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

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

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>66.05%</td>
</tr>
<tr>
<td>Lack of access to specialist</td>
<td>30.86%</td>
</tr>
<tr>
<td>Lack of training</td>
<td>29.01%</td>
</tr>
<tr>
<td>Lack of staff</td>
<td>27.78%</td>
</tr>
<tr>
<td>Patient resistance</td>
<td>25.31%</td>
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<tr>
<td>Competing protocols</td>
<td>25.31%</td>
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<tr>
<td>Unaware of screening tool</td>
<td>24.69%</td>
</tr>
<tr>
<td>Lack of relevance</td>
<td>7.41%</td>
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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)

- 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%

Excludes “Does not apply”  Answered: 175  Skipped: 72
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%
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

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

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
Copyright 2005.
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

#1 Warning signs identified
- Veteran
- Family
- Friend
- Clinician

#2 Triage Assessment
- CPRS Template Part 1:
  - Health Care Technician: Same day as WS identified
- CPRS Template Part 2:
  - Primary Care Provider

#3 Diagnostic Assessment
- Majority performed in primary care
- Clinician option to perform same day or at another time
- Complex cases referred
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
Do you wonder if you or someone you know has a serious memory problem?

Serious memory problems affect your ability to carry out everyday life activities such as driving a car, shopping, or handling money. Signs of serious memory problems may include:

- Asking the same questions over and over again
- Becoming lost in places you know well
- Not being able to follow directions
- Getting very confused about time, people, and places
- Not taking care of yourself—eating poorly, not bathing, or being unsafe

If you are having any of the problems listed above, please take a card and discuss your concerns with your health care team.

Do you wonder if you or someone you know has a serious memory problem?

Mark the items you are concerned about:

- Asking the same questions over and over again
- Becoming lost in places you know well
- Not being able to follow directions
- Getting very confused about time, people, and places
- Not taking care of yourself—eating poorly, not bathing, or being unsafe
- Other: ________________

Show this card to your health care team!

Adapted with permission from the National Institute on Aging: NIH Publication No. 06-5442.
Step #2
Conduct and Document Warning Sign Triage Assessment

#1 Warning signs identified
- Veteran
- Family
- Friend
- Clinician

#2 Triage Assessment
- CPRS Template Part 1:
  - Health Care Technician: Same day as WS identified
- CPRS Template Part 2:
  - Primary Care Provider

#3 Diagnostic Assessment
- Majority performed in primary care
- Clinician option to perform same day or at another time
- Complex cases referred
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)

#1 Warning signs identified
- Veteran
- Family
- Friend
- Clinician

#2 Triage Assessment
- CPRS Template Part 1:
  - Health Care Technician: Same day as WS identified
- CPRS Template Part 2:
  - Primary Care Provider

#3 Diagnostic Assessment
- Majority performed in primary care
- Clinician option to perform same day or at another time
- Complex cases referred
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