Dementia and Alzheimer’s Disease: Providing Quality Care to Patients with Dementia

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Since his retirement from military service in 2013, Dr. Unwin has worked primarily as a nursing home physician and regional geriatrics consultant, with an emphasis on caring for patients with dementia. He has contributed to national research programs and publications regarding dementia and palliative care, and has a particular interest in the needs of veterans and their families. With more than 25 years of experience teaching family medicine and geriatrics, he has taught in U.S. Army family medicine residencies, at the Uniformed Services University of the Health Sciences, Bethesda, Maryland; and in programs affiliated with the Virginia Tech Carilion School of Medicine, Roanoke. In 2011, he received the William P. McGinnis Award for Outstanding Military Education.

He was also awarded the Army Surgeon General’s “A” Proficiency Designator for excellence in clinical care. Dr. Unwin serves on the board of directors for the Central and Western Virginia Chapter of the Alzheimer’s Association. He was chosen to be the U.S. Department of Defense representative to the National Alzheimer’s Project Act. In 2012, he was selected as the AAFP’s representative to the American Academy of Neurology (AAN) and American Psychiatric Association (APA) Dementia Measure Development Work Group.

Learning Objectives

1. Use evidence-based guidelines to screen and evaluate patients who are symptomatic for cognitive decline for dementia.
2. Identify tools and resources available to the care team, caregivers, and patients about strategies to maintain or improve cognitive health.
3. Use evidence-based guidelines to formulate pharmacologic and non-pharmacologic therapies to help slow the progression of Alzheimer’s.
4. Counsel patients and their family members on how to cope with neurologic disorders that result in the loss of cognitive functioning, such as Alzheimer’s disease.

Associated Sessions

• Dementia and Alzheimer’s Disease: PBL
Audience Engagement System

Step 1
Step 2
Step 3

References:


Perspective:

- Family Physician/Geriatrician
- AAFP representative, Dementia Management Measures Group (2012 and 2015)
- Dept of Defense Representative, Advisory Council on Alzheimer’s Research Care and Services (National Alzheimer’s Disease Project Act)
- Board of Directors, Alzheimer’s Association
- Nursing Home Medical Director
- Hospice Medical Director

AES Polling Question #1: What challenges you the most in managing patients who have dementia?

1. I lack sufficient knowledge to do so…
2. There is little to offer these patients…
3. I’m not emotionally/attitudinally ‘equipped’ for their care…
4. What are the priorities? Too many things to do…

Live Long and Prosper…

"Dammit Jim, I'm a doctor... not a social worker, nurse, physical therapist, or counselor."

"Bones...you're a family physician...the leader...of a...multi-disciplinary team."

The Need for Older Adult Care

- From 2005-2015: 30% increase in population age 65+ (36M to 47.8M)
- From 2015-2040, the population age 85+ will nearly TRIPLE from 6.3M to 14.6M
- Additional 20 years of life expectancy at age 65
- About 20% of older adults live alone
- Median income: $31k for men, $18k women
- 13.7% live in poverty

Profile of Older Americans: 2016
Admin on Aging
Importance and Pervasiveness of Dementia

Fast Facts Regarding Dementia

Population Changes

Dementia is Family Medicine Territory…

Core Clinical Criteria for Dementia

DEMENTIA IS A SYNDROME

<9500 citizens with dementia

Neurology Workforce Data
- In 2010, mean wait for new patient = 28 days vs. cardiology (15), ortho (16) and FP (20)
- Mal-distribution (11 neurologists/10,000 in Washington, DC vs 1.78/10,000 in Wyoming)

Geriatrics Workforce Data
- 2010: 3.6 geriatricians/10,000 (age 75+)
- 2040: 1.7 geriatricians/10,000 (age 75+)

Geriatric Psychiatry Workforce Data
- 2010: 0.9 geriatric psychiatrists/10,000 (age 75+)
- 2040: 0.4 geriatric psychiatrists/10,000 (age 75+)

Neurology Workforce Data

Core Clinical Criteria for Dementia

Cognitive or behavioral symptoms that:
- Interfere with ability to function at work or usual activities
- Represent a decline from previous levels of function
- Are not explained by delirium or psychiatric disorder
- Are diagnosed by: patient and informant history, and objective cognitive assessment
- Involve impairment in at least two domains: inability to learn new information; impaired reasoning; impaired visual-spatial abilities; impaired language; changes in personality or behavior

Alzand Dementia, 7 (2011); 263-269
IMPAIRMENTS in:
Memory
Concentration
Reasoning
Personality
Behavior and Function

Medications
Depression
Vision and Hearing
Thyroid
Small Strokes
Alzheimer’s Disease
Normal Aging
Alcohol and Drugs
Large Strokes

Screening Tools
- Montreal Cognitive Assessment
- Saint Louis University Mental Status
- Mini-Mental State Exam (MMSE)

Screening Tool #2 (Informant Questions)
- The AD8

Score ‘yes’ ≥ 2 suggests cognitive impairment

AES Polling Question #2: In 2017, what would quality care "look like" for patients with dementia?
1. We would have easy, low-cost, sensitive and specific tests for the various conditions
2. We would have effective treatments
3. We could prevent dementia in the first place
4. There would be a quality ‘standard’ for dementia care

Domains of Quality*
- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable

Do our current treatments of medications (NMDA, CHIs), Vitamin E, exercise, leisure activities, and Occupational Therapy...

...satisfy our desire for quality care for patients with dementia?

Why have quality measures for dementia?
- Ethnic and socioeconomic disparities
- Preventable acute care episodes
- High transition care
- Inconsistent, reactive and unsystematic care
- Preventing complications of dementia is possible

* Institute of Medicine
Why have quality measures for dementia care (part 2)?

- Emphasis on **patient-caregiver dyad**
- Practical: We have the **Power of the Pen**
- To preserve the **function** of the patient and caregiver

**Goals for Creating the Measures**

- Improving outcomes for patients with dementia
- Emphasis on evaluation and management
- Emphasis on patient-caregiver dyad as a **unit of treatment**
- Feasibility/usability for QI, MIPS, scorecards, etc.

**The Working Group Process**

- American Academy of Neurology's measure development process
- 26 members, 21 organizations (patients, physicians, allied care, nursing, payers)
- Iterative, consensus-based review of the literature
- 249 abstracts > 23 guidelines > 9 recommendations for public review > publication

**The Result: The 2015 Dementia Management Quality Measurement Set Update**

- Disclosure of Dementia Diagnosis
- Caregiver Education and Support
- Functional Status Assessment
- Screening and Treatment of Behavioral and Psychiatric Symptoms
- Safety Concern Screening and Follow-Up
- Driving Screen and Follow-Up
- Advanced Care Planning and Palliative Care Counseling
- Pain Assessment and Follow-up
- Treatment of Dementia

**Disclosure of Diagnosis**

- Approximately 45% of caregivers report not being told of Alzheimer's diagnosis
- Telling people what they don’t have is the diagnostic workup
- Use the words “Probable” vs. “Possible” Alzheimer’s Disease (or Vascular Dementia, Mixed Dementia, Lewy Body, FTD, etc.)
AES Polling Question #3: Why disclose the diagnosis?

1. Physician’s responsibility
2. Patient’s right to know
3. Legal and malpractice considerations
4. The patient-caregiver dyad can start learning and planning

Caregiver Education and Support

- More education = better well-being and perhaps less placement
- Domains:
  1. Adjust expectations
  2. Evaluate sudden decline
  3. Keep requests simple
  4. Redirection if upset/angered
  5. Avoid complex tasks
  6. Don’t confront patient about deficits
  7. Be consistent
  8. Provide explanations/cues

Perhaps 50% of caregivers state they get this education

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Functional Status Assessment

- Advanced Activities of Daily Living (‘meaning of life’)
- Instrumental Activities of Daily Living (fast loss)
- Activities of Daily Living (slow loss)
- Consider: Home Health (PT/OT/SWS) assessment for function, rehab, safety

Why?

- Infrequently assessed
  - 10% assessed in community
  - 18% assessed in hospital
- Disablement impacts the dyad
- Disablement predicts placement, hospitalization, mortality, readmissions, etc.
- Multi-disciplinary interventions help the dyad

Screening and Treatment of Behavioral and Psychiatric Symptoms

- Mood: anxiety, depression, agitation, etc.
- Activity: sleep, impulses, apathy, agitation
- Thought/perceptual: delusions, hallucinations, paranoia

AES Polling Question #4: What is your comfort in prescribing antipsychotics?

1. I don’t go there, I don’t do that
2. I don’t prescribe enough to really say
3. I will with mental health consultation
4. I would get more comfortable with more knowledge
5. Completely comfortable

Safety Concern Screening and Follow-Up

- Meds
- Financial
- Home: HVAC, fire, cooking, etc.
- Aggression
- Wandering
- Guns
- Home alone
- Abuse/neglect/exploitation
- Self neglect

Tools: AARP, Alzheimer’s Association, National Institute on Aging

Driving Screening and Follow-Up

- Useful markers for increased risk:
  - Caregiving rating (Level B), crashes (Level C), reduced driving or avoidance (Level C), MMSE < 25 (Level C), aggression or impulsivity (Level C)
- Not useful:
  - Self-ranking (Level A)
  - Lack of situational avoidance (Level C)
- Insufficient evidence:
  - Neuropsychological testing (Level U)
  - Interventional strategies (Level U)

WHY? 2x risk of crashes
Physician intervention = 15%

Advance Care Planning and Palliative Care Counseling

- Hospitalization
- Surgery
- Treatment of infections
- Nutrition (PEGs), hydration (dialysis)
- CPR
- Ventilation
- Comfort care
- Timing of natural death
- Hospice referral

Why? 41% of nursing home patients with dementia got burdensome procedures, 18% of caregivers report prognostic information, and 47% got end-of-life counseling. Tools: Five Wishes, POA, Power of Attorney, etc.

Pain Assessment and Follow Up

- Still perceive pain, can’t isolate
- Unreported pain increases with disease severity
- Pain BEHAVIORS
  - Changes in breathing
  - Moaning, negative speech
  - Facial expressions
  - Body language
  - Disinterest
  - Depression
  - Functional and cognitive decline
  - Neuropsychologic symptoms

Tool: Pain Assessment in Advanced Dementia (PAINAD)

Treatment of Dementia

- Psycho-social intervention for behaviors
- Realistic expectations
- Other approaches: behavioral, art, music, complementary, aromatherapy, bright light therapy
- Medications (cholinesterase inhibitors/NMDA)
- Medications not effective for MCI

Epperly, Amer Fam Physician 2017;95(11):771-778

What Can You Do?

- If you are a caregiver: FOCUSED/DEDICATED and FREQUENT visits to your physician to discuss JUST these topics
- If you are the physician: FOCUSED/DEDICATED and FREQUENT visits to discuss JUST these topics
- Use the patient’s other strengths to help cope:
  - Physical
  - Emotional
  - Social, and
  - Spiritual
Resources:

- http://aafpcognitivecarekit.info
- Alz.org
- Alzheimer’s Association App
- Caregiver.org
- AARP
- AAA

Practice Recommendations

- The patient’s function, behavior, mood, and cognition become the #1 problem a patient and caregiver will face for the duration of disease until the patient’s death
- Change the concept of diagnostic work-up to the systematic assessment and treatment of the multiple factors that may contribute to the decline (or improvement) of function, behavior, mood and cognition
- Address the important issues facing patient-caregiver dyad as outlined in the Dementia Management Quality Measures
- Use the Dementia Management Quality Measures to establish baselines and to demonstrate improvements in quality of care initiatives for your practices

Questions

Contact Information

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