UVM Project ECHO: Enhanced Diagnosis and Management of Dementia by the Primary Care Team
September 16, 2021

Course Co-Directors: Mary Val Palumbo, DNP, APRN, GNP-BC
John Steele Taylor, MD

ECHO Director: Elizabeth Cote

Series Faculty: Heather Zuk, OTR, CDRS, CDI
John Coffin MSW with Allegra Miller
Tiffany Smith, MA, CRTS, CDP
Lori McKenna, MSW, LICSW
Jackie Rogers, PhD
Zail S. Berry, MD, MPH
Doug Franzoni, PharmD, BCGP

Core Faculty: Michael Lamantia MD and Amelia Gennari MD
(UVM Geriatric Services)
• RECORDING OF SESSION TO BEGIN
Agenda

• Introductions
• Objectives
• Didactic Presentation (~20-30 min)
• Case presentation
  • Clarifying questions
  • Participants – then faculty panel
• Discussion
• Recommendations
• Summary
• Closing Announcements
  • Submission of new cases
  • Completion of evaluations
Series Objectives

Learning objectives for this ECHO series include being able to:

• Describe current standard of care for diagnosis, treatment, and care of patients with cognitive impairment, Alzheimer’s disease (AD), and dementias – evidence-based review and approaches.

• Name non-pharmacological resources for family caregivers including caregiver supports and assistance in management of caregiver stress.

• List pharmacologic approaches to sleep and behavioral issues.

• Discuss side effects of pharmacologic approaches to sleep and behavioral issues.

• Identify Vermont-specific rules regarding driving and guardianship.
CME Disclosures

University of Vermont (UVM) Office of Continuing Medical and Interprofessional Education (CMIE) is approved as a provider of Continuing Medical Education (CME) by the ACCME. UVM designates this internet live activity for a maximum of 1.5 AMA PRA Category 1 Credits. Participants should claim only the credit commensurate with the extent of their participation in the activity.

Interest Disclosures:

• As an organization accredited by the ACCME to sponsor continuing medical education activities, UVMCMIE is required to disclose any real or apparent conflicts of interest (COI) that any speakers may have related to the content of their presentations.
The Importance of Early Evaluation of Cognitive Complaints

John Steele Taylor MD

UVM Medical Center Memory Program: Medical Co-Director

Colchester, Vermont

John.Taylor@uvmhealth.org

I have no conflicts to disclose.
The Importance of Early Evaluation of Cognitive Complaints

Session Objectives:

1. Discuss common patient and practitioner biases that might lead to delayed or missed diagnosis of a neurocognitive disorder

2. Review the proposed benefits of early detection of cognitive decline and degenerative neuro-cognitive disorders

3. Outline the basic components of an office - based evaluation of cognitive complaints

4. Summarize potential next steps following an initial office based cognitive evaluation
Delayed or Missed Diagnosis

- High prevalence of Mild Cognitive Impairment and Dementia in the US population
  - Collectively estimated at around 29% for those >age 65

- PCP is often the first point of contact, but a high percentage of patients with cognitive symptoms are not initially screened or diagnosed in the PCP setting
  - Stands in contrast to much higher rates of routine screening for other chronic conditions

- Upwards of 50% of patients with dementia are ultimately not diagnosed or missed in the PCP setting
Reasons for Delayed or Missed Diagnosis

• Denial or lack of recognition by patient or caregiver

• Practitioner waiting for patient to raise concern; patient waiting for practitioner to ask

• Perceived or actual knowledge gap by practitioner

• Screening not performed due to perceived or actual lack of time or resources

• Erroneous perception that the cognitive changes are a feature of normal aging

• Discomfort with rendering a diagnosis

• Concern about consequences of misdiagnosing dementia

• Erroneous belief that consequences of avoiding/withholding a diagnosis are negligible or that patient does not want to know
The Importance of Early Screening and Timely Detection of Cognitive Impairment

1. Intervene early if reversible or exacerbating factor identified
2. Extended time window to manage medical comorbidities and initiate lifestyle changes
3. Timely initiation of cognitive enhancing pharmacologic agents
4. Patient involved in decision making while in milder stages of neuro-degenerative conditions
5. Appropriate screening for and management of behavioral and psychiatric manifestations of dementia
6. Patient and family education; caregiver empowerment
The Importance of Early Screening and Timely Detection of Cognitive Impairment

7. Patient and family initiation of medical, financial, legal, and end-of-life planning

8. Relief / sense of closure regarding previously concerning or mysterious symptoms

9. Evidence for delay in nursing home admission; prevention of unnecessary hospitalization

10. Evidence for a financial benefit both for the patient and for health care systems

11. Participation in clinical trials

12. Potential initiation of disease modifying therapies (in the future)
Components of the Cognitive Evaluation

1. Cognitive intake (to include collateral historian)
2. Cognitive screening and screening neurologic exam
3. Objective Tests
4. Follow up debrief and next steps
Components of the Cognitive Intake

• Informant / collateral historian should be present for interview

• Pre-morbid cognitive function established

• Onset of symptoms

• Earliest and most prominent symptom / domain of cognition affected

• Evolution of symptoms

• Domain specific intake

• Impact on daily function

See “Approach to the Patient with Cognitive Complaints Module” for further discussion
Components of the Cognitive Intake

**Patient Interview**
**Mode of Onset:** {mode of onset:33398}
**Memory**
Do you forget information over short periods of time? {YES / NO:27689}
Example: Repeating questions and/or stories, forgetting conversations
**Confusion/Disorientation**
Do you become confused in familiar settings? {YES / NO:27689}
{confusion/disorientation:33399}
Have you become lost? {YES / NO:27689}
{dementia lost:33400}
**Aphasia**
Do you have difficulties with expressive speech? {YES / NO:27689}
Example: using incorrect words, incomplete sentences, pauses in speech
{ev aphasia:33401}
**Apraxia**
Do you have difficulty using familiar objects? {YES / NO:27689}
Example: television remove, microwave, tools

**Informant Interview**
**Informant:** ***
**Interviewed by:** ***
**Date:** ***
**Mode of Onset:** {mode of onset:33398}
**Memory**
Is information forgotten over short periods of time? {YES / NO:27689}
Example: Repeating questions and/or stories, forgetting conversations
**Confusion/Disorientation**
Has the person seemed confused in familiar settings? {YES / NO:27689}
{confusion/disorientation:33399}
Has the person become lost? {YES / NO:27689}
{dementia lost:33400}
**Aphasia**
Are there difficulties in expressive language? {YES / NO:27689}
{ev aphasia:33401}
**Apraxia**
Is there difficulty using familiar objects? {YES / NO:27689}
Example: television remove, microwave, tools

**Personality Changes**
Have you noticed any changes in your personality? {YES / NO:27689}
{personality change:33402}

See “Approach to the Patient with Cognitive Complaints Module” for further discussion
Screening for Alternative Etiologies or Exacerbating Factors

• Depression
  • Short form Geriatric Depression Scale, or other familiar office-based screening tool

• Sleep disorder (such as obstructive sleep apnea)
  • Many formal and informal approaches to a brief intake

• Underlying systemic medical condition
  • Systems based ROS, screening labs

• Delirium or delayed neurocognitive recovery
  • Chart review for recent major hospitalization, critical illness, or major surgery

• Sensory impairment
  • Vision and hearing inquiry and screening

• Iatrogenic / medication-induced
  • Careful medication review for anticholinergics, antihistamines, narcotics, sedatives, “Z-medications”, medications on Beer’s criteria, etc

• Substance Induced
  • Many short instruments commonly in use

See “Approach to the Patient with Cognitive Complaints Module” for further discussion
Screen for Red Flags / Atypical Features

• Young Age
• Rapid Onset and Progression
• Accompanying Headaches
• Focal Neurological Deficits
• Early Alteration/Suppression of Level of Consciousness
• Seizures

Presence of a red flag might compel more expedited neuroimaging or ED evaluation. Also consider curbside consultation with on-call Neurologist or Memory Program Neurologist

See “Atypical Features and Red Flags Module” for further discussion
Objective Assessments

- Administer cognitive screening instrument
- Perform screening neurologic examination
- Obtain serum screening labs
- Obtain structural neuro-imaging

See “Approach to the Patient with Cognitive Complaints Module” for further discussion
Potential Next Steps

1. Evaluation reassuring
   - Establish baseline and interval re-assessment
   - Address risk factors for cognitive decline
   - Implement lifestyle factors for cognitive resilience

2. Alternative or exacerbating etiology identified
   - Initiate appropriate interventions to mitigate/resolve

3. Minor or Major Neurocognitive Disorder Identified
   - Characterize clinical phenotype
     - See module on the differential diagnosis of dementia
   - Render diagnosis
     - See modules on dementia ddx, rendering a diagnosis of dementia
   - Consider sub-specialist consult if atypical features
   - Additional possible steps/benefits (next slide)
The Importance of Early Screening and Timely Detection of Cognitive Impairment

1. Intervene early if reversible or exacerbating factor identified
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8. Relief / sense of closure regarding previously concerning or mysterious symptoms
9. Evidence for delay in nursing home admission; prevention of unnecessary hospitalization
10. Evidence for a financial benefit both for the patient and for health care systems
11. Participation in clinical trials
12. Potential initiation of disease modifying therapies (in the future)
Next Steps: Goals of Interventions
Modifiable Risk Factors and Prevention

- Minimise diabetes
- Treat hypertension
- Prevent head injury
- Stop smoking
- Reduce air pollution
- Reduce midlife obesity

- Maintain frequent exercise
- Reduce occurrence of depression
- Avoid excessive alcohol

- Treat hearing impairment
- Maintain frequent social contact
- Attain high level of education

Risk factors for dementia

An update to the Lancet Commission on Dementia prevention, intervention, and care presents a life-course model showing that 12 potentially modifiable risk factors account for around 40% of worldwide dementias.

- Less education (7%)
- Hearing loss (8%)
- Traumatic brain injury (3%)
- Alcohol >21 units per week (2%)
- Obesity (1%)
- Smoking (5%)
- Depression (4%)
- Social isolation (4%)
- Physical inactivity (2%)
- Air pollution (2%)
- Diabetes (1%)
- Potentially modifiable 40%
- Risk unknown 60%

Percentage reduction in dementia prevalence if this risk factor is eliminated.

Newly-identified risk factors.

Primary Prevention and Disease Modification

MIND Diet: What to Eat + What to Limit

**EAT**
- Greens
- Veggies
- Berries
- Nuts
- Olive oil
- Whole grains
- Fish
- Beans
- Poultry
- Red wine

**LIMIT**
- Butter
- Cheese
- Red meat
- Fried foods
- Sweets

THE FINGER TRIAL
- ACTIVE DIET
  - COGNITIVE TRAINING
  - PHYSICAL EXERCISE
- SOCIAL ACTIVITY
- VASCULAR AND METABOLIC MONITORING
References


Discussion and Q & A

Options:

• Put your clarifying question about the case into the chat.

• Use the raise your hand button and unmute when you are recognized, then ask your question

• Turn your camera on and wave your hand until recognized.
The discussion and materials included in this conference are confidential and privileged pursuant to 26VSA Section 1441-1443. This material is intended for use in improving patient care. It is privileged and strictly confidential and is to be used only for the evaluation and improvement of patient care.
Case Presentation Format

Case presentation from a participant (a real-world case, from the field)

Then

Clarifying questions about the case from group to case presenter

Then

Ideas, suggestions, recommendations from participants

Then

Ideas, suggestions, recommendations from ECHO faculty team

Then

Additional discussion, if any (All)

Then

Summary of case discussion

(course co-directors: Mary Val Palumbo, DNP, APRN, GNP-BC and John Steele Taylor MD)
• RECORDING TO BE STOPPED FOR CASE PRESENTATION
Questions and Discussion from the group....

Options:
• Put your clarifying question about the case into the chat OR
• Use the raise your hand button and unmute when you are recognized, then ask your question OR
• Turn your camera on and wave your hand until recognized.

Reminder:
Participant Questions First
Faculty Questions Next
Participant Recommendations Next
Faculty Recommendations Last
Prep for Next Session

Prior to each session, if you have specific questions for our faculty expert(s), please let us know and we will pass along ahead of time.

**SESSIONS ARE ON THURSDAYS FROM 7:30AM TO 9:00AM** (3rd Thursday of each month)

<table>
<thead>
<tr>
<th>DATES</th>
<th>SESSION</th>
<th>DIDACTIC TOPICS (in addition to case review)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep 16</td>
<td>TeleECHO Session 1</td>
<td>Importance of Early Evaluation of Cognitive Complaints (John Taylor, MD, UVMCC Memory Program Co-Director)</td>
</tr>
<tr>
<td>Oct 21</td>
<td>TeleECHO Session 2</td>
<td>Living Alone with Dementia – Challenges for PC teams (Mary Val Palumbo, DNP, APRN, GNP-BC, UVMCC Memory Program)</td>
</tr>
<tr>
<td>Nov 18</td>
<td>TeleECHO Session 3</td>
<td>Care Giver Supports &amp; Services (John Coffin, MSW; Allegra Miller, Family Caregiver)</td>
</tr>
<tr>
<td>Dec 16</td>
<td>TeleECHO Session 4</td>
<td>Dementia and Driving (Heather Zuk, OTR, CDMS, CDI, UVMCC Driver Rehab)</td>
</tr>
<tr>
<td>Jan 20</td>
<td>TeleECHO Session 5</td>
<td>Community Programming for People With Dementia and Care Partners (Tiffany Smith, MA, CRTS, CDP, Program Administrator State Unit on Aging)</td>
</tr>
<tr>
<td>Feb 17</td>
<td>TeleECHO Session 6</td>
<td>Non-pharmacological approaches to behavioral issues for caregivers (Lori McKenna, MSW, LICSW, UVMCC Memory Program)</td>
</tr>
<tr>
<td>Mar 17</td>
<td>TeleECHO Session 7</td>
<td>Legal Issues of Guardianship, Competency and Power of Attorney (Jackie Rogers, PhD, DAIL Public Guardian Program)</td>
</tr>
<tr>
<td>Apr 21</td>
<td>TeleECHO Session 8</td>
<td>End Of Life Planning and Palliative Care (Zail S. Berry, MD, MPH, UVMCC Geriatrics)</td>
</tr>
<tr>
<td>May 19</td>
<td>TeleECHO Session 9</td>
<td>Managing Behavioral Issues and Sleep – Pharmacological Approaches (Doug Franzoni, PharmD, BCGP, Meds To Beds Supervisor, UVMCC Outpatient Pharmacv. Geriatric Consultant Pharmacist)</td>
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</tbody>
</table>
Dementia Clinical Consults
45 min slots available
2nd and 4th Wednesdays
2-4 PM
Sign up at: https://www.signupgenius.com/go/5080B4AA5AACE2FA6FC1-corner

For Primary Care and other healthcare providers.

Or Email:
Mary.Palumbo@med.uvm.edu

Online Learning via Vermont Health Learn
(CMEs at your own pace)

Additional Resources for Dementia Education for Primary Care Teams

TRAINING OPPORTUNITY TO BECOME A FACILITATOR OF THE CARERS PROGRAM

• **Who:** Trainees must be social workers or mental health clinicians. Groups are facilitated by two clinicians and at least one should be licensed. (Licensed social workers/mental health clinicians may bill insurance when conducting these groups).

• **What:** To become a CARERS facilitator, one must successfully complete a 3.5 day training program.

• **When:** November 12-16. (full day, times TBA) November 17 (half day, time TBA)

• **Where:** November 12 (remote only); November 15-17: in-person at the University of Vermont College of Medicine.

• **Cost:** To achieve the goal of increasing dementia care for family caregivers in VT: full scholarships will be available ($3000) for a limited time. This will include on-going mentoring/supervision at select times during mentees first therapy groups.

• **Registration:** Please register by October 22, 2021.

• **Contact:** Lisa K. Lax, LICSW, EdD or Lori P. McKenna, LICSW

• (802) 847-1111  [Lisa.Lax@uvmhealth.org](mailto:Lisa.Lax@uvmhealth.org)  [Lori.McKenna@uvmhealth.org](mailto:Lori.McKenna@uvmhealth.org)
Conclusion

• Slides are posted at www.vtahec.org

• Volunteers to present cases (this is key to the Project ECHO model)
  • Please submit cases to Mary.Palumbo@med.uvm.edu

• Please complete evaluation survey after each session

• Once your completed evaluation is submitted, CE information will be emailed to you.

• Please contact us with any questions, concerns, or suggestions
  • Mary.Palumbo@med.uvm.edu
  • Elizabeth.Cote@uvm.edu