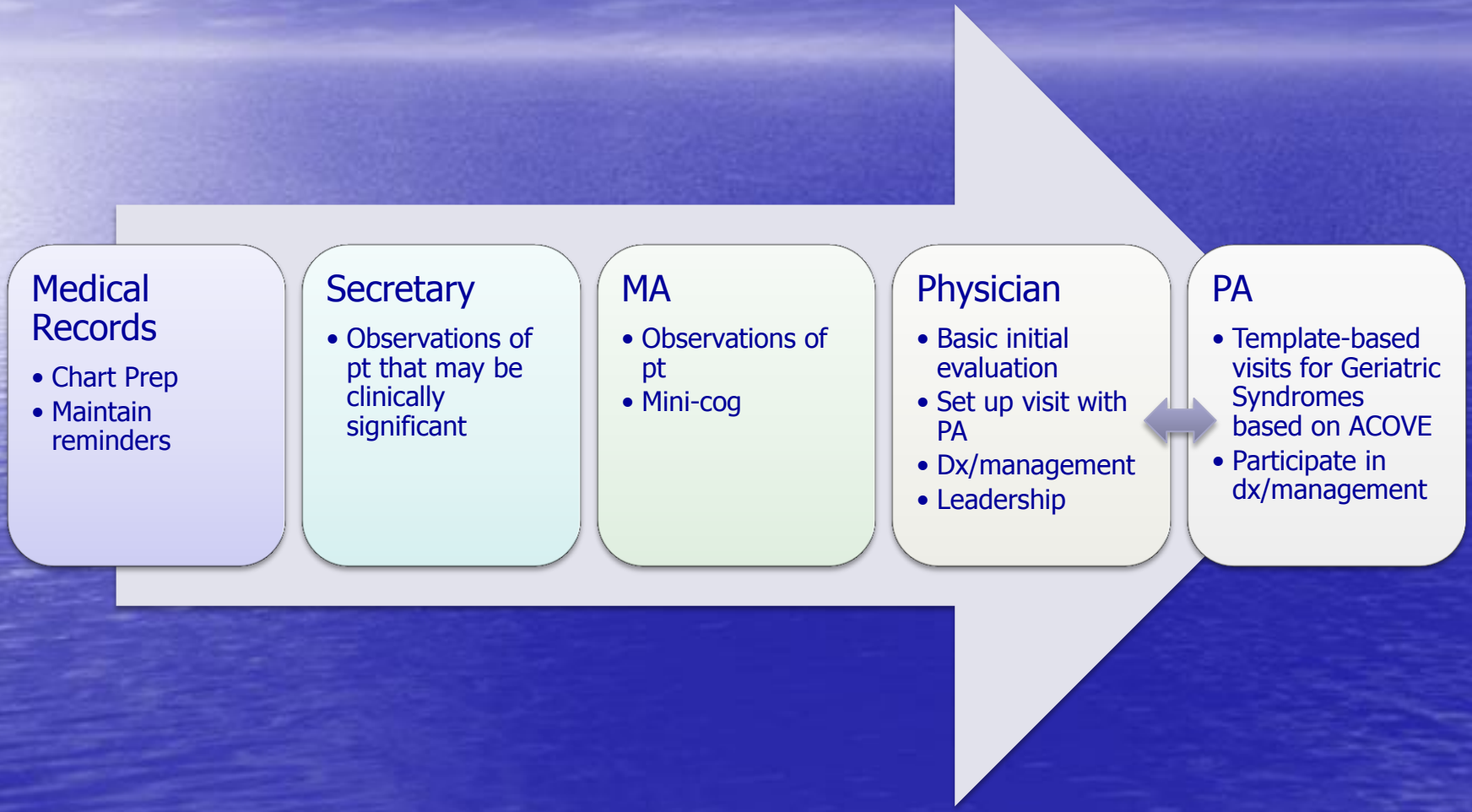
- Effective integration of all
- This is a big job.

TEAM

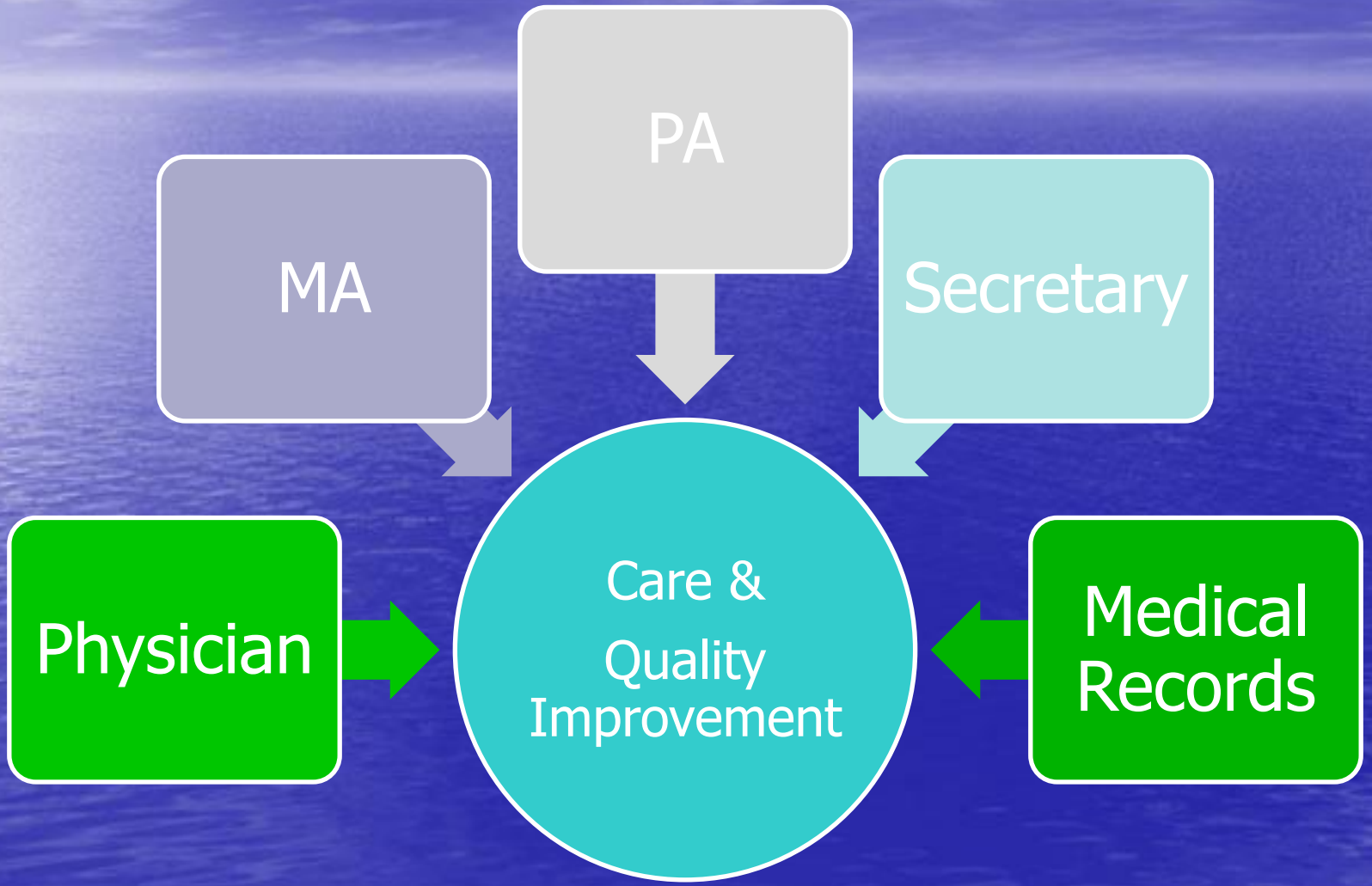
- The team we need extends well beyond the clinician's office.
- Only a small amount of the care of a memory impaired older adult occurs in the office
- The office DOES NOT play the most important role in the individual's care.

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

- 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. 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 + B
- 2 P's Poly Pharmacy
  - CNS active drugs
  - Anticholinergic medications

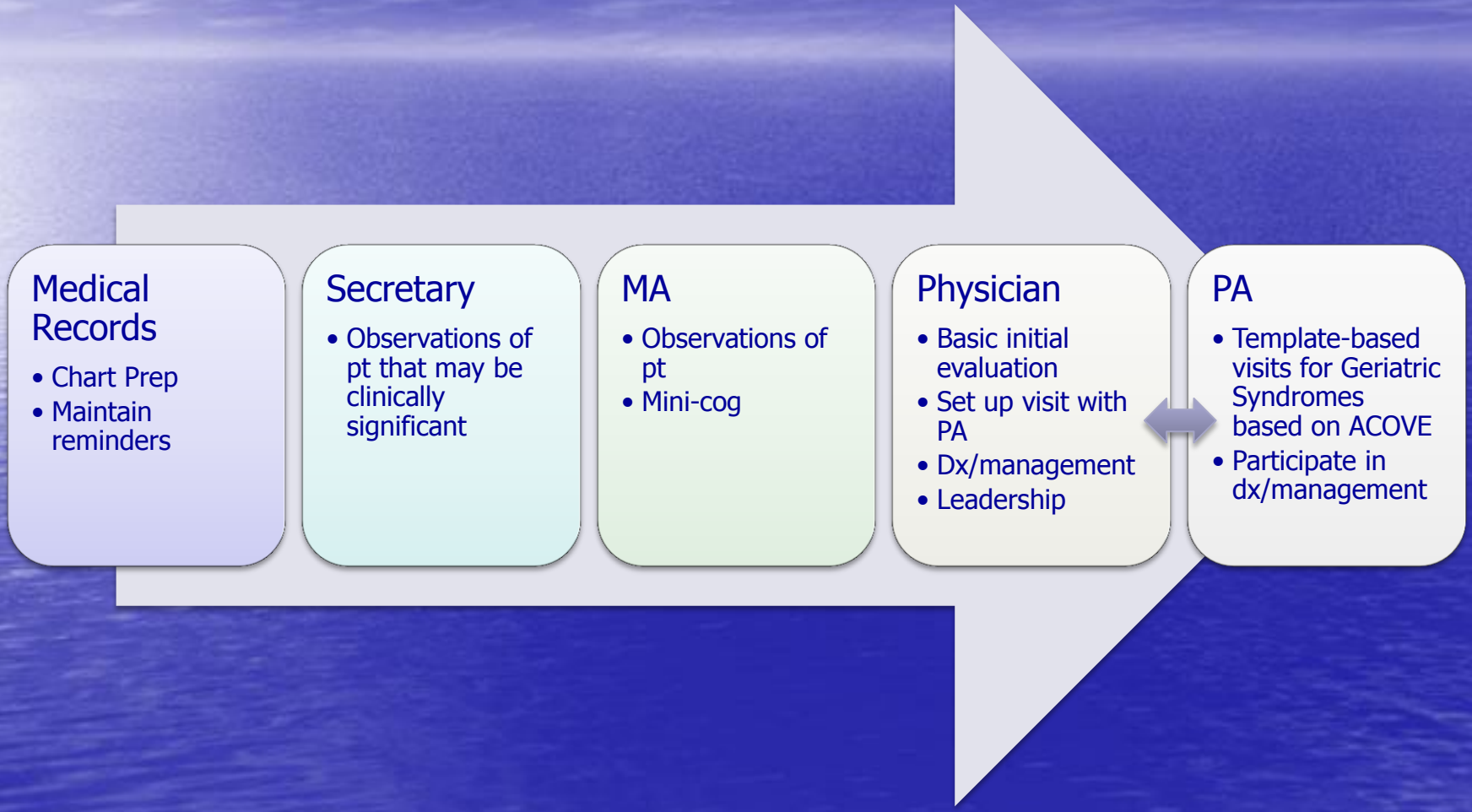
Diagnosis

- 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

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 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

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