Body System: Geriatrics		
Session Topic: Dementia and Alzheimer's Disease		
Educational Format		**Faculty Expertise Required**
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form.

Professional Practice Gap	**Learning Objective(s) that will close the gap and meet the need**	**Outcome Being Measured**
• Geriatric patients often receive inadequate assessments, leading to unrecognized or inadequately addresses functional impairment and dementia. • Welcome to Medicare Visits (WMV) are underutilized. • Knowledge and competence gap related to screening and evaluation of symptomatic patients for cognitive decline. • Many primary care physicians view the treatment of dementia as time-consuming and not fitting well into the usual primary care setting. • Knowledge gap about resources and strategies to maintain or improve cognitive health in the prevention of dementia and Alzheimer's disease. • Knowledge and competence gap related to	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.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

providing support and counseling to caregivers of dementia and Alzheimer's patients. • Knowledge and competence gap related to the consistent implementation and adherence to evidence-based guidelines for the management of dementia and Alzheimer's patients. • Knowledge and competence gap in diagnosing the different types of dementia which have implications for treatment (i.e. Lewy Body dementia has different reactions to medications). • New research showing a possible link between proton pump inhibitors (PPIs) and risk of dementia in older adults.		

ACGME Core Competencies Addressed (select all that apply)

X	Medical Knowledge		Patient Care
X	Interpersonal and Communication Skills		Practice-Based Learning and Improvement
	Professionalism		Systems-Based Practice

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
    - Visit http://www.aafp.org/journals for additional resources

- Visit http://familydoctor.org for patient education and resources

- Provide specific examples illustrating the application of evidence-based guidelines, as it applies to the screening, diagnosis, and management of dementia and Alzheimer's. This should include recommendations regarding screening for depression.
- Provide specific examples of tools and strategies to help make the office visit more efficient, and to appropriately code for reimbursement
- Provide learners with practical strategies to utilize community-based resources as a way to support caregivers of dementia and Alzheimer's patients
- Provide specific, evidence-based information about effective pharmacologic and non-pharmacologic therapies to lessen symptoms of Alzheimer's
- Provide recommendations regarding the ADNI Alzheimer's Disease Neuroimaging Initiative study.
- Provide recommendations regarding guidelines for Medicare reimbursement.
- Provide recommendations to maximize office efficiency and guideline adherence to the diagnosis and management of dementia and Alzheimer's.
- Provide an overview of newly available treatments, including efficacy, safety, contraindications, and cost/benefit relative to existing treatments.
- Demonstrate how Patient Centered Medical Home and Chronic Care Management may be utilized in the treatment strategies for Alzheimer's disease.

Needs Assessment

Dementia is one of the most common afflictions of the elderly, but it is important for patients and their families to understand that it is not a "normal" part of aging. Normal aging does not result in the loss of large numbers of neurons in the brain, which eventually leads to impaired cognition and functioning. While there are numerous disorders that can cause dementia, the most common of which is Alzheimer's disease (AD), family physicians can rule out any other treatable conditions (such as depression or vitamin B_{12} deficiency) that can cause similar symptoms.[1-3] Alzheimer's disease (AD) is the most common neurological disorder and most common cause of dementia for people over the age of 65; it is currently estimated to affect more than 5 million Americans.[4] Alzheimer's disease causes nearly 75,000 deaths per year; it is currently the sixth-leading cause of death in the U.S. It is estimated that 41.8% of assisted living residents, 15.5% of residents of nursing homes, and 7.5% of patients under the care of home hospices have AD.[5] The Alzheimer's Association indicate that the most important risk factors that increase the risk of Alzheimer's is age, family history, and heredity.[4]

Data from a recent American Academy of Family Physicians (AAFP) CME Needs Assessment survey indicate that family physicians have a statistically significant and meaningful knowledge and skill gap related to the management of dementia and Alzheimer disease.[6] More specifically, CME outcomes data from 2012-2016 AAFP FMX (formerly Assembly): *Dementia and Alzheimer Diseases* sessions suggests that physicians have knowledge and practice gaps with regard to cognitive evaluation of symptomatic patients; early testing for asymptomatic patients; appropriate use of diagnostic testing; support of caregivers; pharmacologic and non-pharmacologic therapies, including knowing when to initiate &/or stop medications; and screening for depression.[7-10]

Physicians often feel challenged in caring for dementia patients due to barriers such as lack of time in the office visit, reimbursement issues, lack of access to and poor communication with specialists, access to community services, and lack of interdisciplinary teams.[11,12] The American Academy of Neurology (AAN), American Geriatric Society (AGS), and the American Medical Directors Association (AMDA) in the AMA PCPI Dementia Performance Measure Set has also identified gaps in physician performance and patient care:[13]

- On average, older patients with dementia received the recommended quality of care only about 35 percent of the time
- Some studies suggest that caregivers in general only adhere to evidence-based recommendations for the care of patients with dementia about 40 percent of the time
- Adherence to clinical practice guidelines was moderate to low at VA medical centers with regard to cognitive and depression screening, reporting of elder abuse, discussing care needs and decision making issues with patients' family and implementing caregiver support practices

Additionally, the AAFP National Research Network conducted a study of active members to investigate the practice patterns, beliefs, concerns, and perceived need of family physicians that treat patients with dementia. This study identified a number of factors affecting the diagnosis of dementia and the delivery of dementia care included patient behavior challenges (aggressiveness, restlessness, paranoia, wandering); comorbidities (falls, delirium, adverse medication reactions, urinary incontinence); caregiver challenges (fatigue, planning for patient's institutional placement, anger); and structural barriers (clinician time, time required for screening, limited treatment options). Tools needed to provide enhanced dementia care included better assessment tools, community resources, and diagnostic and screening tools.[14] In fact, recent studies highlight the need for careful drug monitoring, due to findings that older adults with dementia are at heightened risk for adverse drug effects from anticholinergic drugs, benzodiazepines, and opioids, among many others.[15]

Prevention is a key aspect of patient-centered care. Some primary care physicians report barriers to talking with patients about cognitive health such as lack of time, patient negative reactions to recommendations, and many physicians do not believe that strategies for cognitive health have sufficient evidence in their efficacy.[16] A good opportunity to evaluate patients for dementia and Alzheimer's is during the Welcome to Medicare Visit (WMV); however, Older adults may not be aware of preventive services available to them, and that these services are covered by Medicare; thereby leading to health disparities, particularly by the underserved.[17] Often, older adults may rely on their physicians to recommend or refer them for the services yet health care providers may not remember or take the time to promote their use.[17] Additionally, mammography and Pap tests among women aged 65 and 66 years are frequently underutilized, despite being covered through the WMV.[18]

Nearly 12% of people who enroll in Medicare at age 65 wait more than two years before making use of the WMV wellness visit; which is reflective of patterns of use before enrollment – i.e. people who sought preventive care before turning 65 continued to do so after enrolling in Medicare.[19]

Even though a small percentage of older adults take advantage of preventive care visits such as WMV and the annual wellness visit (AWV), providing preventive care visits such as WMV and the annual wellness visit (AWV) has caused an increased burden to the entire medical team.[20] It can be challenging and frustrating for physicians to provide and document the extensive list of required elements in a 20 or 30 minute visit. In addition, misconceptions about the purpose and coverage requirements of the AWV, the Welcome to Medicare visit, and other Medicare wellness exams are common among both patients and providers. It is not uncommon for Medicare wellness visits to lack proper documentation.[20]

As physicians transform their practices to provide patient-centered care, family physicians must remain up to date on current initiatives to maintain or improve cognitive health. On May 15, 2012, the U.S. Department of Health and Human Services released the National Alzheimer's Plan, with a specific goal of finding effective ways to prevent and treat Alzheimer's diseases and related dementias by 2025.[21] Additionally, the Healthy Brain Initiative from the Division of Population Health, National Center for Chronic Prevention and Health Promotion provides resources for providers, caregivers, and patients for cognitive health.[16,22] Physicians should also be aware of studies suggesting a link between dementia and benzodiazepine use, and understand evidence-based recommendations for counseling patients about risk reduction.[23]

The American Academy of Family Physicians (AAFP) and the U.S. Preventive Services Task Force (USPSTF) make no recommendation for or against routine screening for dementia in asymptomatic older adults; however, utilizing the MMSE for screening is recommended whenever cognitive impairment or deterioration is suspected in order to help make diagnostic and treatment decisions.[24,25] In June 2014 the USPSTF updated its recommendation statement regarding screening for cognitive impairment as, "USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for cognitive impairment."[26,27] As such, physicians should be familiar with clinical considerations, and be prepared to make appropriate individual adjustments.

The National Institute on Aging and the Alzheimer's Association has released guidelines for clinical diagnosis of dementia and mild cognitive impairment. Family physicians should use current evidence-based guidelines to evaluate patients with suspected dementia. Physicians may improve their care of patients with dementia by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:[3,28]

- For patients with suspected dementia, quick screening tests, such as a verbal fluency test and the Mini-Cognitive Assessment Instrument, should be performed to determine whether further evaluation is warranted.
- Formal cognitive testing should be performed in patients with abnormal results on initial dementia screening.
- Routine blood work (i.e., complete blood count; complete metabolic panel; and measurement of thyroid-stimulating hormone, vitamin B12, folate, and calcium levels) should be performed in patients with suspected dementia.

- Additional testing (e.g., neuroimaging, cerebrospinal fluid analysis, human immunodeficiency virus testing, Lyme titer, and rapid plasma reagin test) can be performed in patients with suspected dementia and specific risk factors or symptoms.
- A second visit should include a Mini-Mental State Examination, Geriatric Depression Scale, and verbal fluency and clock drawing tests, if not previously completed
- Nonpharmacologic interventions should be used as first-line treatment for behavioral and psychological symptoms of dementia.
- Before initiating antipsychotic therapy in older patients, physicians should have and document a discussion with patients and caregivers about the risks and benefits of these medications.
- The use of atypical antipsychotics for behavioral and psychological symptoms of dementia is associated with increased mortality.
- Antipsychotic medications should be discontinued if there is no evidence of symptom improvement.

Best Practice in Psychiatry: Recommendations from the Choosing Wisely® Campaign:

- Do not prescribe antipsychotic medications for behavioral and psychological symptoms of dementia in individuals with dementia without an assessment for an underlying cause of the behavior. (American Medical Directors Association)
- Do not use antipsychotics as first choice to treat behavioral and psychological symptoms of dementia. (American Geriatrics Society American Psychiatric Association)

Physicians should also be familiar with the Montreal Cognitive Assessment (MoCA), and be able to determine whether the MoCA or the MMSE is the appropriate assessment, under the given situation.[3,29,30] When scores are adjusted based on a patient's education level, the MMSE may be useful to rule out a diagnosis of dementia in clinically unevaluated patients 65 years and older (sensitivity = 97%; specificity = 70%). Scores of less than 24 may also be useful to rule in dementia in patients 65 years and older (sensitivity = 85%; specificity = 90%). These patients warrant further evaluation. There is insufficient evidence to recommend a specific score on the MMSE to confidently rule out or rule in dementia in patients 65 years and older.1 (Strength of Recommendation: B, based on inconsistent or limited-quality patient-oriented evidence.)[31]

A study from the AAFP National Research Network indicates that if screening and diagnostic testing for ECI/dementia as demonstrated in this project is going to be implemented in primary care offices, there must be:[32]

- ways to implement this process without disrupting ordinary practice flow, including alternatives for its implementation that can be shown to work;
- reimbursable to the extent to which it will be worth the effort financially for the practice to implement systematically; and
- (Probably most importantly) effective treatments for ECI and dementia or demonstration of other benefits from early recognition of the problem.

Recent studies indicate that positron emission tomography (PET) imaging in the evaluation of patients with cognitive impairment or dementia is uncertain.[33,34]

Many primary care physicians view the treatment of dementia as time-consuming and not fitting well into the usual primary care setting. Group medical visits for the treatment of dementia can lead to better compliance, improved outcomes, and provide needed support for caregivers.[11]

Researchers are constantly looking for pharmacologic and non-pharmacologic treatments to help with both cognitive and behavioral symptoms, such as antidepressants for agitation and psychosis in patients with dementia.[35] A Cochrane review recommends that selective serotonin reuptake inhibitors only be used if non-pharmacologic interventions are unsuccessful.[35] Still other recent Cochrane reviews suggest that exercise improves cognitive function and the ability to perform activities of daily living in patients with dementia.[36] Physicians must be provided up to date on effective and ineffective therapies.[4]

The AAFP and the American College of Physicians (ACP) have released guidelines for the current pharmacologic treatment of dementia.[37,38] The key recommendations are summarized as follows:

- Clinicians should base the decision to initiate a trial of therapy with a cholinesterase inhibitor or memantine on individualized assessment. (Grade: weak recommendation, moderate-quality evidence.)
- Clinicians should base the choice of pharmacologic agents on tolerability, adverse effect profile, ease of use, and cost of medication. The evidence is insufficient to compare the effectiveness of different pharmacologic agents for the treatment of dementia. (Grade: weak recommendation, low-quality evidence.)
- There is an urgent need for further research on the clinical effectiveness of pharmacologic management of dementia.

In 2012, 15.4 million caregivers provided more than 17.5 billion hours of unpaid care, valued at $216 billion, to family members with Alzheimer's.[39] Family and caretaker involvement is critical in the treatment of patients with dementia and Alzheimer's, so family physicians are uniquely positioned to initiate discussions with families about the importance of treatment and monitoring the patient's behavior and activities of daily living (ADLs). Some family members and/or caregivers may also investigate specific treatments (such as integrative therapies) and inquire about them with family physicians, in which case family physicians should be prepared to address questions and provide accurate and appropriate information.

Family physicians are also in a unique position to provide not just information to caregivers, but also to help refer them to community resources (such as support groups) that can be helpful. Some studies also suggest that family physicians are unaware of community-based social services for patients with dementia or Alzheimer's disease; therefore, family physicians should be aware of these services and be able to provide guidance to caregivers.[40] Family physicians should be provided education and strategies to assist them with the integration of behavioral health specialist into practice.[41] Physicians can also make their visits with patients in nursing homes or other long-term care facilities more efficient by using a standardized clinician documentation tool.[42] The stress and burden of caring for someone who has dementia or Alzheimer's can cause physical and psychological problems for caregivers; family physicians should be aware of this and discuss any problems, and should be aware of existing resources and be prepared to refer patients and/or family members to such resources.

Family physicians required education and strategies to consistently implement evidence-based guidelines for the management of dementia and Alzheimer's in their patient population.

Physicians may improve their care of patients with Alzheimer's Disease by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:[43,44]

- Cholinesterase inhibitors, including donepezil (Aricept, 5 to 10 mg per day), galantamine (Razadyne, at least 16 mg per day), or rivastigmine (Exelon, 6 to 12 mg per day orally or 9.5 mg per day transdermally), should be considered for treatment of cognitive and functional decline in patients with mild to moderate Alzheimer disease.
- Memantine (Namenda, 20 mg per day) should be considered for treatment of cognitive and functional decline in patients with moderate to severe Alzheimer disease.
- The addition of memantine should be considered for treatment of cognitive and functional symptoms in patients with moderate to severe Alzheimer disease or mixed dementia who are already receiving a cholinesterase inhibitor.
- The addition of vitamin E (2,000 IU per day) should be considered for treatment of mild to moderate Alzheimer disease in patients who are already receiving a cholinesterase inhibitor.
- A structured physical exercise program should be recommended for patients with Alzheimer disease of any severity.
- Cognitive stimulation programs should be recommended for patients with mild to moderate cognitive impairment.
- Acetylcholinesterase inhibitors are modestly effective in patients with mild to moderate Alzheimer disease, although limited by their adverse effects.
- Combination therapy with an acetylcholinesterase inhibitor and memantine (Namenda) should be considered in patients with moderate to severe Alzheimer disease.
- Atypical antipsychotic agents can improve some behavioral manifestations of Alzheimer disease but are associated with increased mortality in older patients.
- Nonsteroidal anti-inflammatory drugs, vitamin E, testosterone, estrogen, statins, and insulin sensitizers are not recommended for the treatment of Alzheimer disease.
- Physicians should consider discontinuing treatment for Alzheimer disease in patients who continue to decline despite maximal therapy.

Best Practice in Psychiatry: Recommendations from the Choosing Wisely® Campaign:

- A 2014 randomized controlled trial in veterans with mild to moderate Alzheimer disease who were already receiving a cholinesterase inhibitor found that vitamin E slowed functional status decline (3.15 points less than placebo on a 78-point assessment scale over 4 years), with a delay in progression of about 6 months.
- A 2012 Cochrane meta-analysis of 15 randomized controlled trials concluded that cognitive stimulation programs are beneficial for maintenance of cognitive function and self-reported quality of life in patients with mild to moderate dementia from Alzheimer disease. However, cognitive stimulation techniques are highly variable and lack standardization, and no effects were noted on functional status, behavior, or mood.

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Physicians should also be kept up to date on current research showing a possible link between proton pump inhibitors (PPIs) and risk of dementia in older adults.[45,46]

Finally, the Alzheimer's Disease Neuroimaging Initiative (ADNI)(adcs.org) is asking for help from family physicians throughout the United States.[47] The largest and most comprehensive Alzheimer's disease research effort in history, ADNI is moving into its second phase -- ADNI2(www.nia.nih.gov) -- but finds itself hampered by recruitment challenges. According to principal investigator Michael Weiner, M.D., a professor of medicine, radiology, psychiatry and neurology at the University of California, San Francisco, ADNI2 is seeking 400 volunteers between the ages of 55 and 90 who have been diagnosed with early mild cognitive impairment, late mild cognitive impairment or early/mild Alzheimer's disease. The plan sets forth five goals, including the development of effective prevention and treatment approaches for Alzheimer's disease and related dementias by 2025.

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Initial evaluation of the patient with suspected dementia[2]
- Behavioral Disorders in Dementia: Appropriate Nondrug Interventions and Antipsychotic Use[28]
- Evaluation of suspected dementia[3]
- (AMA) PCPI Approved Quality Measures: Dementia[13]
- (AMDA) Dementia in the long term care setting[48]
- Treating Dementia With Shared Group Visits[11]
- Treatment of Alzheimer disease[44]
- Alzheimer Disease: Pharmacologic and Nonpharmacologic Therapies for Cognitive and Functional Symptoms[43]
- CDC Healthy Aging: Healthy Brain Initiative[22]
- (AAFP) Clinical Preventive Services Recommendations[25]
- Integrating a behavioral health specialist into your practice[41]
- A nursing home documentation tool for more efficient visits[42]
- Alzheimer's Association recommendations for operationalizing the detection of cognitive impairment during the Medicare Annual Wellness Visit in a primary care setting[49]
- AAFP and ACP Guideline on dementia treatment[38]
- ACR Appropriateness Criteria - dementia and movement disorders[50]
- FamilyDoctor.org. Alzheimer's Disease | Overview (patient resource)[51]
- FamilyDoctor.org. Dementia | Overview (patient resource)[52]

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