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Managing Chronic Conditions for Patients with Dementia in Primary Care

Moderator:

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Dementia Care Aware

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Financial Disclosures

The presenters have no financial disclosures.

Housekeeping

We will leave 10-15 minutes at the end of this session for Q&A. Throughout the webinar, you can put your questions into the Q&A/chat functions, and some may be answered in real time.

We will share instructions for claiming Continuing Education (CE) credit at the end of this webinar and via email within 48 hours.

You will receive the recording of this webinar via email within 48 hours

You can also access the webinar slides and recording from the Dementia Care Aware website and YouTube channel.

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Dementia Care Aware Program Offerings

Warmline:
1-800-933-1789
A provider support and consultation service that connects primary care teams with Dementia Care Aware experts

Trainings and Education:
- Online Trainings e.g., Cognitive Health Assessment training
- Monthly Webinars
- Podcasts

Interactive Case Conferences:
- UCLA and UCI ECHO (Extension for Community Healthcare Outcome) conferences

Practice Change Support:
- UCLA Alzheimer's and Dementia Care Program
- Alzheimer's Association Health Systems

Our Training

Welcome!

Welcome to the Dementia Care Aware (DCA) learning management system. This site provides access to the training modules for the DCA program. When you registered, you were automatically enrolled in the "*The Cognitive Health Assessment: The Basics*" course. Select Start in the "The Cognitive Health Assessment: The Basics" block below to begin.

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Screening for Dementia: The Cognitive Health Assessment (CHA)

Goal: Screen patients older than age 65 annually (who don't have a pre-existing diagnosis of dementia)

Part 1

Take a Brief Patient History

Part 2

Use Screening Tools

Part 3

Document Care Partner Information

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Sign Up for Upcoming Live CHA Trainings

- Dementia Care Aware offers the CHA training as **a free 1-hour live session** multiple times each month.
- Led by Dementia Care Aware partners at the Alzheimer's Association and UC, Irvine.
- Open for anyone who is interested.
- Eligible participants can claim **1 free CE/CME/MOC credi**t.

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Learning Objectives

1. Describe 2 challenges of managing chronic conditions in people living with dementia (PLWD)
2. Implement an effective medication management strategy in PLWD
3. Enhance collaboration with caregivers for patients with multimorbidity for better outcomes.

Introduction

Michael Goldrich, MD
Geriatrician, LifeLong Medical Care, Over 60 Health Center

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Associate Professor of Medicine, UCSF Division of Geriatrics

Anna Chodos, MD, MPH
Executive Director
Dementia Care Aware

Introduction

Multimorbidity (≥2 chronic diseases)

- Mid-life chronic conditions increase the risk of reporting cognitive decline and mid and later-life chronic conditions increase the risk of developing dementia later in life. (2, 3)

People living with dementia have multimorbidity

Many conditions increase the risk of dementia

- Approximately 80%+ of people age 75+ have 2+ chronic conditions. (1)
- The prevalence is increasing in patients who go to community health centers. (1)
- 1/5 people with dementia have 6+ chronic conditions. (4)

1. Quiñones AR, et al. doi:10.1001/jamanetworkopen.2023.7497
2. CDC: www.cdc.gov/aging/publications/chronic-diseases-brief.html
3. Ben Hassen C, et al. : BMJ 2022;376:e068005
4. Bunn et al., *Health Serv. Deliv. Res.* 4, 4080. doi: 10.3310/hsdr04080

The impact of multimorbidity on older adults

Multimorbidity is associated with a decline in function and quality of life.

Multimorbidity is associated with an increase in symptoms and mortality, as well as a higher risk of hospitalization and residency in a nursing home.

For Medicare beneficiaries: more chronic conditions -> higher health care costs.

Boyd C, Rtichie CS. "Chapter 15: Addressing multimorbidity", Current Diagnosis and Treatment: Geriatrics. 3rd Ed. 2021.

Managing Multimorbidity: Considerations in PLWD

General considerations

- Complexity of treatment regimens and overlap of complications from symptoms or side effects
- Increased communication needs with patients and caregivers
- Addressing patient-specific goals and preferences
- Time and reimbursement

Considerations in PLWD: Even harder!

- Complexity is higher when the person at the center of care struggles with self-management.
- PLWD have more vulnerability to adverse events and may not benefit as much from the standard care plan
- Communication becomes harder and more critical
- The prognosis and goals may be different
- Time is still a barrier!

Key questions you may be asking yourself

- Do standard guidelines for X condition apply to my patient?
- How do I prioritize the care plan when recommendations conflict?
- Is my patient at risk of more harm from treatment for X than a patient without dementia?
- What are the patient's goals for this condition given that they are living with dementia?

Limitations of current practice

Lack of evidence of what to do for people with multimorbidity.

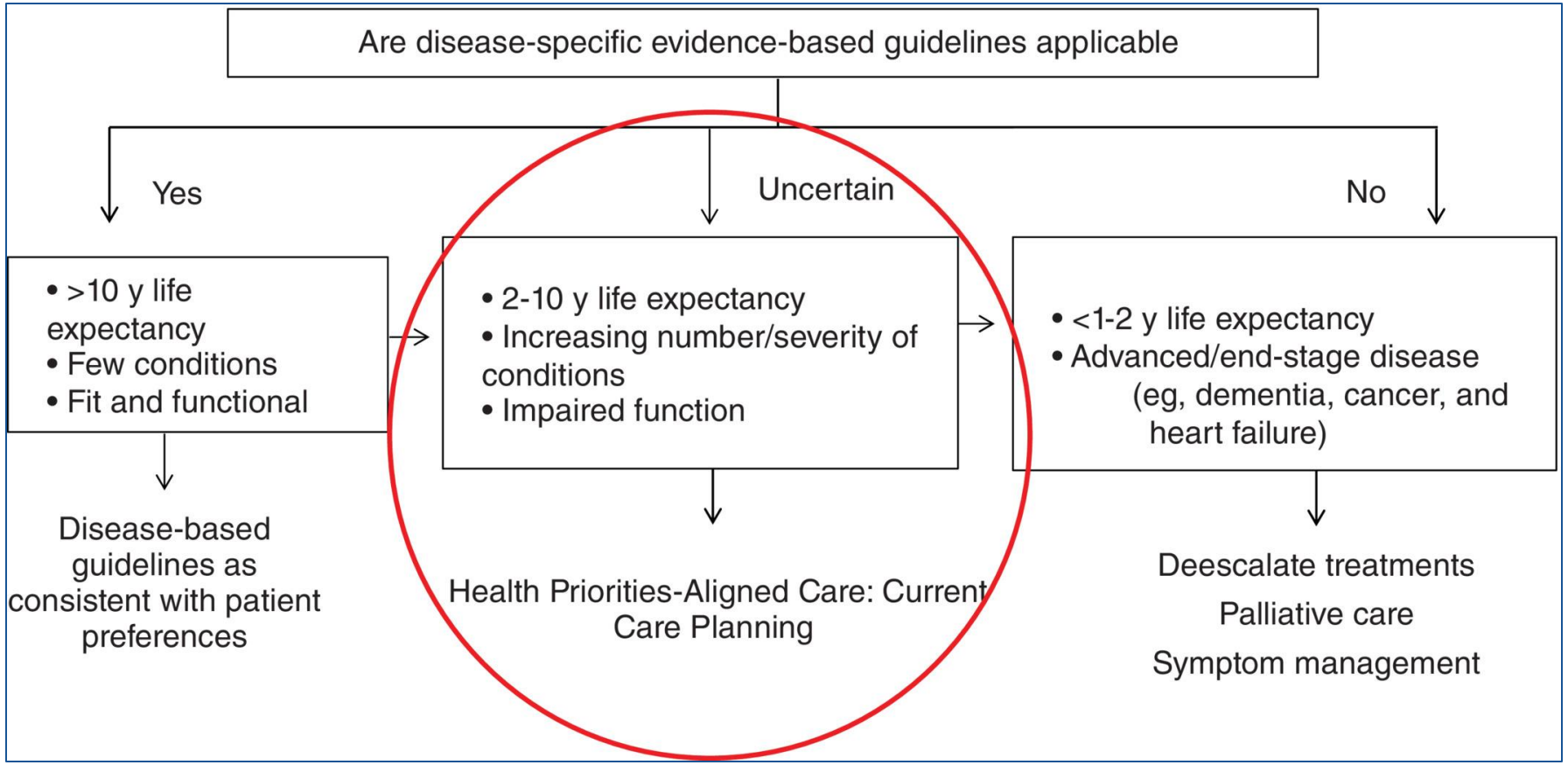
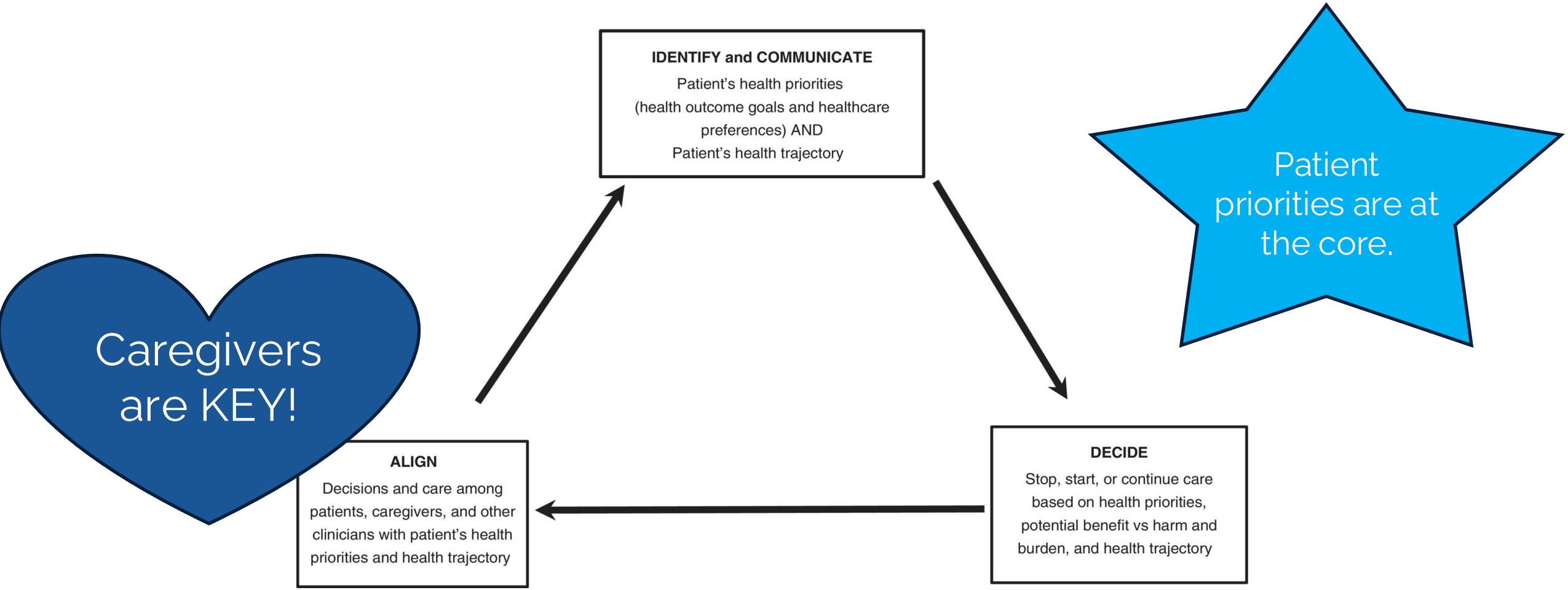


Figure from **J Am Geriatr Soc 67:665–673, 2019**

American Geriatrics Society framework

Patient priorities-aligned decision-making for older adults with multiple chronic conditions.



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Decision Making for Older Adults With Multiple Chronic Conditions: Executive Summary for the American Geriatrics Society Guiding Principles on the Care of Older Adults With Multimorbidity J Am Geriatr Soc 67:665–673, 2019

Let’s begin our discussion

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Case 1

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Case 1: Mr. Yang

Mr. Yang is an 86yo M who comes in for new patient appointment. His daughter-in-law is a nurse in a home health program and comes with him. He speaks Cantonese and Mandarin Chinese languages.

Last year he was diagnosed with dementia due to Alzheimer's disease, mild stage, after twice being hospitalized in the span of 2 months for hypoglycemia related to medication error. He accidentally dosed himself twice with mealtime insulin on both occasions.

He lives with his wife, who is very mobility-limited after a hip fracture 3 years ago and he sees his son and daughter-in-law three to four times a week. He is getting help from them for multiple IADLs, he is independent in ADLs.

His family switched to you because it's easier for them to bring him to your office for appointments. His prior PCP was far away.

You notice that conversation is difficult because of his prominent hearing loss.

Mr. Yang

Medical History

- Diabetes, last A1c 7.8 (9 months ago)
- Hypertension
- CKD stage 3a (Cre 1.8-2.0)
- Sensorineural Hearing Loss (moderate)
- Vision loss: central retinal artery occlusion (left) and diabetic retinopathy
- Dementia, likely due to Alzheimer's disease, mild stage

Medications

Sliding scale NPH twice a day (q12h) with meals

Empagliflozin 10mg daily

Amlodipine 10mg daily

Benazepril 40mg daily

Spironolactone 50mg daily

Aspirin 81mg daily

Atorvastatin 40mg at bedtime

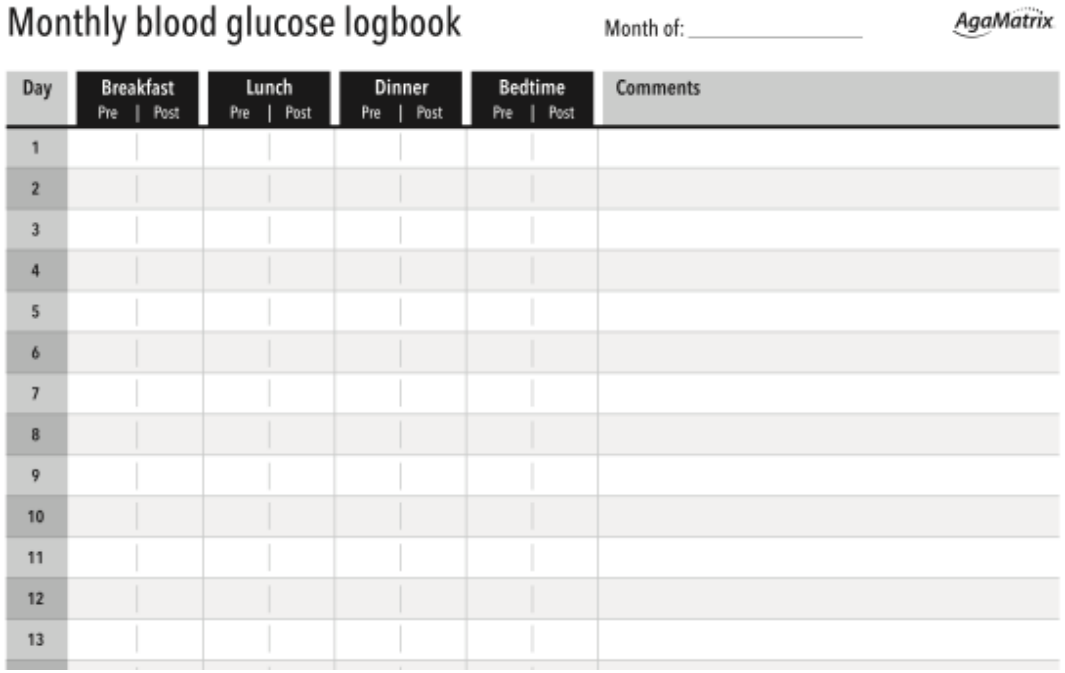
Vitamin D-3 1000 units daily

Mr. Yang: Data

- Blood pressure today: 164/79
  - *RN in clinic had calibrated his cuff because always high at visits*
- Blood pressure log in the last month:
  - Sys 110-130s
  - Dias 70s-80s

- Blood glucose log:
  - 117-190 in AM
  - 132-197 in PM, a couple readings of 300-310

  - Per prior PCP notes: “goal A1c 7-8”



Monthly blood glucose logbook

Month of: _____

AgaMatrix

Day	Breakfast Pre | Post	Lunch Pre | Post	Dinner Pre | Post	Bedtime Pre | Post	Comments
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

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Review: Identify and communicate patients' health priorities and health trajectory

Identify and communicate patients' health priorities

- Use a validated approach to identifying patients' health priorities
- Transmit patients' health priorities

Assess and communicate patients' health trajectory

- Estimate life expectancy, trajectory, and lag time (time horizon) to benefit
- Determine patients' readiness to discuss their trajectory or prognosis
- Assess patients' perceptions of their prognosis and trajectory

For our discussants, in this case:

How would you approach learning about **his preferences and priorities**?

Health Priorities Template:

Health Priorities Identification can be done by a facilitator (any member of the healthcare team) or self-directed by the patient. At the end of the process the patient should have a fil ed out Health Priorities Template to share with their health care team. This will be used to learn more about what matters most to the patient and guide decision-making.

I. What Matters Most (Values):

II. Most Important Health Outcome Goal: The specific activity you most want to do that is realistic and doable with your health care.

I want to (insert specific activity) _____

for/ in/ over (include time frame) _____.

If needed, revise health goal: _____

III. Current Bothersome Symptoms or Health Problems:

IV. Current Bothersome Health Care Tasks and Medications:

Task: Why Bothersome:

Helpful Health Care Tasks and Medications (if any):

V. The One Thing (Top Priority):

I most want to focus on (symptom, health problem, task, or medication) _____

_____ so that I can (insert health goal)

_____ more often or more easily.

patientprioritiescare.org/wp-content/uploads/2024/04/Health-Priorities-Template.pdf

Mr. Yang

- Priorities:

**Daughter-in-law helped because of hearing difficulty.*

- She says he is very social and COVID deeply affected his ability to be social. He now mostly keeps to himself but does 1 hour in a coffee shop with friends in the morning.
- The ability to see and remember meds is a big barrier, so right now, they are asking his wife to set up the syringe and then he can inject himself.
- Daughter-in-law is very concerned about his kidney failure and the risk of poorly controlled diabetes on CKD progression.

- He repeatedly says he's fine, and when asked what he enjoys most: going out to eat with family and friends. He wants to continue his daily walk and going out to eat.

Mr. Yang: the plan

- Given the danger of hypoglycemia:
- We discuss prioritizing a slightly higher A1c goal, in contrast to the daughter -in- law's hope that his insulin will increase to prevent him from getting too high.
- Discussed the fact there is not much evidence to suggest a slightly more liberal goal will injure his kidneys too much.
- Check A1c and agree to a follow-up appointment to review his DM regimen.

For our discussants, in this case:

How would you discuss matching his preferences to his plan, both with him and his daughter-in-law?

Case 2

Case 2: Ms. Lopez

Ms. Lopez is a 72-year-old woman with dementia with behavioral symptoms (irritability, paranoia), mild stage as she is independent in ADLs; she presents for follow-up with her son, Luis. She usually comes with Ana, her daughter, who lives with her and assists her with IADLs.

She is here to follow-up her chronic disease management.

She is tangential during the interview and seems suspicious of questions. She is hesitant to answer questions. Her son has no goals for the visit and states that most management changes can be coordinated with his sister when she is back.

Recent care activities:

- She is getting q6month mammograms for a finding in a screening exam in her left breast. The report states that findings "are almost certainly benign, but Q6month imaging is recommended for 3 years to show stability". The follow-up exams so far have shown benign findings.
- She attends regular visits with the help of her family.

Ms. Lopez

Medical History

- Diabetes, last A1c 6.0
- Hypertension
- Hyperlipidemia
- Metabolic-associated steatohepatitis (fibrosis stage 2)
- TBI 20 years ago with post-traumatic headache
- Gastritis, dyspepsia
- Depression (dx 2012)
- Osteoporosis
- Constipation
- B12 deficiency
- Dementia, mild stage

Medications

- Metformin 850mg BID
- Miralax PRN
- Lisinopril 5mg daily
- Metoprolol tartrate 25mg BID
- Nortriptyline 25mg at bedtime (pt states she takes 2 at night)
- Atorvastatin 80mg at bedtime
- Alendronate 70mg weekly (started 7/2024)
- Famotidine 40mg at bedtime
- Sertraline 50mg daily
- Vitamin B12 1000mcg daily

Review: Stop, start, or continue care based on health priorities, potential benefit vs. harm and burden, and health trajectory

Acknowledge uncertainty and variable health priorities in decision-making and communication

Stop or do not start medications for which harm or burden may outweigh benefit

- Stop medications deemed inappropriate in older adults
- Avoid medication cascades
- Perform serial trials if treatments may be contributing to bothersome symptoms
- Discontinue treatments no longer indicated or needed
- Review and adjust self-management tasks

Consider whether the patient has advanced illness or limited life expectancy that affects benefits and harms of treatments

- Consider health trajectory and time-to-benefit for preventive interventions
- Explain cessation of screening and prevention as a shift in priorities and use positive messaging

For our discussants, in this case:

How would you approach identifying which treatments she could consider stopping?
How do you weigh benefit vs. harm?

Consider her risk of dying from breast cancer

Breast Cancer Risk Assessment for Postmenopausal Women Age 55 or Older with Consideration of Competing Mortality Risks

Population: Postmenopausal women age 55 years and older (with no history of breast cancer or genetic mutations that increase their risk of breast cancer)

Outcomes: 5- and 10-year breast cancer risk, 10-year risk of non-breast cancer death, 10-year risk of breast cancer death

Scroll to the bottom for more detailed information.

Risk of breast cancer	
5 years	1.2%
10 years	2.2%
Risk of breast cancer death	
10 years	0.4%
Risk of death from other causes	
10 years	60.1%

Finish

Question: Is it worth pursuing her mammograms?

https://eprognosis.ucsf.edu/breastcancerrisk.php

Mrs. Lopez: targets for improvement

RISK OF:

Stopping nortriptyline: Risk of headache

Stopping metformin: may worsen MASH

2 antihypertensives: falls

Continuing mammograms: false positives and subsequent harms

BENEFIT OF:

Stopping nortriptyline: Eliminate risk of confusion, falls

Stopping metformin: A1c already low, less polypharmacy, vitamin b12 def may improve

2 antihypertensives: cardiovascular protection (includes brain)

Stopping mammograms: may have a missed cancer

For our discussants, in this case:

How do you help patients and caregivers with polypharmacy in dementia?

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Case 3

Case 3: Ms. Jefferson

88yo W, with dementia thought due to Alzheimer's disease, comes with her daughter, who lives in South Carolina but has come out because of her mother's behavior. She lives independently but needs more help with cleaning her home and managing her finances in the last year. Her son who lives nearby helps with those things.

In the last year, she has had repeated episodes of troubling delusions and hallucinations that have disrupted her life.

First, she was convinced that a neighbor's animal had brought fleas into the apartment building, and then those infested her room. She was very upset about that for a few weeks and then that tapered off and seemed to stop being a concern.

Now, she is increasingly anxious, worried, and distraught over her neighbors' behavior. She is convinced they kidnapped another neighbor. She can hear him crying for help at night. She has started accusing her neighbors of this and banging on their doors late at night to demand they free him.

Now that the daughter has been staying with her, she realizes how poorly she sleeps. She snores loudly and seems to vocalize all night. You were aware of some of these symptoms and ordered a sleep study months ago, but it has not been done yet.

Ms. Jefferson

Next steps in her care

- Ms. Jefferson sees the LCSW in your clinic and then is willing to connect with a mental health clinic focused on older adults later that day. In the next 2 weeks she is treated for her anxiety with frequent visits, buspirone, and a low-dose antipsychotic is started.
- 1 week after that, a sleep study is completed, and she is prescribed a CPAP machine for sleep apnea. She starts to improve markedly in terms of her anxiety. Her daughter starts to plan to go back to her job in South Carolina. She mentions that her house is "clean but cluttered" and she has noticed her mother almost fall a few times.
- You decide to re-address her sensory issues with her now that she is less bothered by her delusions.
  - You believe that the low vision and diminished hearing that she is dealing with may be contributing to her delusions and hallucinations. And it may be leading to her clutter (unwilling to change her environment). You point out that now it is even more important to try to address this.
  - She does not agree, and for years has declined referrals to low-vision specialists and occupational therapists. Or to an audiologist to getting hearing aids.
  - Her objections are that she knows her apartment where she has lived for 40+ years and she could hear her neighbors recently. Her hearing can't be that bad.

Ms. Jefferson

Medical History

- Hypertension
- Lower extremity venous insufficiency
- Macular degeneration with low vision
- SNHL
- Sleep apnea, severe, on CPAP
- Low back pain with sciatica
- Seasonal allergies
- Dementia, mild stage, with behavioral changes

Medications

- Buspirone 5mg as needed
- Lisinopril 30mg daily
- Claritin 10mg daily
- Tylenol 500mg Q8H PRN

Review: Align decisions and care among patients, caregivers, and other clinicians with patients' health priorities and health trajectory

- **Affirm shared understanding of patients' health priorities and the information that informs decision-making**
  - Agree on the factors and information that will inform decision-making and care
  - Encourage patients and family/caregivers to participate in decision-making
- **Align decisions when patient and clinician have different perspectives**
  - Link decision to something meaningful to the patient
  - Ensure that patients' health outcome goals are consistent with their healthcare preferences
  - Identify and change bothersome aspects of treatment
  - Accept patients' decisions
- **Align decisions when clinicians have different perspectives or recommendations**
  - Focus discussion on patients' health priorities, not only on diseases
  - Acknowledge absence of one "right answer" for patients with MCCs
  - Use collaborative negotiation to arrive at shared recommendations

For our discussants, in this case:

What could we ask her to understand her reluctance to accept your recommendations?

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Ms. Jefferson

Use principles of motivational interviewing.

- Identifying her goals. How does your recommended plan help/threaten her goals? ***How could telling her she needs help seeing and hearing threaten her?***
  - Reassure her she is in the driver's seat and making the decisions.
  - How does your plan help her meet her goals?

She states she wants to be independent and keep her apartment.

Ms. Jefferson

Use principles of motivational interviewing.

- Identifying her goals. How does your recommended plan help/threaten her goals? ***How could telling her she needs help seeing and hearing threaten her?***
  - Reassure her she is in the driver's seat and making the decisions.
  - How does your plan help her meet her goals?

Consider:

When living with dementia, people are often afraid of losing autonomy and may be sensitive to suggestions where it may seem like control is going to be taken away.

When living with dementia, patients may not be able to communicate as clearly or directly.

Refusal may be a way of saying that a treatment suggestion is not within their goals, even if they can't articulate that thought.

Reinforce how your plan can help protect their goals, or offer another such as wellbeing and safety.

She states she wants to be independent and keep her apartment.

You can provide information on how working with a vision specialist to improver her skills and with her daughter to clear clutter could both help prevent a fall. A fall could lead to injury and be a big threat to her independence.

For our discussants, in this case:

How do you balance accepting patient preferences that conflict with recommended care?

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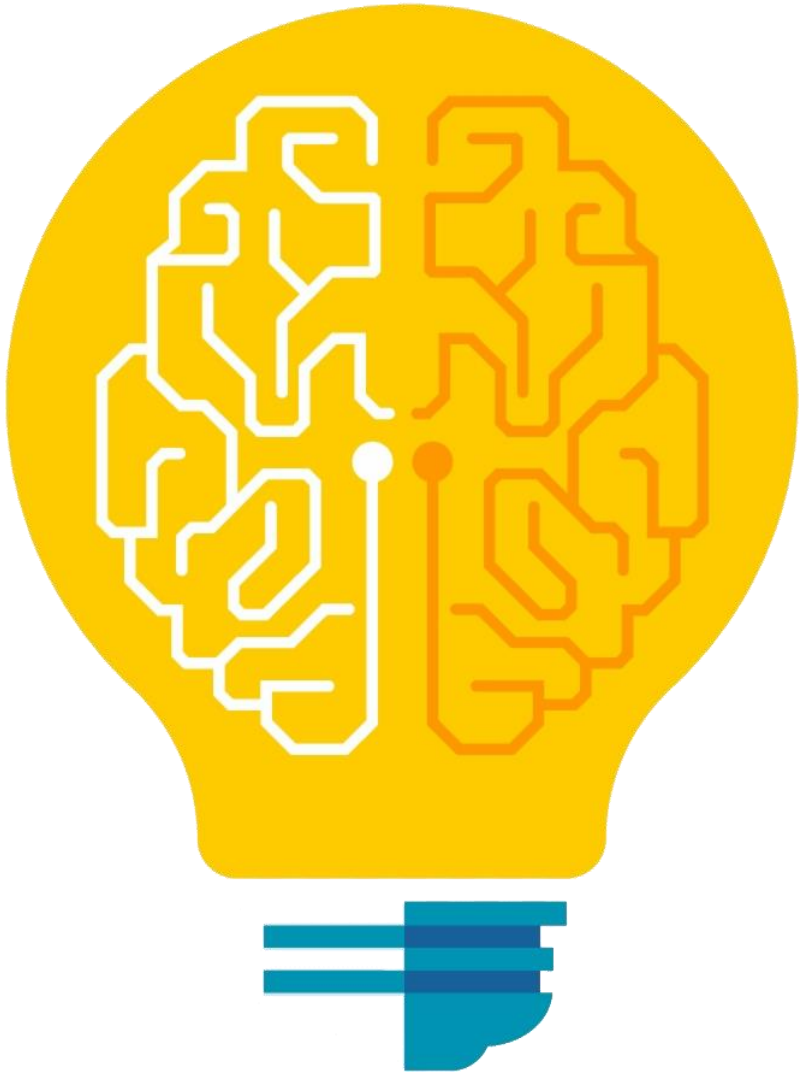
Take-Home Points



Thank you!

For more information please contact:

Anna Chodos@ucsf.edu

Have more questions? Get answers through our Warmline @ **1-800-933-1789** or our support page!

Here are some examples!

What do I prioritize if my patient tests positive for cognitive impairment?

What cognitive assessment should I use for a Spanish speaking patient experiencing homelessness?

What medications should I avoid if my patient has cognitive complaints?

Open your phone camera and scan the QR code to submit questions:

Or visit: www.dementiacareaware.org

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CALIFORNIA HEALTH UCSF University of California San Francisco

UCI Division of Geriatric Medicine and Gerontology

UC San Diego School of Medicine

UCLA Health

UCSF-UC Law

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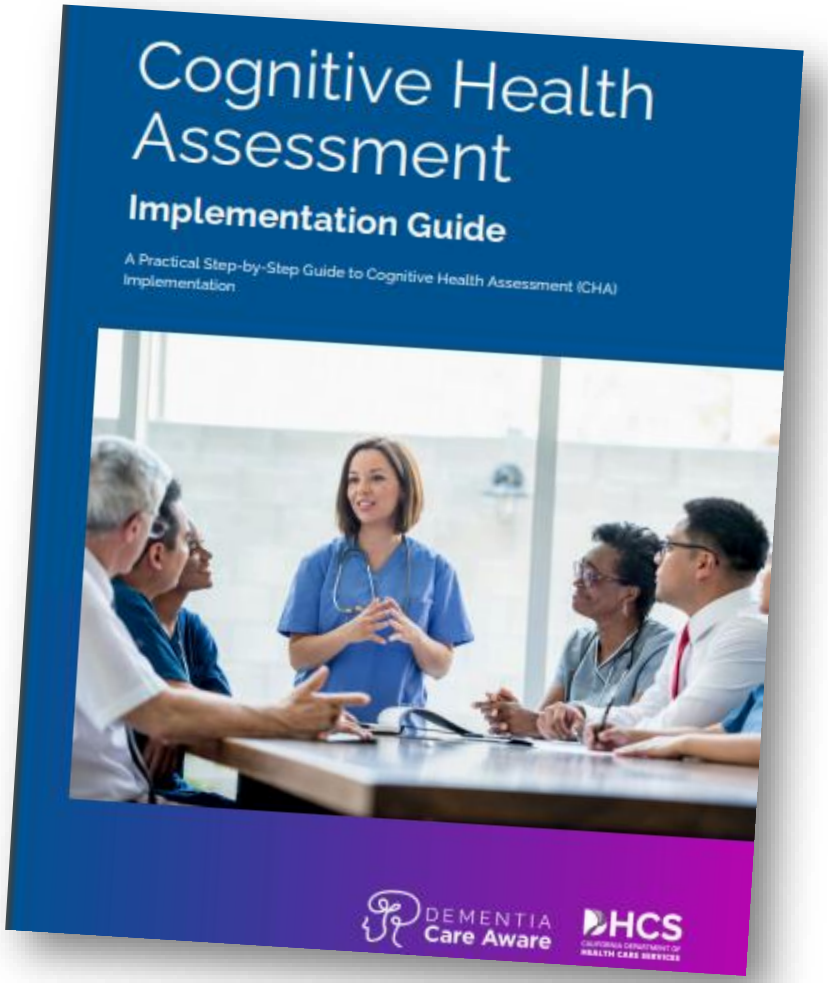
The Cognitive Health Assessment Implementation Guide

A comprehensive **step-by-step guide** through the CHA implementation process

Digestible steps broken down into 4 pillars

Includes a workbook, tip sheets, case studies, workflows, supplementary resources, rationale behind each step

Learn more a: www.DementiaCareAware.org/implementation



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- **ASWB** for social workers and **Licensed Marriage and Family Therapist, and Educational Psychologists**.

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- Enter your first name, last name, profession, and claim **1 CE credit** for the webinar

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