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Early Recognition of Dementia Webinar

January 26, 2010
12:00 pm – 1:30 pm

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General Information

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Faculty disclosures

The following faculty has indicated their financial interests and/or relationships with commercial manufacturers as follows:

Sanford Auerbach, MD has participated on the speaker's bureau for Forest Pharmaceuticals.

Juergen H. A. Bludau, MD is a co-founder of the Galaxy Institute.

Activity planners of today's webinar have nothing to disclose.

All potential relevant conflicts of interest have been resolved.

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Faculty introductions

Moderator



Sanford Auerbach, MD
Director, Behavioral Neurology
Boston Medical Center

Presenter



Juergen H. A. Bludau, MD
Director, Clinical Geriatric Service
Brigham & Women's Hospital

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Early recognition of dementia: A phase change in primary care practice

A webinar co-sponsored by the Massachusetts Medical Society & the Alzheimer's Association, Massachusetts/New Hampshire Chapter

Welcome & opening remarks

Sanford Auerbach, MD, Associate Professor of Neurology and Psychiatry; Director, Behavioral Neurology; Director, Sleep Disorders Center, Boston University Medical Center; Co-chair, Medical & Scientific Advisory Committee, Alzheimer's Association MA/NH Chapter

Presentation

Juergen H.A. Bludau, MD, Acting Clinical Chief and Director, Clinical Geriatric Service, Brigham and Women's Hospital and Faulkner Hospital; Co-chair, Medical & Scientific Advisory Committee, Alzheimer's Association MA/NH Chapter

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Learning goals

1. How a time-saving new care model can aid in early recognition, diagnosis and treatment of Alzheimer's disease (AD) and other dementia
2. How patient/caregiver referral services can enhance practice and care of dementia patients
3. Use of practical screening and diagnostic tools
4. Management of major safety risks

Our ultimate goal is a reduction in the burden on an overtaxed primary care system, with the parallel aim of addressing the social impact of the millions of people with or at risk for dementia now and in the very near future

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Primary care resources & opportunities



- Health Liaison Program
 - Links PCP to free expert patient/family support
 - Addresses psychosocial aspects of dementia
 - Complements the work of the PCP team
- Practice Circles Initiative
 - A proven practice change model
- Research opportunities
 - Directory of studies open to patients/care partners
- Webinar part II is coming
 - Recent advancements in imaging, current research and lifestyle risk factors

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AD & other dementia: Sobering statistics¹

- Age is the greatest risk factor and boomers are aging
 - Currently 5.3 million cases (of AD alone) in the U.S.
- Dementia costs U.S. economy over \$148 billion annually
 - It triples healthcare costs for Americans age 65+
- AD is closely associated with other common medical conditions such as diabetes and hypertension
- Vast majority live at home with care by family and friends
 - About 20% are living alone
- AD disproportionately affects some minority populations^{2,3,4}
- Up to 10% of those with dementia are age 65 or younger

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Common types of dementia¹

60-80% of all dementia is due to AD

Other causes (in order of prevalence):

- Vascular dementia
- Mixed dementia
- Dementia with Lewy bodies
- Parkinson's disease
- Frontotemporal dementia
- Creutzfeldt-Jakob disease
- Normal pressure hydrocephalus

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Phase change

The term “phase change” simply recognizes that new and efficient models of care are necessary to meet the medical and therapeutic needs of a dementia population that will continue to expand dramatically well into the 21st century

- That primary care physicians will continue to assume the lion's share of medical care for these patients and families
- That dementia makes interaction with patients unreliable and may necessitate the need for a co-respondent
- That a complementary, “team” approach integrating medical treatment and community supports is a best practice public health model for primary dementia care

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Postmortem (1907): Auguste D



Cortical senile plaques, neurofibrillary tangles

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AD & other dementia: What *you* see

“Dementia is characterized by a complex interaction of cognitive, functional, behavioral and psychological symptoms that decrease the quality of life of both patient and the caregiver.”⁵

—Refer also to standardized clinical diagnostic criteria (*DSM-IV*)

- Subtle abnormalities present years before actual dx⁶
- MCI or early dementia vs. changes expected with aging
- Alzheimer's Association 10 Warning Signs

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Primary complaints about memory

- Frequent misplacing things
- Repeats questions
- Impaired new learning
- Impaired retrieval
- Rapid forgetting



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Language

- Word-finding
- Simplification
- Empty speech
- Word substitution (paraphasia)
- Comprehension deficit



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Frontal/executive system: The real impact

- Judgment
- Reasoning
- Logic
- Problem solving
- Organizational skills



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And a real problem

Although can now quite accurately diagnose AD and other dementia, with autopsy results supporting the clinical diagnosis in 86-90% of cases...⁷

...fewer than 35% of people with AD or other dementia have the diagnosis in their medical record.⁸

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Who in the medical community is most challenged by this problem?

Most older adults receive their health care “solely” from a primary care physician⁹

More than 80% of all medical care for dementia occurs in primary care settings^{10,11}

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The ways this problem challenges primary care: A baker's dozen

- Time constraints
- Reimbursement constraints
- Skepticism about effectiveness of medications
- No regular screening used
- Structured nature of PCP interview
 - Yes/no answers

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...challenges (cont.)

- Time consuming diagnosis
(By means of careful history-taking from patient/
caregiver with no one specific, universal complaint)
- No user-friendly guidelines available
(Guidelines from 1990s not updated^{12,13,14} or have
focused on treatment more than on diagnosis¹⁵)
- No clear cut physical exam signs
- No current specific lab or imaging test

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...challenges (cont.)



- Dementia diagnosis opens “Pandora’s box”
- Difficulties in communicating with patient and
caregiver^{16,17}
- Depression may also delay early recognition
- Lack of knowledge about available community
support services
 - Lack of central referral clearinghouse for community
resources¹⁸ such as Alzheimer’s Association 24-hour 800 line

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In the face of these challenges, what do our patients want us to know?

From people with AD or other
dementia:¹⁹

“Talk to me directly.”

“Test early.”

“Coordinate with other care providers.”

“Give me the tools for living with this disease.”



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What do our patients' care partners want us to know?

Four major problem areas most
often mentioned:²⁰

- Symptom management
- Medication management
- Support service linkage
- Emotional support for themselves



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And what is the #1 concern we share with our patients and their care partners?

- ✓ The difficulty in locating and accessing appropriate community services¹⁶

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Addressing these concerns:
Timely diagnosis & referral

Timely diagnosis and referral for dementia are critical because there are medical and psychosocial interventions for your patients and their families that can mitigate issues not normally addressed in primary care settings.

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Why else we need to take the time

- Dementia patients are at high risk for delirium at the time of hospitalization^{21,22}
- These patients suffer significant functional decline associated with acute hospital care²⁵
- They also suffer from medication side-effects and psychiatric complications^{22,23}
- Behavioral interventions for caregivers—education, emotional support—can delay costly institutionalization by 18 months²⁴
- “Treatment delayed is treatment denied.”

(Christine Bryden, dementia patient, *Remarks*, Annual Meeting, Alzheimer’s Disease International, 2001)

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Why take the time (cont.)

- 30-40% of patients with dementia experience treatable stress, depression, psychosis or agitation^{26,27}
- At least 30% of caregivers will experience treatable clinical depression²⁸



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How does the traditional primary care model address—or not address—the problems and concerns highlighted here?

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Traditional care model

Structured interview with yes/no questions

- Primary care physician *may* wait for patient or caregiver to mention a memory problem
- PCP *may* question patient or caregiver about a possible memory problem
- Patient or caregiver *may* initiate the discussion
- PCP *may* then start work-up or refers patient to neurology, psychiatry, or to memory centers
- Any combination (or none) of the above

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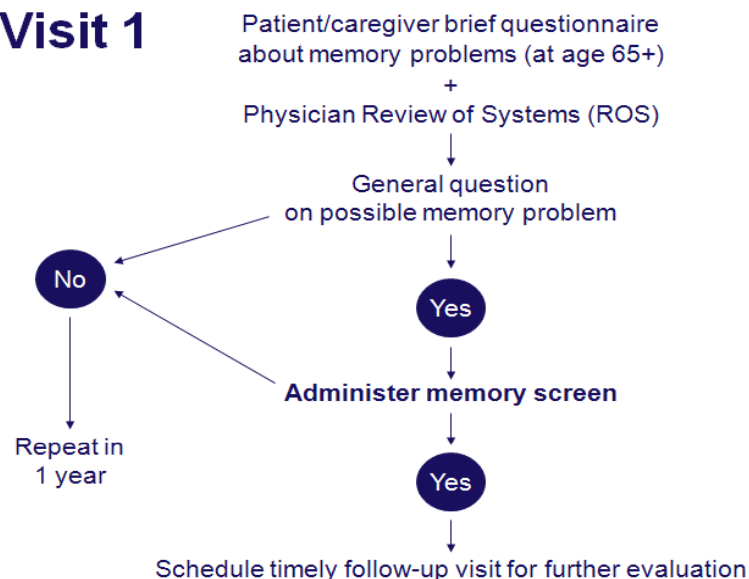
Cognitive surveillance model

- This model of care optimizes better recognition of memory problems, especially early on
- It is practical and doable in a busy PCP practice
- It is reimbursable
- Asking a simple question about recent changes in memory allows the patient to open up
 - Casual, conversational tone

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Visit 1



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Visit 1

Screening for cognitive deficits

"Clinicians should select 1 primary tool based on (1) the population receiving care; (2) an awareness of the effects of educational level, race, and age on scoring; and (3) consideration of adding 1 or 2 other tools for special situations as needed."²⁹

Brief tools recommended for primary care:^{30,31,32}

- Mini-Cog (Mini-Cognitive Assessment Instrument)
- MIS (Memory Impairment Screen)
- GPCOG (General Practitioner Assessment of Cognition)

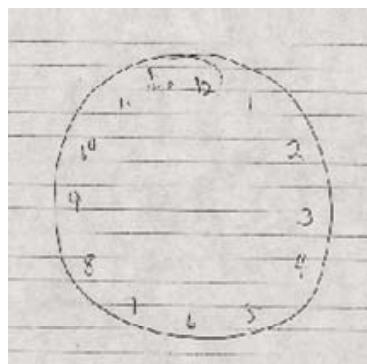
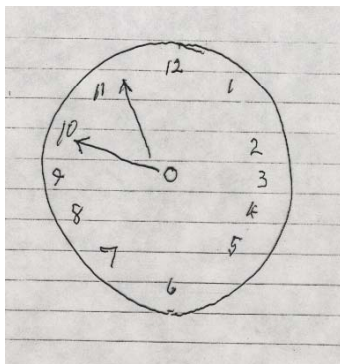
Staff can be trained to administer cognitive screens

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Visit 1

Clock drawing & 3 word recall



3 word recall: Patient is asked to remember 3 words after a delay; failure to recall >1 word after 2-minute delay warrants further screening

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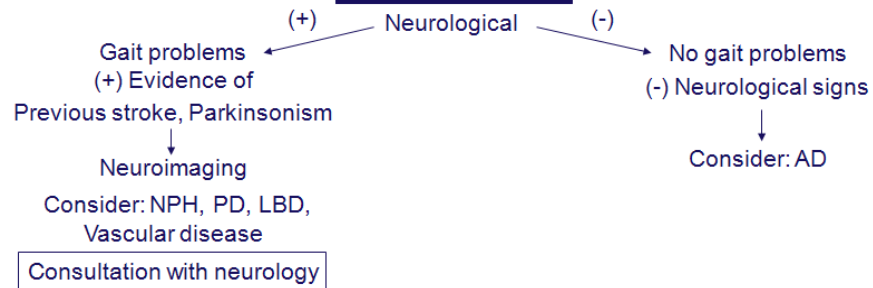
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Visit 2

History

1. How memory impacts IADLs/ADLs
2. Inquire about association with:
 - Gait and balance problems, falls
 - Urinary incontinence
 - Hallucinations
3. Medications review

Examination



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Visit 2

Follow-up: Neuroimaging

Typically recommended when:

- Young age
- Rapid onset
- Head trauma
- Neurological symptoms
- History of cancer or bleeding
- Gait disturbance

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Visit 2

Follow-up: Lab tests

Note that extensive investigation for potential reversibility is no longer justified^{33,34}

Recommended:

- CBC
- Serum electrolytes
- TSH
- Glucose
- B complex, folate

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Specialist referral: Key indications

- Inconclusive diagnosis
- Atypical presentation
- Behavioral/psychiatric symptoms
- Second opinion
- Family dispute
- Caregiver support



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Treatment planning

Develop an ongoing plan with defined goals

- Discuss with patient and family
- Consider cholinesterase inhibitors, NMDA antagonist, other meds if clinically indicated
- Refer to community services, including those offering legal/financial planning

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Pharmacologic treatments

MOA	Cholinesterase Inhibitors			NMDA-Receptor Antagonist
Drug	Donepezil	Galantamine	Rivastigmine	Memantine
Indication	Mild to moderate AD; severe AD	Mild to moderate AD	Mild to moderate AD	Moderate to severe AD
Initial dose	Tablet: 5 mg every day	Tablet/oral solution: 4 mg twice a day ER capsule: 8 mg every day	Capsule/oral solution: 1.5 mg twice a day Patch: 4.6 mg every day	Tablet/oral solution: 5 mg every day
Maximal dose	Tablet: 10 mg every day	Tablet/oral solution: 12 mg twice a day ER capsule: 24 mg every day	Capsule/oral solution: 6 mg twice a day Patch: 9.5 mg every day	Table/oral solution: 10 mg twice a day

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Treatment planning (cont.): Modify lifestyle risk factors



While current dementia medications are only modestly effective,³⁵ delaying decline is also possible through modification of lifestyle risk factors³⁶⁻⁴⁰

- Consider exercise, socialization, and nutrition



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Treatment planning (cont.): Behavioral, mood & sleep disorders

- First try non-pharmacologic approaches
 - Suggest modifying environment
 - Suggest simplifying tasks
 - Suggest structuring activities
- When non-pharmacologic approach doesn't work, try meds targeted to specific behaviors if clinically indicated. Note side effects.
- Treat co-morbid conditions

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Treatment planning (4): Integrate medical treatment & support

Referral to sources of education and support can mitigate problematic symptoms and reduce burden of family care.^{24,41}

Integrating Alzheimer's Association's care consultation with managed care health services decreases caregiver depression⁴¹

- Families learn to communicate with patient and structure the day with stage-appropriate activities
- Patients can benefit from community-based services (adult day programs, support groups, in-home services)
- Both may benefit from professional sources of psychological support

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Patient & public safety

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Wandering & becoming lost

"I do not leave the house by myself ... never. To not be able to create a map in your mind is so scary."

—Early-stage AD patient support group member

This behavior is:⁴²⁻⁴⁷

- Common (3 of 5 patients)
- Recurrent (3 of 4 patients)
- Life threatening (2 of 5 die after 24 hrs)
- Highly stressful for care partners

Management option:

- Refer to *MedicAlert®+Safe Return®* program at **888.572.8566**



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Driving

*"I can barely see,
I can barely hear, and
I can barely walk,
but at least
I can still drive."*

AD and other dementia significantly elevate crash risk⁴⁸

Ethical responsibility: "...where clear evidence of substantial driving impairment implies a strong threat to patient and public safety, and where the physician's advice to discontinue driving privileges is ignored, it is desirable and ethical to notify the Department of Motor Vehicles." (AMA Ethical Opinion E-2.24)

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Driving: Management Options

- Counsel patient/care partner about driving risks
 - Insert note in medical record
- For serious concerns notify RMV Medical Affairs Branch
 - Physician reporting is voluntary in MA
- Advise care partner to report serious impairment to RMV
- Refer to Alzheimer's Association for family consultation
- Refer for professional, medical, driver evaluation

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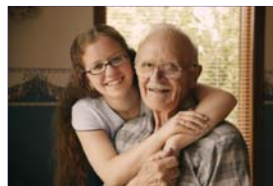
Additional safety concerns

- Medications management
- Elder abuse or neglect (mandated reporting)
- Household accidents (e.g. kitchen fire, power tools)
- Falls
- Financial exploitation, scams
- Misuse of firearms
- Safety of young children or others in patient's care

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Partnering with the Alzheimer's Association



24-hour Helpline

800-272-3900 (nationwide)

www.alz.org (nationwide)

www.alz.org/MANH (MA/NH Chapter)

Free patient/family care consultation, education & support

The Health Liaison Program—link your practice to our services

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Questions



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