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
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
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

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.
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

- Community resources
- Person’s Support system
- Office Team
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
- Medical Records
- Care & Quality Improvement
- Secretary
- MA
- PA

- Team roles contributing to care and quality improvement.
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
  – 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.*
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

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
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