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

Patient encounter

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
Audience role in caring for Older Adults with Memory Impairment

- PCP’s
- Other Providers
Audience role in caring for Older Adults with Memory Impairment

- PCP’s
- Other Providers
- Provide care or services for older adults with memory problems
Audience role in caring for Older Adults with Memory Impairment

- PCP’s
- Other Providers
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- PCMH
Audience role in caring for Older Adults with Memory Impairment

- PCP’s
- Other Providers
- Provide care or services for older adults with memory problems
- PCMH
- 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. 

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

- You are already ½ an hour behind schedule.
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
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
- MA
- PA
- Secretary
- Medical Records
- Care & 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

• 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.*
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

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 3\textsuperscript{rd} 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
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
GOALS
Structured Team Approach

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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