Geriatric-Competent Care: Caring for Individuals with Alzheimer's Disease
Presentation and Diagnosis of Alzheimer's Disease

If you would like to receive CME/CE credits for this event, please complete and submit the pre-test questions on the right-hand side of your screen. You will also be required to complete a post-test and evaluation – this will appear in a new browser when the event ends.

To connect to the audio portion of this event, you may use the call-back prompt on your screen, or dial (763)957-6300 and enter access code: 647 921 599#

Closed captioning for this event is available by following the link in the Q&A tab on the right-hand side of your screen.

If you are experiencing any technical difficulties with this platform, please use the Q&A feature on the right-hand side of your screen, or email RIC@Lewin.com.

Geriatric-Competent Care: Caring for Individuals with Alzheimer's Disease

Presentation and Diagnosis of Alzheimer's Disease



Overview

- This is the first session of a two-part series, "Geriatric-Competent Care: Caring for Individuals with Alzheimer's Disease."
- Each session will include 60 minutes of presenter-led discussion, followed by a 30 minutes questions and answer session.
- Video replay and slide presentations are available after each session at: www.resourcesforintegratedcare.com

Presentation and Diagnosis of Alzheimer's Disease

Developed by:

- The American Geriatrics Society
- Community Catalyst
- The Lewin Group

Hosted by:

The Medicare-Medicaid Coordination Office (MMCO)
Resources for Integrated Care

Continuing Education Information

- **Accreditation:**

The American Geriatrics Society is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

- **Continuing Medical Education (CME):**

The American Geriatrics Society designates this live educational activity for a maximum of 1 AMA PRA Category 1 Credit™.

- **Continuing Education Credit for Social Workers:**

The National Association of Social Workers (NASW) designates this webinar for a maximum of 1 Continuing Education (CE) credit.

Support Statement

This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) to ensure beneficiaries enrolled in Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated, coordinated care to Medicare-Medicaid enrollees, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar series.

To learn more about current efforts and resources, visit Resources for Integrated Care at: **www.resourcesforintegratedcare.com**

Carol Regan, Senior Advisor, Center for Consumer Engagement in Health Innovation at Community Catalyst

CENTER FOR CONSUMER ENGAGEMENT in health innovation
A better way to better health. For everyone.

Webinar Planning Committee and Faculty Disclosures

The following webinar planning committee members and webinar faculty have returned disclosure forms indicating that they (and/or their spouses/partners) have no affiliation with, or financial interest in, any commercial interest that may have direct interest in the subject matter of their presentation(s):

Planning Committee:

- Gregg Warshaw, MD
- Nancy Wilson, MSW

Faculty:

- Christopher Callahan, MD
- Elizabeth Galik, PhD, CRNP
- Irene Moore, MSW, LISW-S

Introductions

- **Chris Callahan, MD,** Professor, Department of Medicine, Indiana University; Director of Indiana University Center for Aging Research
- **Elizabeth Galik, PhD, CRNP**, Associate Professor, School of Nursing, University of Maryland; Robert Wood Johnson Nurse Faculty Scholar
- **Irene Moore, MSW, LISW-S, AGSF**, Professor Emerita of Family and Community Medicine, University of Cincinnati College of Medicine

Webinar Outline/Agenda

- Case Example
- Background and Presentation of Alzheimer's Disease
- Assessment and Diagnosis of Dementia: How it Can Help
- Communication of Alzheimer's Disease Diagnosis and Caregiving Concerns
- Resources
- Q&A
- Evaluation

Webinar Learning Objectives

Upon completion of this webinar, participants will be able to:

- Identify at least three major causes of progressive dementias in older adults.
- Demonstrate knowledge of at least one tool used to assess cognitive functioning.
- Outline some key elements of a social assessment that may inform a comprehensive evaluation of dementia.

Background and Presentation of Alzheimer's Disease

Chris Callahan, MD

Case Study

Case Study

- 70 year old man is brought by his daughter to see his primary care provider.
- The patient has no complaints and feels that he is well.
- His daughter is concerned because he is forgetting to take his medications and he recently damaged his car when he was attempting to pull into his garage.

Case Study

- Gradual, progressive decline in short term memory and functioning over the past year (help with taxes, bills, forgetting appointments)

- Physical exam and mental status exam are normal except decreased insight and judgment into his cognitive deficits and MMSE = 22

Case Study

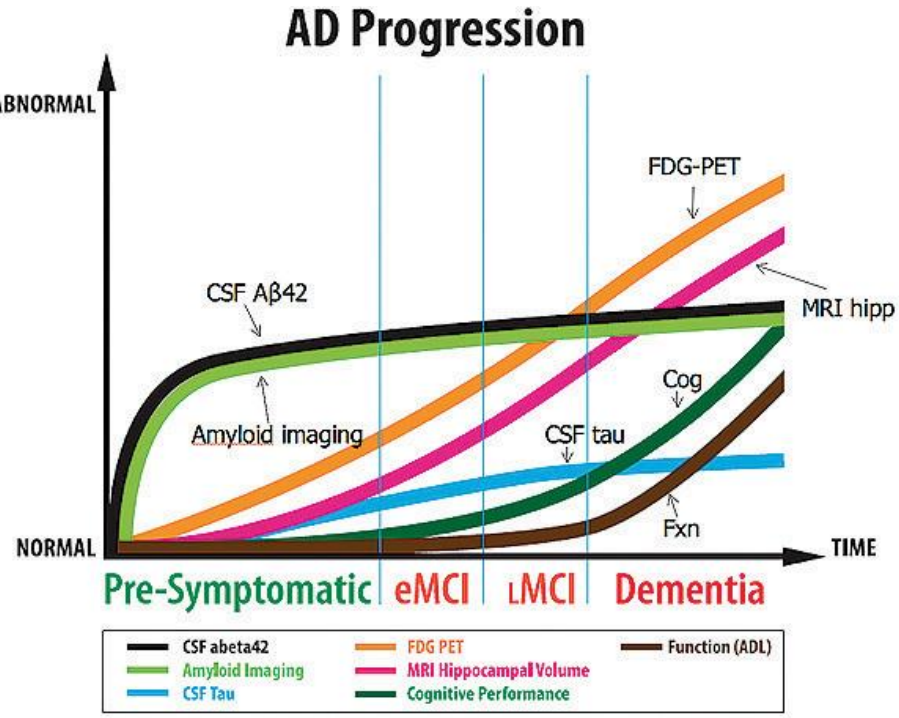
- What do you think is wrong with the patient?
- Is further testing required?
- What guidance would you give the patient and family?

Background - Definitions

- Dementia is a decline in memory, language, problem-solving, and other cognitive skills that affects a person's ability to perform everyday activities
- Clinically, we sometimes summarize dementia as "a decline in cognitive function from a prior level of functioning severe enough to impair social functioning"
- Dementia is caused by cell death in the brain. Neurons stop functioning and die
- Alzheimer's Disease (AD) is the most common form of dementia

Background - New Concepts

- Dementia develops insidiously over several decades - pathology begins before symptoms
- Persons pass through stages of mild impairment to end-stage disease
- AD is most common but most people have mixed pathology or subtypes



Background – Main Subtypes

- **Alzheimer's disease**: typically presents with prominent short term memory loss
- **Vascular dementia**: language impairment, executive dysfunction, vascular risk factors
- **Lewy Body dementia**: hallucinations, visuospatial impairment, motor impairment (Parkinsonian)
- **Frontotemporal dementia**: change in personality, embarrassing, or inappropriate social interactions

These are early traits that overlap - in late stages very difficult to distinguish subtypes

Mild Cognitive Impairment

Subjective memory complaints without functional impairment

"The differentiation of dementia from MCI rests on the determination of whether or not there is significant interference in the ability to function at work or in usual daily activities. This is inherently a clinical judgment made by a skilled clinician on the basis of the individual circumstances of the patient and the description of daily affairs of the patient obtained from the patient and from a knowledgeable informant"

From : McKhann et al. Alzheimer and Dementia 2011; see also Albert et al. 2011

Risk Factors

- Age is far and away the greatest risk factor
  - Persons over the age of 75 account for 80% of all cases of dementia
  - About 1/3 of persons over the age of 80 have dementia

- Other risk factors include:
  - Low educational attainment
  - Family history of dementia
  - Cardiovascular comorbidity

- About 60% of people with AD are women

Background – Clinical Epidemiology

- About 5 million people already live with dementia and 15 million people will live with dementia in 2050; many more have MCI
- Worldwide, dementia is one of the leading causes of disability and health care costs
- Most persons with dementia will die within about 5 years; about 1 in 3 older adults who die have been diagnosed with dementia
- US costs estimated at $226 billion

Background – Barriers to Care in Primary Care Settings

- Most patients with dementia also have several other chronic conditions as well as multiple medications
- Primary care not well-designed or funded to identify and care for persons with dementia
- Best practice care requires practice redesign

Background – Barriers to Care in Primary Care Settings

- The typical primary care physician cares for a panel of ~2000 patients
- About 300 (15%) of these patients are older adults
- Among these 300 older adults, half will have three or more chronic medical conditions
- Primary care providers need ~10 hours per day to deliver recommended care for chronic conditions and ~7 hours per day to provide preventive services
- 20-30 patients in the entire panel will have dementia – this means that only a fraction of the entire panel has dementia/AD
- Multiple patient, provider, and system barriers to best practices care for dementia

Background – Principles of Care

- Care is a journey that unfolds over 5-10 years with changing needs and goals of care over time
- A family caregiver is the fundamental foundation of longitudinal care for persons with AD
- Care for persons with AD is centered around the caregiver and care recipient dyad
- Primary care should be re-organized around a team approach to care
- Care begins with an accurate diagnosis and disclosing the diagnosis to the patient

Practice Redesign in Practice

- Screening of older adults who do not have symptoms is not recommended by the US Preventive Services Task Force
- "Case finding" refers to testing of older adults who do have symptoms that could be due to cognitive impairment- case finding is done with "cognitive screening tools"
- One redesign example is to organize a program of case finding, diagnosis, care, and possible referral around the Medicare Wellness visit

One Example of Practice Redesign

- Use the Medicare Wellness visit as an opportunity for case finding
- Choose one case finding instrument that your practice will use consistently (e.g. Mini-Cog, but many others are available)
- For patients who appear to have cognitive impairment:
  - Develop a protocol for further evaluation or a plan for referral. **Case finding instruments are not diagnostic**
  - Understand what is available in your community for education, referral, caregiver support, and services
  - Remember the importance of ongoing care for chronic conditions

Cordell et al *Alzheimers Dement* 2013; See Borson et al Alzheimers Dement 2013

Resources

- Boustani M et al. Implementing a screening and diagnosis program for dementia in primary care. Journal of General Internal Medicine. Jul 2005;20(7):572-577.
- Iliffe et al. Primary care and dementia: diagnosis, screening, and disclosure. Int J Geriatr Psychiatry 2009; 24: 895–901
- Simmons et al. Evaluation of suspected dementia. Am Fam Physician. 2011;84(8):895-902
- McKhann GM et al. The diagnosis of dementia due to Alzheimer's disease. Alzheimer's & dementia 2011.
- Cordell CB et al. Medicare Detection of Cognitive Impairment Workgroup. Alzheimer's Association recommendations for operationalizing the detection of cognitive impairment during the Medicare annual wellness visit in a primary care setting. Alzheimers Dement. 2013;9(2):141–150.
- Geldmacher DS et al. Practical diagnosis and management of dementia due to Alzheimer's disease in the primary care setting: an evidence-based approach. Prim Care Companion CNS Disord. 2013;15
- Callahan CM et al. Redesigning systems of care for older adults with Alzheimer's disease. Health Affairs. 2014.
- 2015 Alzheimer's Disease Facts and Figures (available at www.alz.org)

Assessment and Diagnosis of Dementia: How It Can Help

Elizabeth Galik, PhD, CRNP

It Helps to Identify Potentially Treatable Conditions

- Depression
- Substance abuse
- Vitamin B12 deficiency
- Hypothyroidism
- Normal Pressure Hydrocephalus
- Tumor
- Delirium as mimic of dementia
  - Medication side effects
  - Dehydration
  - Infection
  - Hypoxia
  - Acute exacerbation of chronic illness

Depression, Dementia, Delirium

Characteristic	Depression	Dementia	Delirium
Onset	Gradual	Gradual	Sudden
Course	Gradual worsening	Gradual decline	Fluctuating
Attention	Intact but slowed	Intact	Disrupted
Functional decline	Can do, but slow	Present	Abrupt decline
Lethargy	Typical	Apathy, but not sleepy	Typical fluctuations in sleepiness and agitation
Psychotic symptoms	Rare, only when severe; mood congruent delusions	25% typically in moderate stages	Hallucinations are most common

Components of Diagnostic Assessment

- Patient History
- Physical Examination
- Functional Assessment
- Mental Status Examination with Cognitive Assessment
- Additional Diagnostic Testing

Patient History

- Description and nature of the symptoms (cognitive, functional, behavioral)
- Onset and progression of symptoms
- Family history of dementia (age of onset, symptoms, progression)
- Patient interview
- Importance of a reliable informant interview

Patient History

- Medical history and medications
  - Any recent changes in medical history or medications?
  - Particular attention to anticholinergics, narcotics, psychotropics, any medication that acts on the central nervous system
  - Any recent falls or trauma?
- Substance use history
- Personal history and social support
  - Education, occupation, hobbies/interests, sources of social support

Strategies For Success When Gathering the History

- Review medical records in advance when possible
- Obtain some preliminary history from caregiver prior to the appointment (telephone, paper, or computerized history gathering)
- Team approach or mutual activities so that patient and caregiver are involved in the assessment process simultaneously

Warning signs of AD when assessing the patient

- Confused about appointment date or location
- Cannot remember recent events or conversations
- Defers to caregiver to answer questions
- Inappropriate dressing or poor hygiene

Physical Examination

- Careful physical examination to identify acute medical problem(s)

- Particular attention to neurologic and musculoskeletal exam
  - Gait and balance
  - Strength and reflexes (any weakness or asymmetry?)

Functional Assessment

- Incorporated as part of the history taking from a reliable informant
- Focus on self care, instrumental activities of daily living, mobility, and actual performance
- Standardized Rating Scales (examples: Barthel Index, Lawton, Get Up and Go)

The Mental Status Exam

- Includes several basic components that are essential in diagnosing Alzheimer's disease, delirium, or other syndromes.

- Several factors may influence performance:
  - educational level
  - primary language
  - impaired hearing
  - poor baseline intellectual function

Components of a Mental Status Exam

- Level of consciousness
- Appearance and behavior
- Speech and language
- Mood
- Thought content and process
- Insight and judgment
- Cognition

Components of the Mental Status Exam

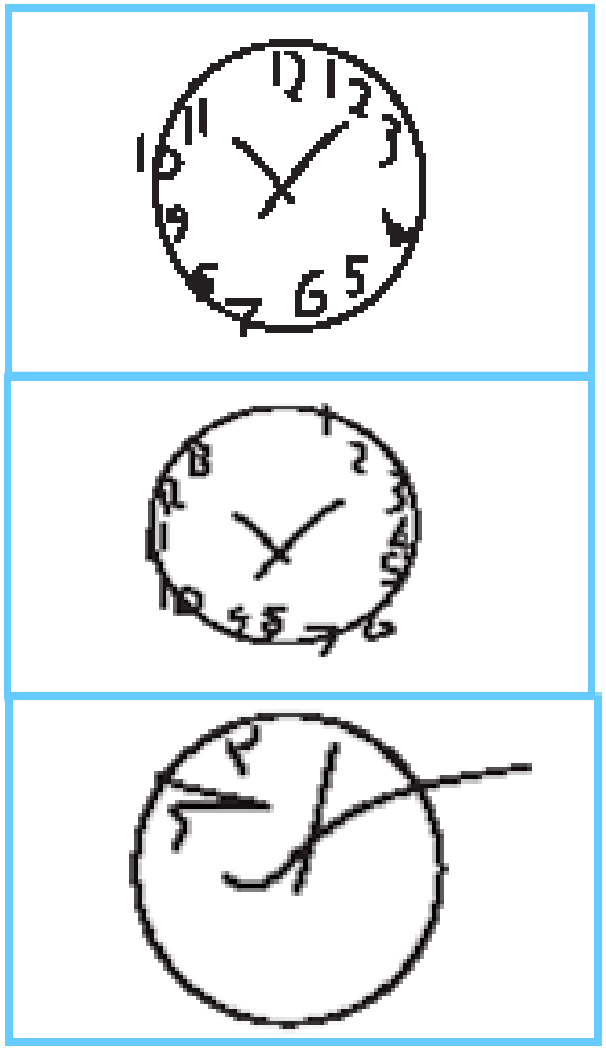
- Level of Consciousness
  - Awake and alert, lethargic, fluctuating, hyper vigilant?
- Appearance and behavior
  - Dress, grooming, motor behavior
- Speech and language
  - Spontaneous, hesitation, word finding difficulty, rate, rhythm and volume
- Mood
  - Vital sense, feelings of guilt or self-deprecation, outlook on the future, anhedonia
- Thought content and process
  - Delusions, hallucinations, bizarre thoughts?
- Cognition

The Cognitive Exam

- Memory (immediate recall, delayed recall, remote memory)
- Orientation (person, place, time)
- Verbal fluency (animals, grocery items, “s” words)
- Visuospatial abilities (intersecting pentagons, drawing a cube, clock drawing)
- Insight & judgment (level of awareness of deficits, problem solving)
- Executive function (serial 7s, 3s, verbal trails)

Rapid Cognitive Screening: Mini-Cog

- Three item recall
- Clock Drawing Test
  - "Draw the face of a clock and place the hands at 11:10."
- Assesses short term memory, executive function and visual spatial skills
- 3 minutes to administer



Cognitive Assessment Tools

- **Mini-Cog**
http://www.hospitalmedicine.org/geriresource/toolbox/mini_cog.htm

- **Montreal Cognitive Assessment**
http://www.mocatest.org/

- **Saint Louis University Mental Status Examination (SLUMS)**
http://aging.slu.edu/index.php?page=saint-louis-university-mental-status-slums-exam

- **Memory Impairment Screen (MIS)**
http://www.alz.org/documents_custom/mis.pdf

- **Mini Mental Status Exam**:
widely used in the past, but now proprietary

Diagnostic Testing

- Laboratory studies: CMP, CBC, TSH, Vitamin B12, Folate,
  - Depending on history and risk factors, also consider RPR, HIV screen, sedimentation rate/CEA for inflammation, U/A and culture

- Brain imaging (CT versus MRI)…stroke, tumor, bleed

Future Biomarkers for AD

- Beta-amyloid measured in cerebrospinal fluid
- Tau protein measured in cerebrospinal fluid
- Neural thread protein/AD7C-NTP in CSF and urine
- Advanced neuroimaging (PET: glucose metabolism, beta-amyloid imaging)
- Show promise, but not 100% sensitive or specific, costly, invasive, and exposes the patient to risk

Communication of Alzheimer's Disease Diagnosis and Caregiving Concerns

Irene Moore, MSW, LISW-S, AGSF

Alzheimer's Disease: Communicating the Diagnosis

- Use open ended statements…
- "With all of the medical appointments, TV news, written information, and being the expert on your relative, I wonder if you had to give a diagnosis, what it would be?"
- Have a conversation, avoid excessive questioning

Alzheimer's Disease: Communicating the Diagnosis

- Keep focus on patient and caregiver
- Explain the importance of understanding the diagnosis
- Develop realistic plan
- Establish transparency
- Prepare caregiver for fragmentation of care/ exposure to multiple providers

Alzheimer's Disease: Communicating the Diagnosis

- Allow caregiver control to make decisions and meet patient's needs
- Support caregiver coping skills
- Support caregiver's advocacy for patient
- Remember: Caregiver is a crucial, constant source of history across time and health care settings

Alzheimer's Disease: Communicating the Diagnosis

Talking to the patient with Alzheimer's disease

- Obtain patient's self-perceived abilities
- Ask, what would be of *real* help?
- Does the patient know the reason for the assessment?
- Discussing the diagnosis

Support for Caregivers

Who are the AD Caregivers?

- **Spouses** – the largest group. Most are older with their own health problems
- **Daughters** – the second largest group. Called the "sandwich generation," many are married and raising children of their own
- **Grandchildren** – may become major helpers

- **Daughters-in-law** – the third largest group
- **Sons** – often focus on the financial, legal, and business aspects of caregiving
- **Brothers and Sisters** – many are older with their own health problems
- **Other** – friends, neighbors, members of the faith community

Care Manager and Alzheimer's Disease

- Ethical responsibility to advocate for patient
- Start where patient and caregiver are
- Make patient-specific interventions
- For each patient some help can always be given despite the inevitable
- Communicate very clearly that caregiver may be contacted to set up services by many callers

Care Manager and Alzheimer's Disease

- Care manager will be the *point person*: proactive in setting up services
- Reassure that you are the contact person for further questions
- Ensure services are dignified
- Objectively look at the caregiver and patient actual situation - will services be acceptable?

Special Considerations When Working with Families/Caregivers

- Ethnic diversity
- Health literacy
- Previous relationship between caregiver and patient

Ethnic Diversity

- Ethnic diversity may inhibit caregiver comfort to ask for clarification
- Transitions of care to include cultural expectations
- Sensitive to culture, spokesperson for family may not be primary caregiver

Health Literacy

- May not ask questions in order to keep their lack of understanding private
- With limited health literacy, the more confusing choices are for caregivers
- Patient and caregiver will need help navigating the system
- Do not use jargon
- Written educational materials must be 4th grade reading level

Previous Relationship between Caregiver and Patient

- Explore life-long relationships between caregiver and patient
- Previous coping with trauma - direct predictor for dealing with Alzheimer's disease diagnosis
- Ask about past family history of Alzheimer's disease or late life memory problems

Assisting with Caregiver Response to Diagnosis of Alzheimer's disease

- Recognize fear
- Acknowledge this is new unexpected information for family
- Understanding Alzheimer's disease can assist with coping/response – especially, slow course
- Caregivers need clear guidance to assist with *their* situation

Assisting with Caregiver Response to Diagnosis of Alzheimer's disease

- Provide timely services and accurate resource information
- Anticipate caregiver's need to relinquish previous roles
- Assist caregiver in maintaining control of life and personal environment

Resources

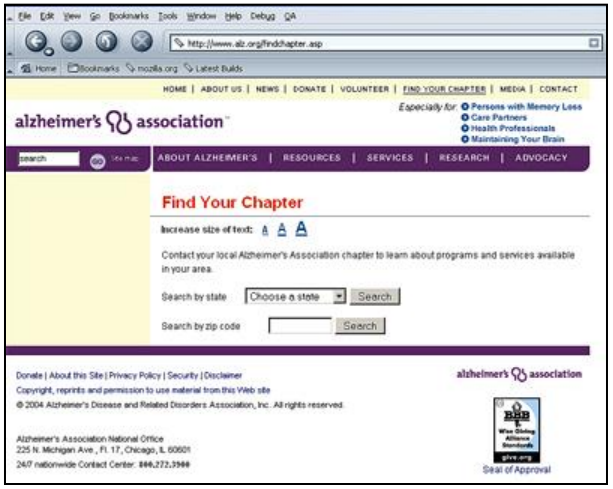
National Support for Caregivers

Alzheimer's Association

Local chapters provide referrals to area resources and services, and sponsor the Safe Return Program, support groups, and educational programs:

1-800-272-3900

www.alz.org



Eldercare Locator

Nationwide service of the Federal Government helps caregivers locate local support and resources:

1-800-677-1116

www.eldercare.gov

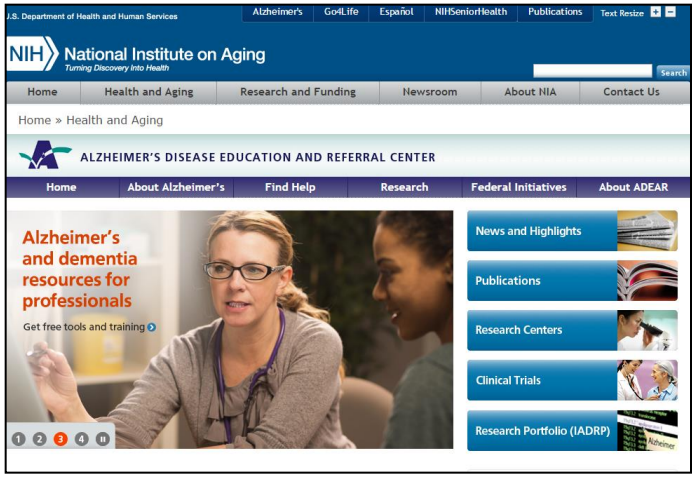
Alzheimer's Disease Resources

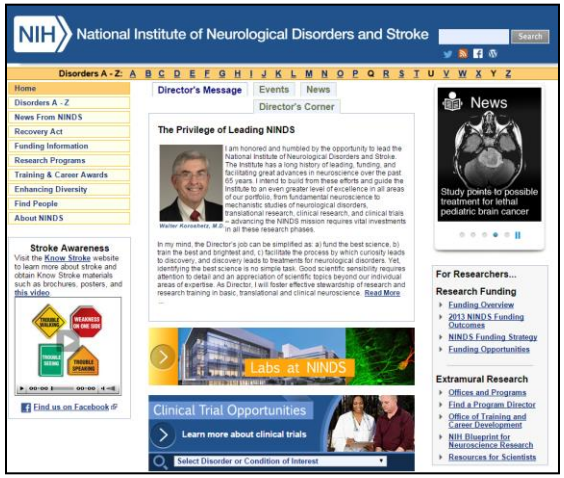
Alzheimer's Disease Education and Referral Center (ADEAR)

ADEAR is a current, comprehensive, unbiased source of information about Alzheimer's disease with a staff of Information Specialists available for consultation.

1-800-438-4380

https://www.nia.nih.gov/alzheimers





National Institute of Neurological Disorders and Stroke (NINDS)

NINDS conducts and supports research on brain and nervous system disorders.

1-800- 352-9424

http://www.ninds.nih.gov/

Questions

More Resources!

- The next webinar in this series will be presented on June 30th:

After The Diagnosis Of Alzheimer's Disease: Preparing The Patient And Caregivers

- For more information and to register for this and other webinars, please visit: www.ResourcesForIntegratedCare.com

- The **Geriatric Services Capacity Assessment** was developed to help health plans and health systems, including community providers, hospitals, and other health care delivery organizations, evaluate their current ability to meet the needs of older adults and to identify strategic opportunities for improvement. Please visit www.ResourcesForIntegratedCare.com to download this tool.

Evaluation Form and Post-test

Thank you for joining our webinar.

If you are applying for CME/CE credit you must complete the evaluation as well as the post-test - this will appear in a new browser window when the WebEx platform is closed.

- The post test must be completed by 2pm EDT in order to receive CME or CE credit.
- The evaluation must be completed by 5pm EDT in order to receive CME or CE credit.

If you have any questions, please email RIC@Lewin.com.