Alzheimer's Disease in Primary Care

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Objectives

- Briefly review epi of ADRD
- Discuss the context and +'s and –'s of screening and early intervention
- Discuss clinical recognition of symptoms
- Describe two AD primary care programs
- Education and training resources

Briefly Review- ADRD Epi

- 5.3 million diagnosed cases in US, increasing to ~13.8 million in 2050
- Two-thirds of Americans with Alzheimer's are women
- Prevalence of 8% in 65+ & 43% in 85+
- AA and Hispanics higher rate than Whites
- Every 67 seconds someone in the US develops AD

Alzheimer's Association. 2015 Alzheimer's Disease Facts and Figures. *Alzheimer's & Dementia* 2015;11(3)332+.

(Thies, 2012; Pimlot, 2009; Boustani, 2005; http://alz.org/facts/overview, 2015 Facts accessed 3/2016)

ADRD- To Screen or Not to Screen

- The debate
- The changes:
  1. Growing elder population
  2. Growing incidence of ADRD, & related $
  3. Now 5 Rx's for treatment, and other secondary prevention data
  4. Welcome to Medicare
  5. Alzheimer's Disease Foundation Nov. 16 "National Alzheimer's Screening Day,"
  6. Availability of caregiver training & support services

Why Not to Screen

- Diagnostic uncertainty
- No curative treatments
- Fear of emotional distress
- Patient refusal for further workup if diagnosed
- Many clinical settings lack expertise in providing on-going support services

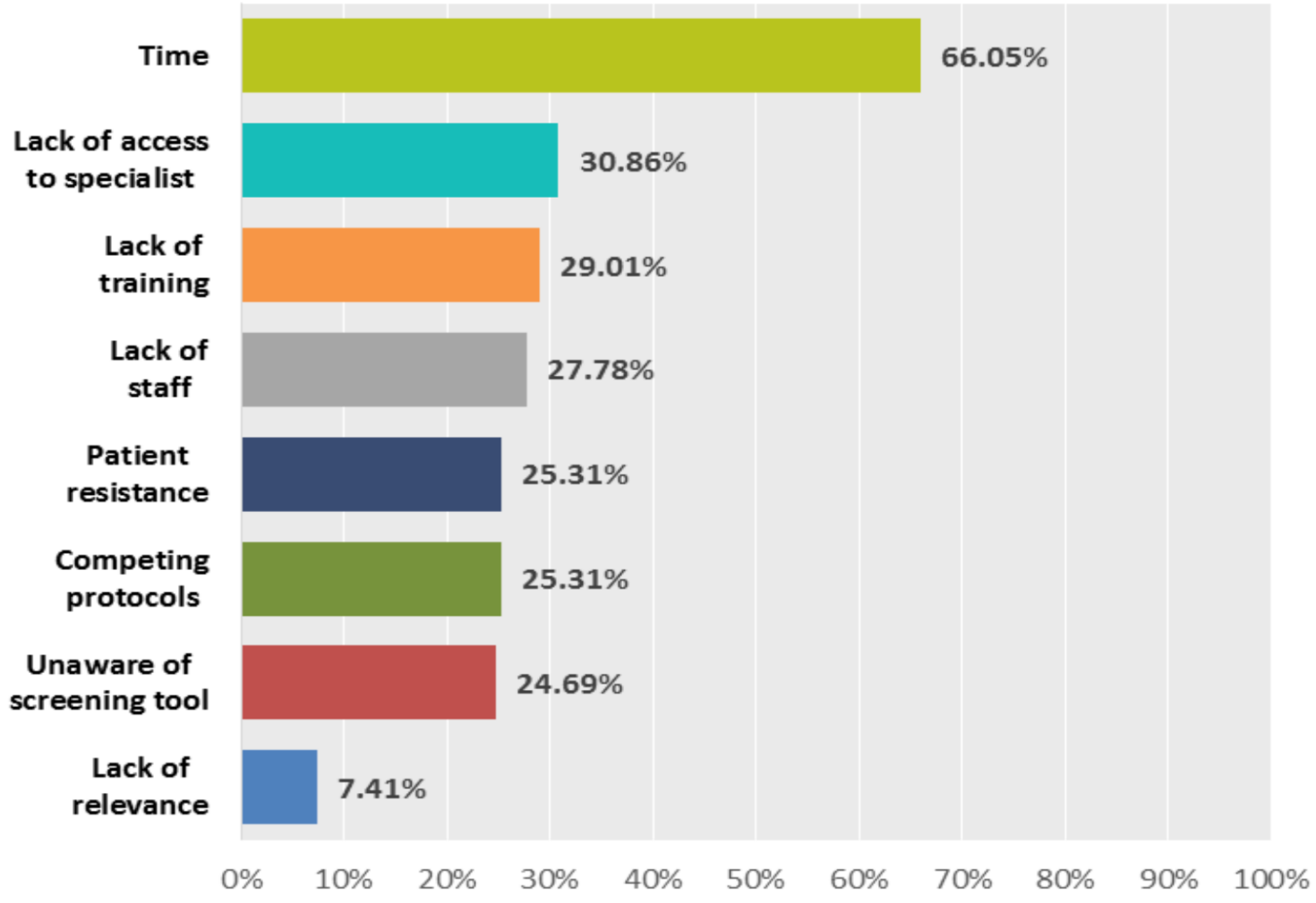
AD Working Group Primary Care Survey 2015

- N=250 PCPs (mostly FP and IM in WA)
- Importance of screening?
  - Very 78% / Somewhat 22%
- 46% did not know about cog. Screening in Welcome to Medicare
- 66% screened only when concerned re sx.
- Barriers to screening

Alzheimer's Disease Working Group Webpage:
https://www.dshs.wa.gov/altsa/stakeholders/developing-state-plan-address-alzheimers-disease

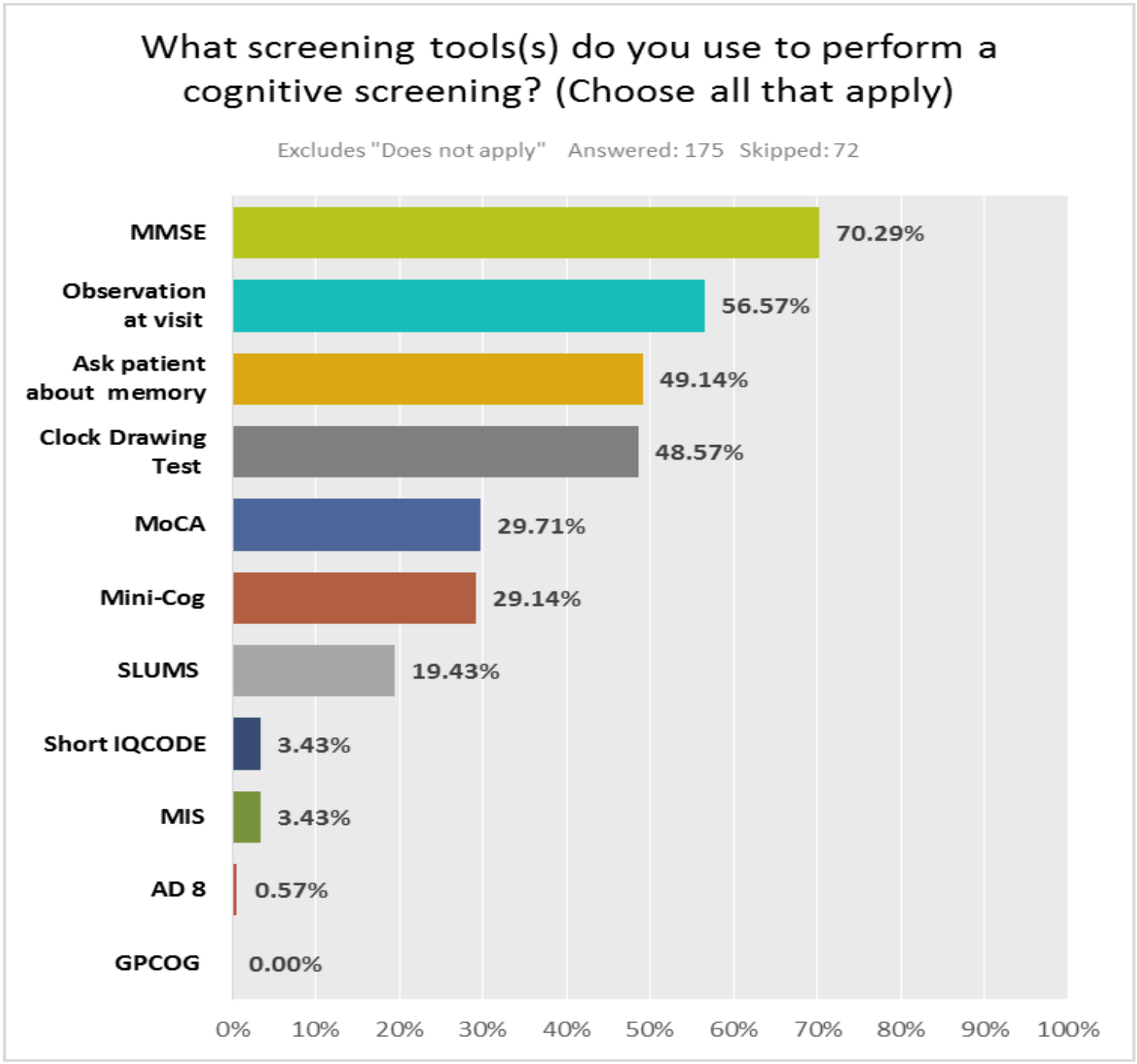
What are challenges or barriers in performing cognitive screening in your practice? (Choose your top THREE)

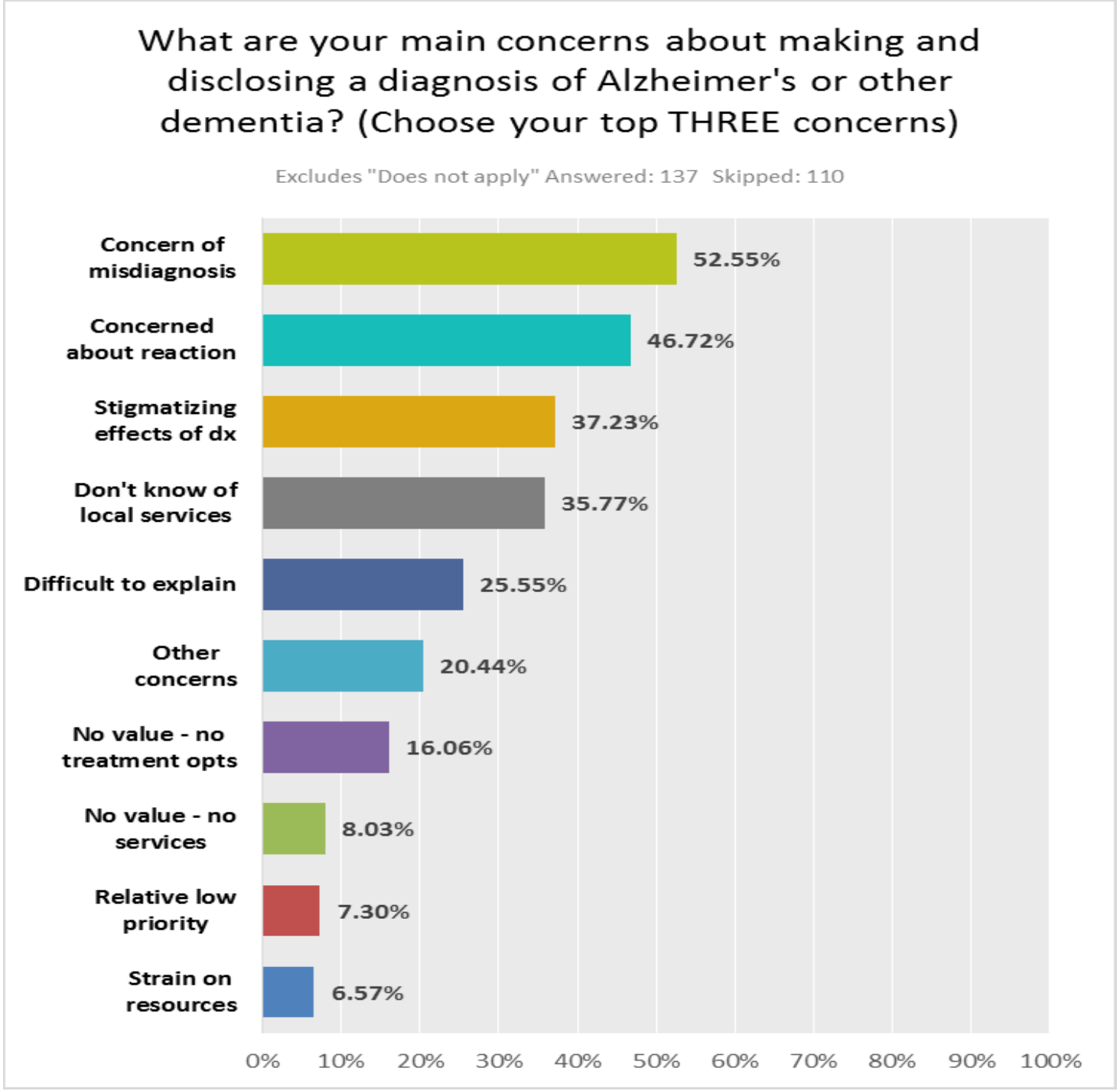
Excludes "Does not apply" Answered: 162 Skipped: 85



Dementia Case Finding

- Most patients with dementia receive medical care in primary care
- 66% of them are not diagnosed in the early stages
- Clinicians and caregivers fail to recognize dementia symptoms
- Lack of response is exacerbated by limited resources such as time and cost,
- Many clinicians have negative attitudes toward the value of detecting and managing dementia.
- Early case finding would reduce the time lag reported by many caregivers and families between the first notification of patient problems to clinicians and activation of diagnosis, treatment, and support services


What screening tools(s) do you use to perform a cognitive screening? (Choose all that apply)
Excludes "Does not apply" Answered: 175 Skipped: 72
MMSE
70.29%
Observation at visit
56.57%
Ask patient about memory
49.14%
Clock Drawing Test
48.57%
MoCA
29.71%
Mini-Cog
29.14%
SLUMS
19.43%
Short IQCODE
3.43%
MIS
3.43%
AD 8
0.57%
GPCOG
0.00%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%


What are your main concerns about making and disclosing a diagnosis of Alzheimer's or other dementia? (Choose your top THREE concerns)
Excludes "Does not apply" Answered: 137 Skipped: 110
Concern of misdiagnosis
52.55%
Concerned about reaction
46.72%
Stigmatizing effects of dx
37.23%
Don't know of local services
35.77%
Difficult to explain
25.55%
Other concerns
20.44%
No value - no treatment opts
16.06%
No value - no services
8.03%
Relative low priority
7.30%
Strain on resources
6.57%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

Why Recognize Early Sx???

- Respect for autonomy and decision-making
  - Gun, fire and driving safety
  - Financial and legal issues
  - Treatment decisions
  - Planning while having capacity
  - Resources and referrals
- Truth–telling is warranted ethically

Wilkinson H, et al. Sharing a diagnosis of dementia. Aging Ment. Health, 2003)

Two Early Recognition Programs

- Tucson Community FFHCCS and the Desert Southwest Alzheimer's Association in collaboration with AZ-CHOW and CHWs

- Banner University Internal Medicine Clinic

Brayne C, Fox C, Boustani M. Dementia Screening in Primary Care: Is It Time?. JAMA. 2007;298(20):2409-2411.
Solomon PR, Murphy CA. Should we screen for Alzheimer's disease? a review of the evidence for and against screening Alzheimer's disease in primary care practice. *Geriatrics*. 2005;60(11):26-31

Community

- AZ-CHOW training in cognitive screening (AD-8) and how to communicate with concerned families
- Fax referral to PCP with AD8
- Fax referral to DSAA for resources and follow-up
- Resources left in the home

AD8 Dementia Screening Interview

1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)
2. Less interest in hobbies/activities
3. Repeats the same things over and over (questions, stories, or statements)
4. Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)
5. Forgets correct month or year
6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)
7. Trouble remembering appointments
8. Daily problems with thinking and/or memory

TOTAL AD8 SCORE

2 or more yeses: Cognitive impairment is likely to be present

Galvin JE et al, The AD8, a brief informant interview to detect dementia, Neurology 2005:65:559-564

Banner University Internal Medicine Clinic

- MA screening with “are you concerned about your thinking or memory?
- If so, AD-8 review with PCP
- If + referral to DSAA, as desired
- F/u with diagnostics as is appropriate

Training Materials

- Alzheimer's Association essentiALZ® professional certification and practical implementation tools via AZ-GWEP
- Certification
- 32 hrs of 1 hr modules

Dementia Warning Signs

An alternative to screening in primary care settings

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Interim Chief, Division of Geriatric Medicine

UCSD School of Medicine

Section Chief, Hospital Medicine

VA San Diego Healthcare

Co-Chair – VHA Dementia Warning Signs Workgroup 2010-2012

Objectives

- Understand the concept of Dementia Warning Signs
- Identify Dementia Warning Signs
- Describe a process for initiating a dementia evaluation in primary care, prompted by the presence of Dementia Warning Signs

Recommendations from VHA Dementia Steering Committee

- Use warning signs to trigger cognitive assessment
- Standardize diagnostic evaluation
- Conduct diagnostic evaluation in primary care setting except for complex cases
- Specialty referral for complex cases
  - Atypical or rapidly progressive
  - Early onset
  - Behavior problems or movement disorder

Charter

- Develop practice methods to implement Dementia Warning Signs in primary care
- Pilot test the methods for feasibility
- NOT a research study
- NOT designed as a large scale data collection throughout VA healthcare systems

Why not just screen everyone over a certain age?

- USPSTF Insufficient Information to recommend either for or against routine screening
  - Limitations of existing screening tools
  - Limited data on outcomes from early detection and treatment in asymptomatic patients
  - Concerns about potential harms
  - Risk of diverting primary care time and resources from activities with strong evidence of benefit

Dementia Detection Challenges

- Up to 60% of cases are not diagnosed until later in the disease

- Challenges occur at multiple levels:
  - Disease
  - Provider
  - System

https://www.va.gov/HEALTHPolicyPlanning/reports1.asp

Possible Consequences of Under-Detection

- Poor chronic disease control and premature decline in functional status
- Strained family relationships
- Delayed access to treatments
- Safety issues

A Warning Signs Approach

- Opportunistic case finding
- Observing and responding to behavior and/or concerns expressed by caregivers
- Performing a focused history, physical examination, and brief cognitive assessment
- Not an application of a standardized instrument or clinical reminder to all older veterans

Background

- Dementia Warning Signs Workgroup
  - Convened from 2009-2011 to develop written guidance for key recommendation from VHA Dementia Steering Committee
- Multi professional team
  - Nursing, Psychology, Social Work, Pharmacy
  - Geriatrics, Psychiatry, Neurology, Primary Care
- Workgroup report and selected tools available as supplemental materials

Tools include…

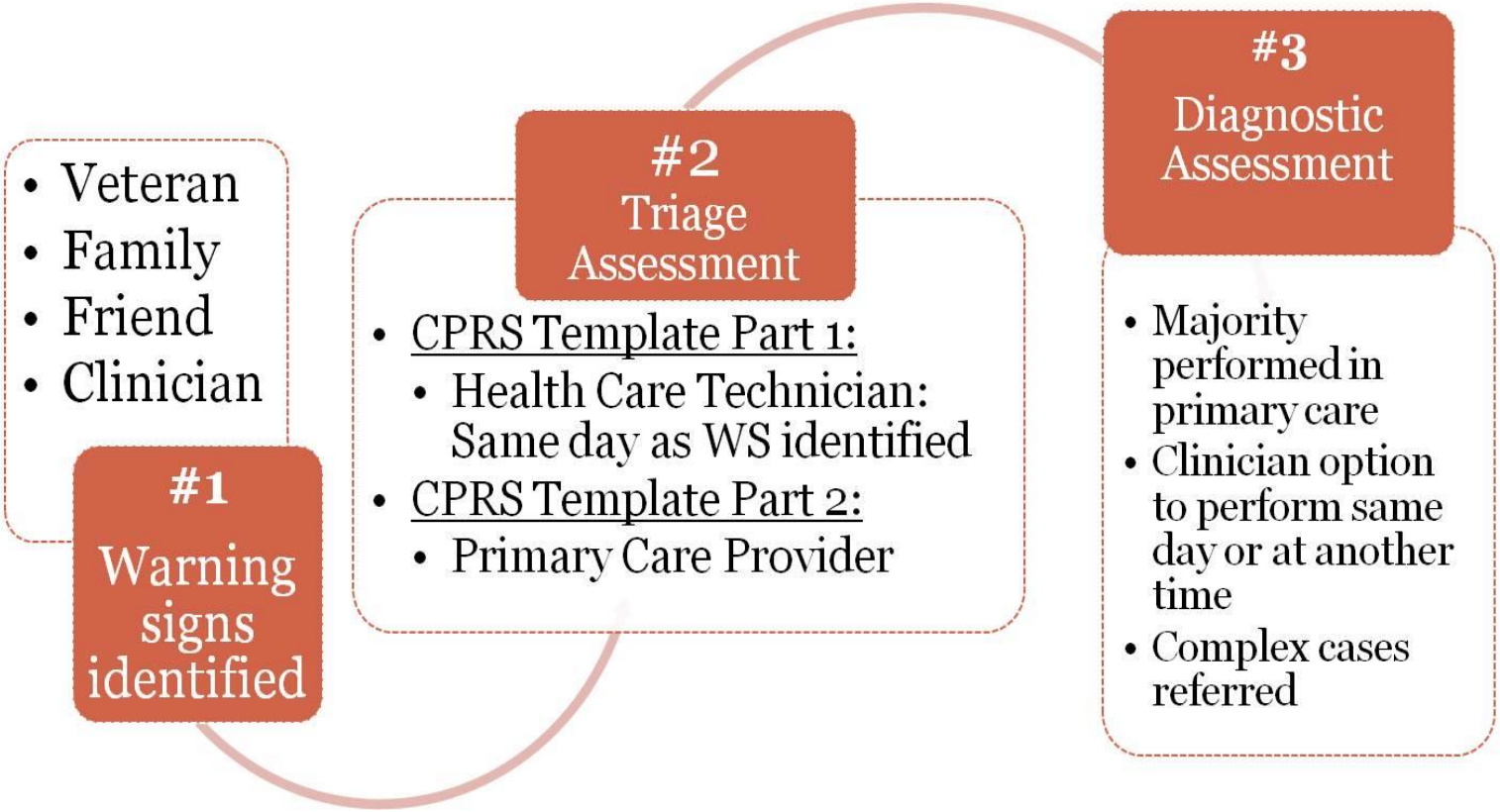
- Staff education slides
- Waiting room posters
- Warning Signs tear sheets
- FAQs

Dementia Warning Signs

- Asking the same questions over and over again
- Becoming lost in places previously well known
- Inability to follow directions
- Confusion over time, people, and places
- Lack of self care – nutrition, bathing, unsafe behaviors

- NIH Alzheimer's Disease Education and Referral (ADEAR) Center

Step #1
Identify the Dementia Warning Signs



Watch, Ask, Be Aware

- If you see a Patient displaying a warning sign, ask him/her or a family member about warning sign behaviors
- Use resources to educate clinic staff and post reminders in the clinic

Dementia Warning Sign Tools

- Training materials for front-line staff
- Posters and tear sheets that list warning signs
- Electronic note templates
- FAQs

Clinician Fact Sheet

Detection of Dementia

Your patients rely on you for accurate, up-to-date, preventive health information. This fact sheet for clinicians provides information about detection of **symptomatic** dementia:

- There is insufficient evidence to recommend for or against routine screening for dementia among **asymptomatic** individuals, regardless of age[1].
  - Screening means routinely and proactively administering a test or tool to all individuals, including asymptomatic patients, for the purpose of detecting dementia.
- Use of "Dementia Warning Signs" is recommended to prompt provider evaluation of cognition. Dementia Warning Signs are a set of 'red flags' or signs/symptoms that a clinician, a caregiver, or a patient may notice.

Why is detection of symptomatic dementia important?

Dementia is a prevalent, under-recognized problem among older adults affecting between 3% and 11% of individuals older than age 65[2] and about 14% of those age 71 and older[3]. Diagnosis is often not made until later in the disease.

Potential benefits of more timely diagnosis may include:

- Access to treatments that may control symptoms.
- Interventions to reduce caregiver burden.
- Increased opportunity to engage interested patients in advance care planning.

Use Dementia Warning Signs!

Using dementia warning signs mean that:

- Clinicians, Veterans and caregivers attend to 'red flags' that signal a diagnostic evaluation is needed.
- Staff perform a diagnostic evaluation if any warning signs emerge in the course of providing clinical care.

Dementia Warning Signs that clinicians may notice[4]

Is your patient...

- Inattentive to appearance or unkempt, inappropriately dressed for weather or disheveled?
- A "poor historian" or forgetful?

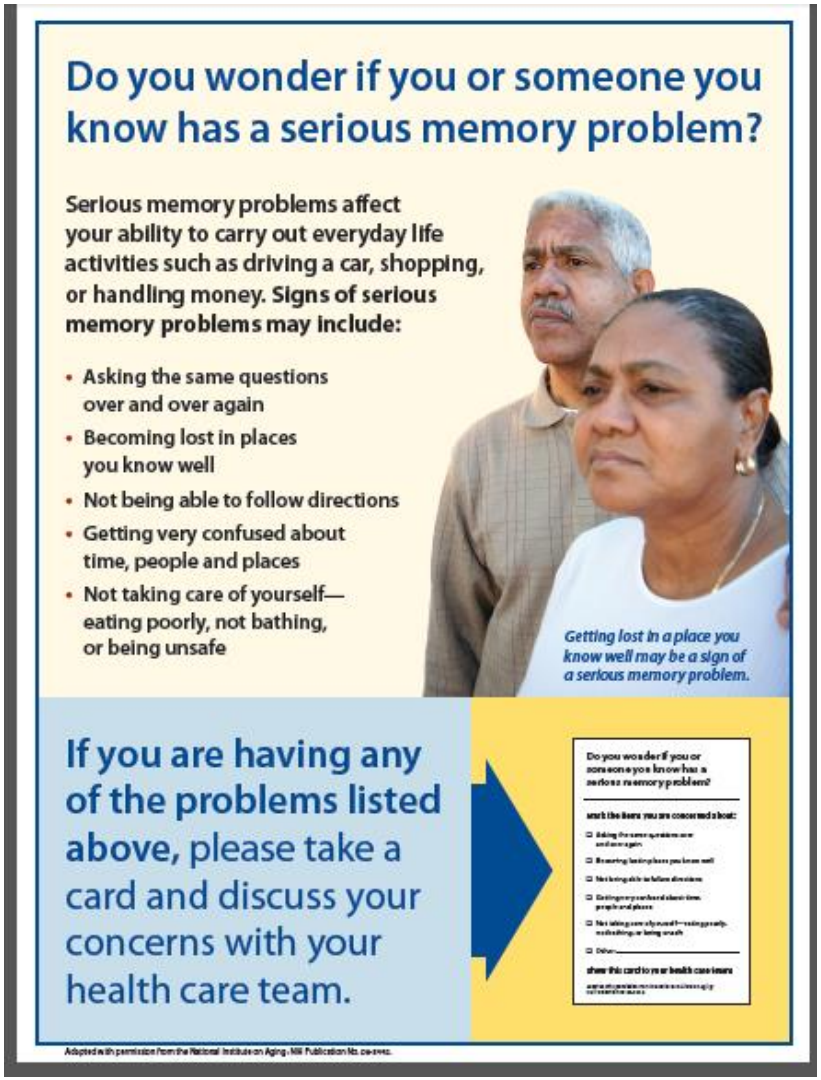
Does your patient...

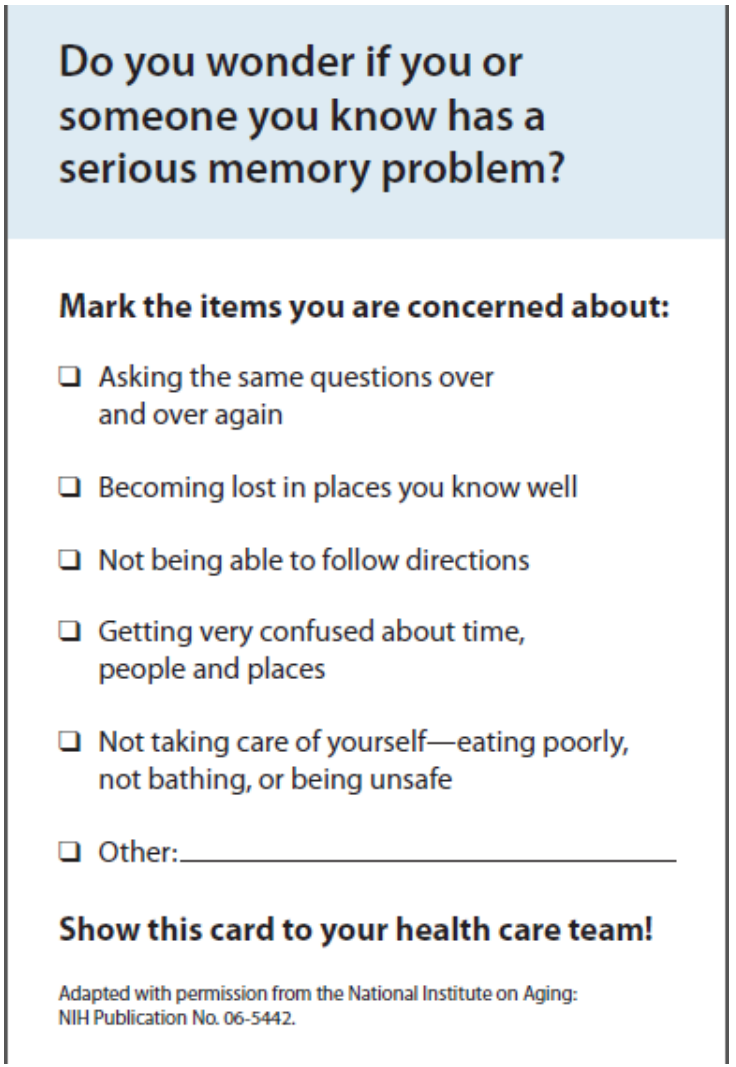
- Fail to keep appointments, or appear on the wrong day or wrong time for an appointment?
- Have unexplained weight loss, "failure to thrive" or vague symptoms e.g., dizziness, weakness?
- Repeatedly and apparently unintentionally fail to follow directions e.g., not following through with medication changes?
- Defer to a caregiver or family member to answer questions?

Dementia Warning Signs that patients and caregivers may report[5]

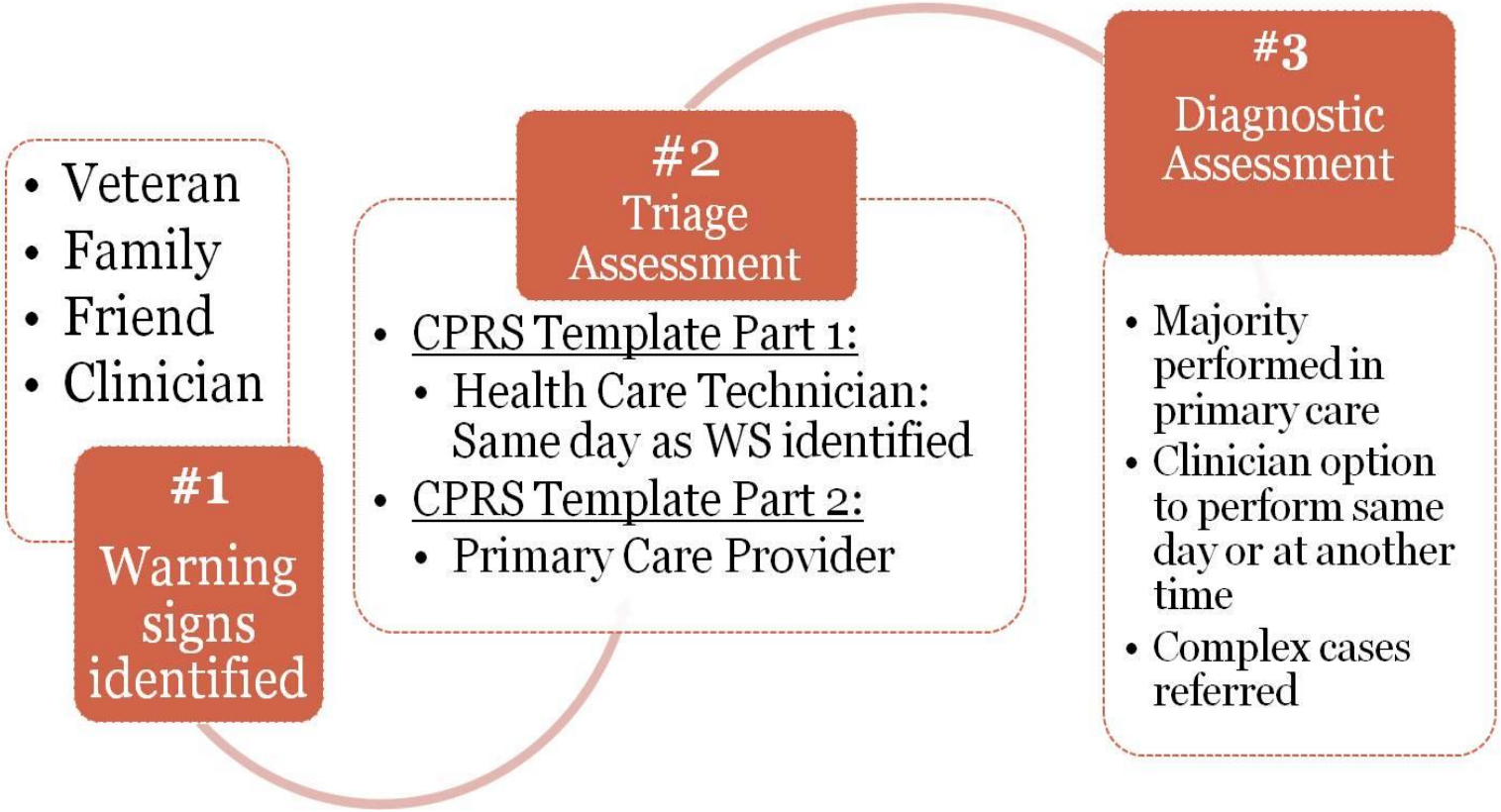
- Asking the same questions over and over again.
- Becoming lost in familiar places.
- Not being able to follow directions.
- Getting very confused about time, people and places.
- Problems with self-care, nutrition, bathing or safety.

Dementia Warning Signs Posters and Tear Sheets





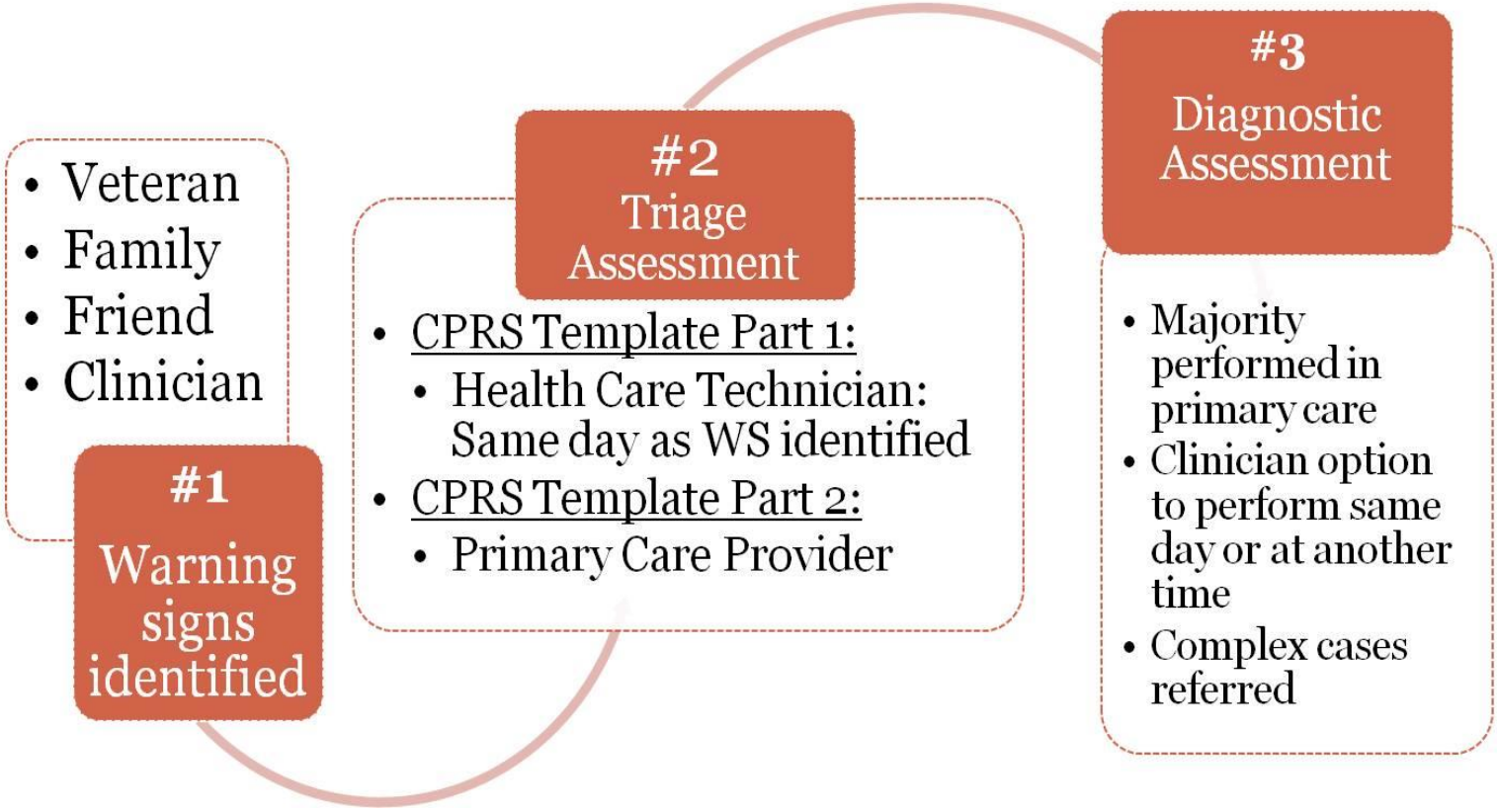
Step #2
Conduct and Document Warning Sign Triage Assessment



Triage Assessment

- Which warning signs are present?
- What is the time course?
- Are they affecting daily activities?
- Are there safety issues?
- Help provider prioritize actions
  - No further action
  - Defer to problem focused evaluation
  - Urgent assessment

Step #3
Conduct and Document Diagnostic Assessment (if necessary)



Outline of Recommended Evaluation - History

- Onset and time course of cognitive symptoms
- Impact on activities and social interactions
- Behavioral problems
- Past medical history including vascular risk, delirium, head trauma, vision & hearing, psychiatric disorders
- Medication review

Outline of Recommended Evaluation - History

- Family history of dementia or cognitive impairment
- Social History including support, education level, drug and alcohol use, driving and firearms
- Functional status assessment examples:
  - Katz
  - Lawton

Outline of Recommended Evaluation – Physical Exam

- Mental Status including mood, behavior and objective evaluation of cognitive function
- Neurological
- Cardiovascular
- Functional capabilities
  - Vision, hearing

Outline of Recommended Evaluation - Laboratory

- CBC
- Thyroid & Liver function
- Metabolic Panel
- Vitamin B12
- Urine Analysis
- HIV* (with verbal consent documented)

Special Diagnostic Testing

- When indicated by history and exam findings
  - Syphilis
  - Heavy metals or toxin exposures
  - Methylmalonic Acid
  - Endocrine disorders
  - Targeted rheumatologic tests for vasculitis
  - Lumbar puncture and CSF analysis

Outline of Recommended Evaluation - Imaging

- Imaging is indicated when cognitive decline develops suddenly or is associated with focal neurological deficits that cannot be explained by known, preexisting pathology

- Highly recommended: When investigating or establishing the suspected diagnosis of dementia for at-risk patients: VA providers should obtain a CT or MRI if one has not been obtained within the past two years

Outline of Recommended Evaluation Brief Cognitive Instruments

- BOMC – Blessed Orientation, Memory and Concentration
- GPCOG – General Practitioner Assessment of Cognition
- Mini-Cog
- MMSE – Folstein Mini Mental State Exam
- MoCA – Montreal Cognitive Assessment
- SLUMS – St. Louis University Mental Status
- STMS – Short Test of Mental Status

DSM-5 criteria for neuro-cognitive disorder

- Evidence of significant decline in one or more cognitive domains, preferably documented by a standardized instrument
- The cognitive deficits interfere with independence in everyday activities
- The cognitive deficits do not occur exclusively in the context of a delirium
- The cognitive deficits are not better explained by another mental disorder

Feedback on Pilot Tests of DWS in Primary Care Clinics

- Earlier detection without intrusive testing
- Earlier engagement dementia care management
- Clinicians more likely to note warning signs than Veterans or family caregivers
- CPRS template helpful in structuring evaluation
- No reports unnecessary evaluations

DWS in Primary Care Clinics: Lessons Learned

- Volume was not overwhelming
  - 0-2 cases per week
- Majority identified by clinic staff rather than Veteran or family caregiver report

DWS in Primary Care Clinics: Lessons Learned

- Impact on workflow is small
  - Time to learn template, to address new problem
  - Engaging non-provider staff leads to smoother workflow
  - Small number required specialty referral
  - No complaints of unnecessary evaluations

Summary

- Warning signs prompt further assessment
  - Warning signs are NOT diagnostic of dementia
  - Brief Cognitive Instruments NOT diagnostic
  - History, physical exam and labs
- Team-based care for optimal outcomes
  - Patient and family education
  - Care coordination over time, settings, providers
  - Support for Veteran and caregiver
  - Medications in accordance with guidelines