INTACT

INDIANS TRANSFORMING
ALZHEIMER'S CARE TRAINING

Follow-up Meeting #2

WORKING TOGETHER FOR HEALTH EQUITY

IREACH

INSTITUTE FOR RESEARCH AND EDUCATION
TO ADVANCE COMMUNITY HEALTH

Plan today

Recap/ overview

Your questions

Advance care planning and dementia

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~ BE AWARE

- Patient or family mention a concern.
- At an Annual Wellness Visit: there's a "yes" answer to a concern.
- Anyone in clinic (front desk, MA, PCP, etc.) notices confusion about appointments / medications.

When there is a worrisome concern

Schedule a Cognitive Evaluation Visit

- Strongly encourage a **family member** or a close friend to come to that next visit.

Three Parts to a Dedicated Visit to Evaluate Cognitive Concerns

1. **Cognitive Checklist**: reversible causes and other factors you can fix.

2. **Assess cognitive function** e.g. with a MoCA.

3. **Get input** from a family member (e.g. with AD8).

BMJ. 2017;357:j2353

Cognitive Checklist

- ❑ **Labs** B12 + thyroid
- ❑ **Med list** Sedating/ anticholinergic meds
  Oxybutynin, Tylenol PM, benzodiazepines, Ambien
- ❑ **Alcohol** Even mild-to-moderate drinking can impair cognition once people > age 70
- ❑ **Conditions**: Sleep apnea, hearing loss, depression

NAME QUICK TEXT: Cognition - Evaluation Checklist

Evaluating Cognitive Function

The assessment is a combination of…

MoCA test + Family input

Ann Intern Med. 2019;171(5)

Enter MoCA results in EHR

Now a spot for this next to PHQ-9

Essential : Make it a *result* to easily find and track

Best practice : Also save / scan the form in chart

Family / Observer Input

History questions to ask family member or a close friend:

- Are they repeating the same question 30 min later?
- Losing ability to do complex tasks that they once found easy to do? (e.g. complex recipe or outdoor lighting)
- Getting disoriented in a familiar place?

Remember these three questions (in the Quick Text)

Or use a validated 8-item form called: **the AD8** in your clinic!

Neurology 2005:65:559

Observer Input

AD8

validated tool to get input from a family member or close friend.

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	YES, A change	NO, No change
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)		

Neurology 2005; 65(4) p. 559-64

Put It Together

MoCA result + Family input

MoCA less than 20 (out of 30)

+ Observer notes worrisome changes, and

+ Difficulty with *activities of daily living*

= **Dementia**

Put It Together

MoCA result + Family input

MoCA intermediate 22-26 (out of 30)

+ Observer notes worrisome changes

But still able to dress and cook and clean house

= **Mild Cognitive Impairment**

EHR Checklist: Follow-up After Diagnosis

NAME OF TOOL: "Cognition - Newly Diagnosed Checklist"

Cognition - Newly Diagnosed Checklist

[ ] Counseled about diagnosis. (Consider saying "possible Alzheimer's" even if diagnosis is mild cognitive impairment.)

[ ] Offered possible specialist referral. (Refer soon if age <65 or visual hallucinations.)

Recommended Brain Interventions:
[ ] Regular exercise.
[ ] Reduce alcohol intake. (> 2-3 drinks per day affects cognition.)
[ ] Brain healthy diet. (Very similar to heart healthy diet.)
[ ] Advance care planning. (High value to setting durable power of attorney with backups.)

Community Resources Clinical Tools

Session 1: Make a diagnosis of cognitive impairment

Provide better care for your patients.

Link to recording on YouTube Link to access PowerPoint slides

Session 2: Set a plan for the newly diagnosed patient

Learn an efficient framework for the initial care of someone with cognitive impairment.

Link to recording on YouTube Link to access PowerPoint slides

Session 3: Manage dementia as it progresses

Medications to treat cognitive impairment, managing agitation, and advance care planning improve care.

Link to recording on YouTube Link to access PowerPoint slides

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https://ireach.wsu.edu/near/intact-nuihc/

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How are things going?

Plan today

Recap/ overview

Your questions

Advance care planning and dementia

Advance Care Planning for Dementia

Path to better care.

In Early Impairment: Proxies (DPOA-HC)

- Early-on in the disease, it is important to designate, in a **legal form** who someone want their proxy decision makers to be.
- With *alternates*.
- Because over 10-15 years, their default (usually their spouse) may no longer be available to serve as their decision maker.

Dementia is Complex

- People with early dementia may have many years with a good quality of life.
- Often a slow decrease in quality of life: from mild, to moderate, to severe stages.
- It makes sense that people would want different goals for their medical care, from one stage to another.

Tips For Goals of Care Discussions

"Imagine if your loved one could look on themselves now, what might they say they'd want?"

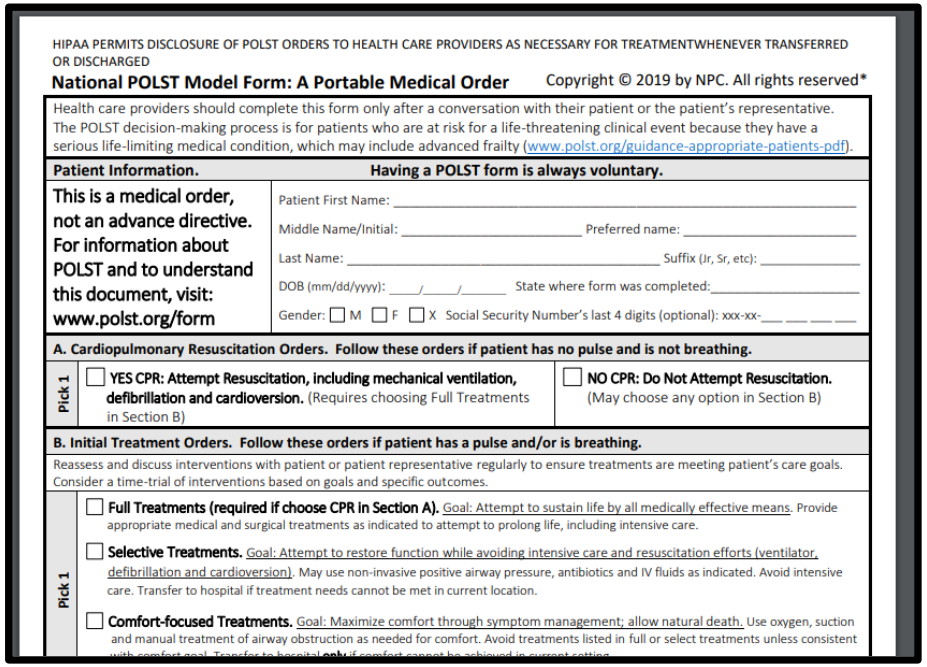
- It is OK to make a recommendation, such as:

  "I would recommend not doing CPR. Even if you survived cardiac arrest, your brain is more vulnerable, so you'd be in a worse state afterwards than now. And a stay in the ICU would likely be a hard and very painful time."

Int J Nursing: 2020. https://doi.org/10.1016/j.ijnurstu.2020.103576

Value of POLST form

Provider **O**rders **L**ife **S**ustaining **T**reatment



HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENTWHENEVER TRANSFERRED OR DISCHARGED

National POLST Model Form: A Portable Medical Order Copyright © 2019 by NPC. All rights reserved*

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information. **Having a POLST form is always voluntary.**

This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form

Patient First Name: _____

Middle Name/Initial: _____ Preferred name: _____

Last Name: _____ Suffix (Jr, Sr, etc): _____

DOB (mm/dd/yyyy): ____/____/_____ State where form was completed:_____

Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-___ ___ ___ ___

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1

☐ **YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.** (Requires choosing Full Treatments in Section B)

☐ **NO CPR: Do Not Attempt Resuscitation.** (May choose any option in Section B)

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ **Full Treatments (required if choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting

- A crucial tool: anchors goals of care conversations. Invaluable communication across sites.
- Sets goals of care **now**: What if heart stops. Or can't breathe on own. Is the preference for: comfort care? ICU care?

Remember the "Why"

- **No CPR, no intubation**: Why might choose: People with dementia, who survive, are at high risk of being in a worsened state if they survive.

- **Comfort-focused care**: Symptom relief only. Why: High risk of adverse effects, of agitation, more complications from many interventions.

"Imagine if your loved one could look on themselves now, what might they say they'd want?"

Dementia-specific Advance Directive

- Developed with input from experts in palliative care, neurology, and geriatrics.
- Tested and refined in primary care.
- Available for anyone to download from:

Dementia-directive.org

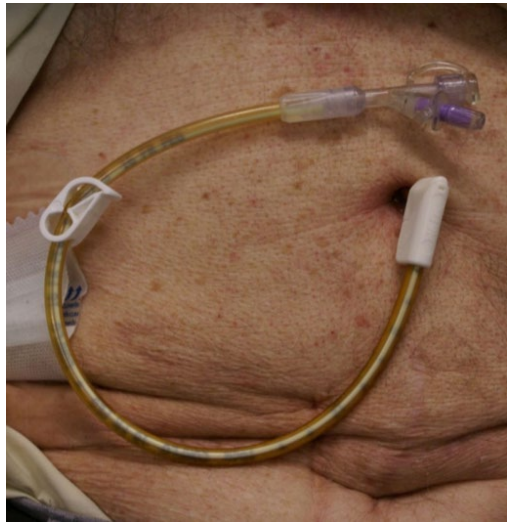
JAMA. 2017;318(22):2175–2176

Best time to offer a Dementia Directive

- ✓ Before signs of dementia occur.
- ✓ Consider: for everyone over age 65

www.dementia-directive.org

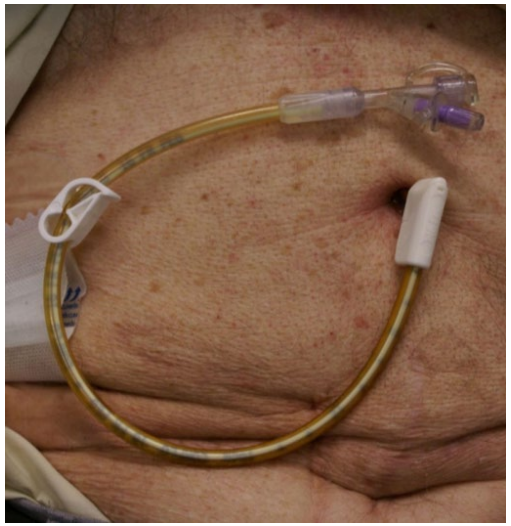
What About Tube Feeding?



- In dementia: feeding tubes do more harm than good.
- Strong expert guidelines, solid data-driven research.
- They don’t make people more comfortable, don’t prolong life, they cause more aspiration pneumonia, more suffering.

J Am Ger Soc. 2014:1590.

Tube Feeding Does Harm



- People in health care may know this. But families usually don't. Key is to have this conversation in a caring and empathic way.
- Useful wording: "Tube feeding does not fix what is a slow dying process. It's been shown to make people less comfortable."

  "I worry the tube will *cause…*"

J Am Geriatr Soc. 2011;59(11):2009-16

Key Points: Advance Care Planning and Dementia

- **Before dementia:** To everyone over age 65, offer a dementia directive: Dementia-directive.org
- **Mild dementia**: fill out a DPOA-HC proxy document (with *alternates*) as soon as possible.
- **Mod/severe dementia**: POLST appropriate and valuable
- **Key phrase:** "Imagine if your loved one could look on themselves now, what might they say they would want?"

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Questions and Answers

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