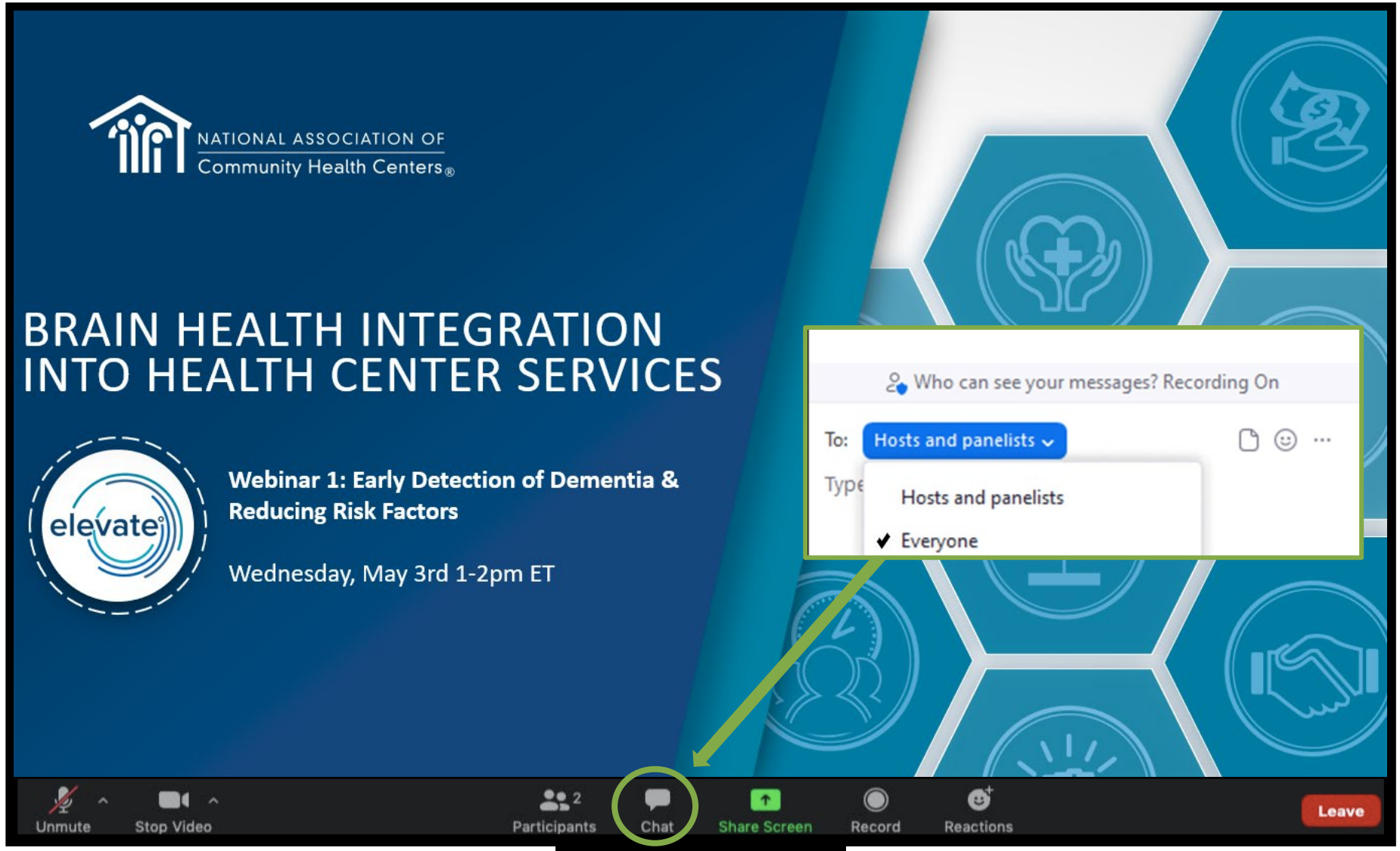
NATIONAL ASSOCIATION OF Community Health Centers®

BRAIN HEALTH INTEGRATION INTO HEALTH CENTER SERVICES

elevate

Webinar 1: Early Detection of Dementia & Reducing Risk Factors

Wednesday, May 3rd 1-2pm ET



During today's session:

- **Questions:** Throughout the webinar, type your questions in the chat feature. Be sure to select "Everyone"! There will be Q&A and discussion at the end.
- **Resources:** If you have a tool or resource to share, let us know in the chat!

THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

NATIONAL ASSOCIATION OF Community Health Centers®

NACHC Quality Center

Cheryl Modica

Director,
Quality Center

Cassie Lindholm

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Quality Center

Holly Nicholson

Manager, Instructional
Design & Learning

NACHC Quality Center

Packaging and implementing evidence-based transformational strategies for safety-net providers

Bringing science, knowledge, and innovation to practice

NACHC Quality Center

Our Goal

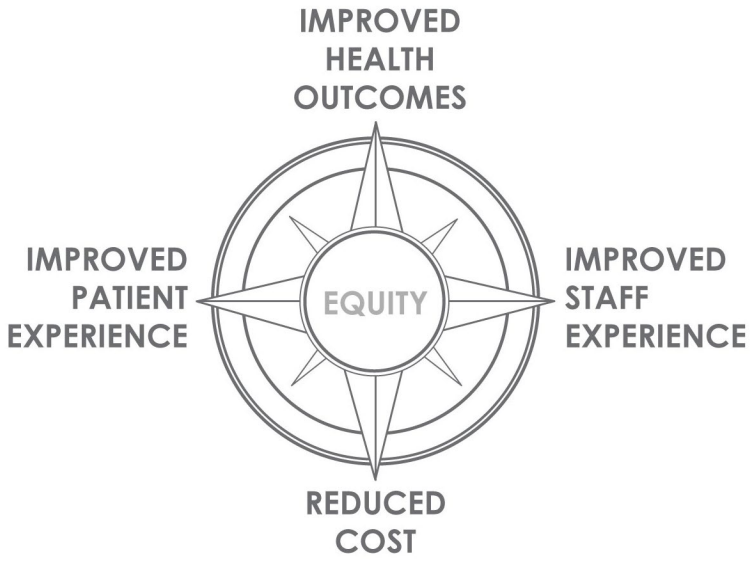
Improved Health Center

Performance

through

Systems Transformation

Quintuple Aim Goals



Brain Health Webinar Series

This 3-part webinar series is focused on the important role health centers play in dementia – early detection, reducing risk factors, care management, and effective partnerships.

Each webinar will offer health center-oriented action steps, and will feature subject matter experts in brain health, reimbursement, care management, and more!

Wednesday, May 3rd 1-2pm ET
Early Detection of Dementia & Reducing Risk Factors

Wednesday, May 17th 1-2pm ET
Care Management for Patients with Dementia & Leveraging Reimbursement Opportunities

Wednesday, May 31st 1-2pm ET
Health Center Partnerships & Community Linkages to care for Patients with Dementia

Agenda: Early Detection of Dementia & Reducing Risk Factors

Systems Approach to Primary Care and Value-Based Care Transformation

Cheryl Modica, PhD, MPH, BSN | NACHC

- The Value Transformation Framework and Elevate
- Systems approach to brain health, evidence-based care

Dementia: Early Detection and Reducing Risk Factors

Dr. Nicole Purcell, DO, MS | Alzheimer's Association

- **Why** it is critical for health center care teams and providers to focus on dementia
- **What** can be done to identify and reduce risk factors

Dr. Soo Borson, MD | NYU BOLD Center

- **How** health centers and primary care providers can provide early detection

Dr. Barak Gaster, MD | University of Washington

- Reflections from the point of a primary care provider

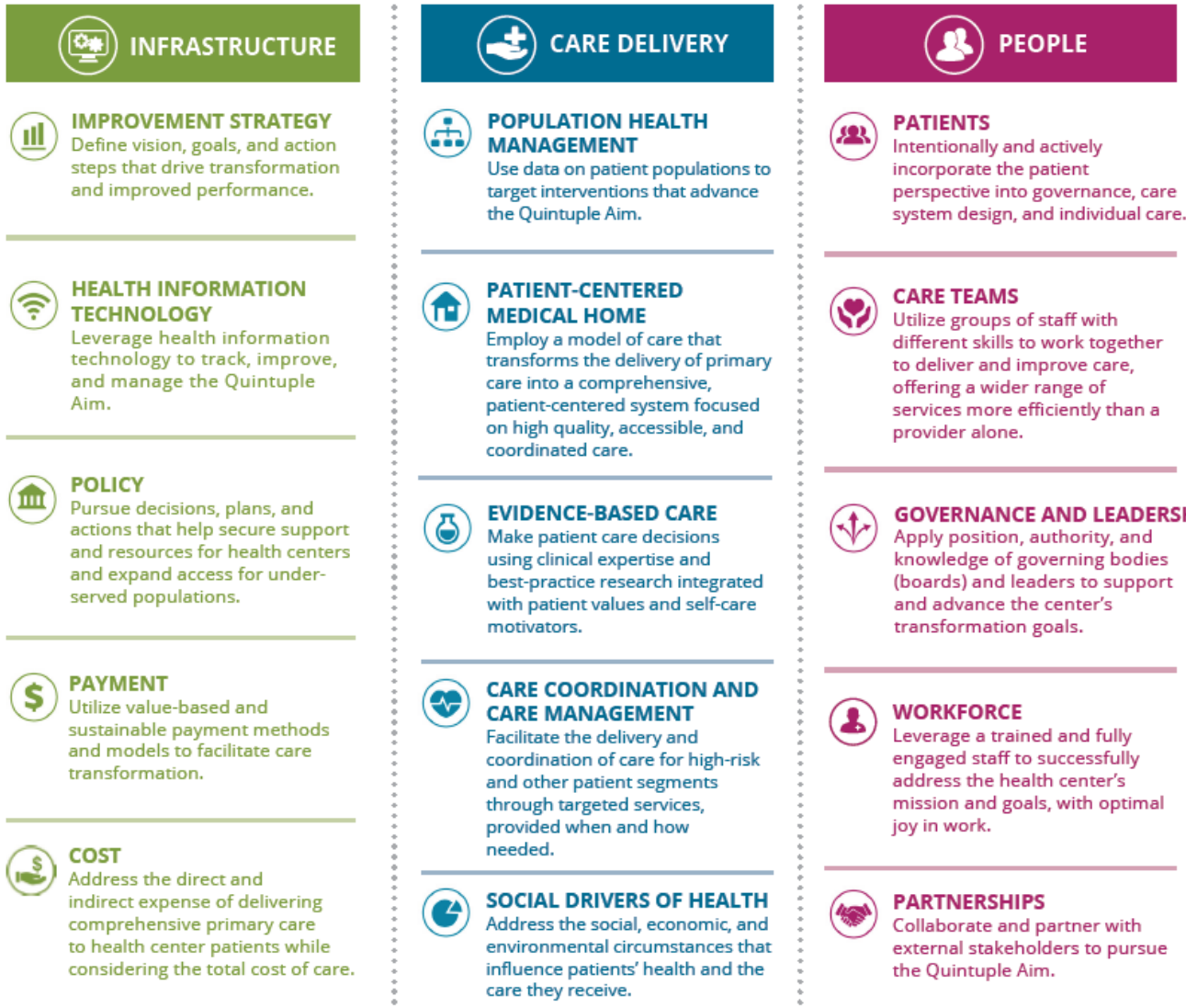
Discussion/Q&A

The Value Transformation Framework

The Value Transformation Framework (VTF) is ***an organizing framework*** to guide health center systems change:

- ***Supports change*** in many parts of the health center simultaneously
- ***Organizes and distills evidence-based interventions*** for discrete parts of the systems called 'Change Areas'
- ***Incorporates evidence, knowledge, tools and resources*** relevant for action within different parts of the system, or Change Areas
- ***Links health center performance to the Quintuple Aim***

The Value Transformation Framework



15 Change Areas organized by 3 Domains:

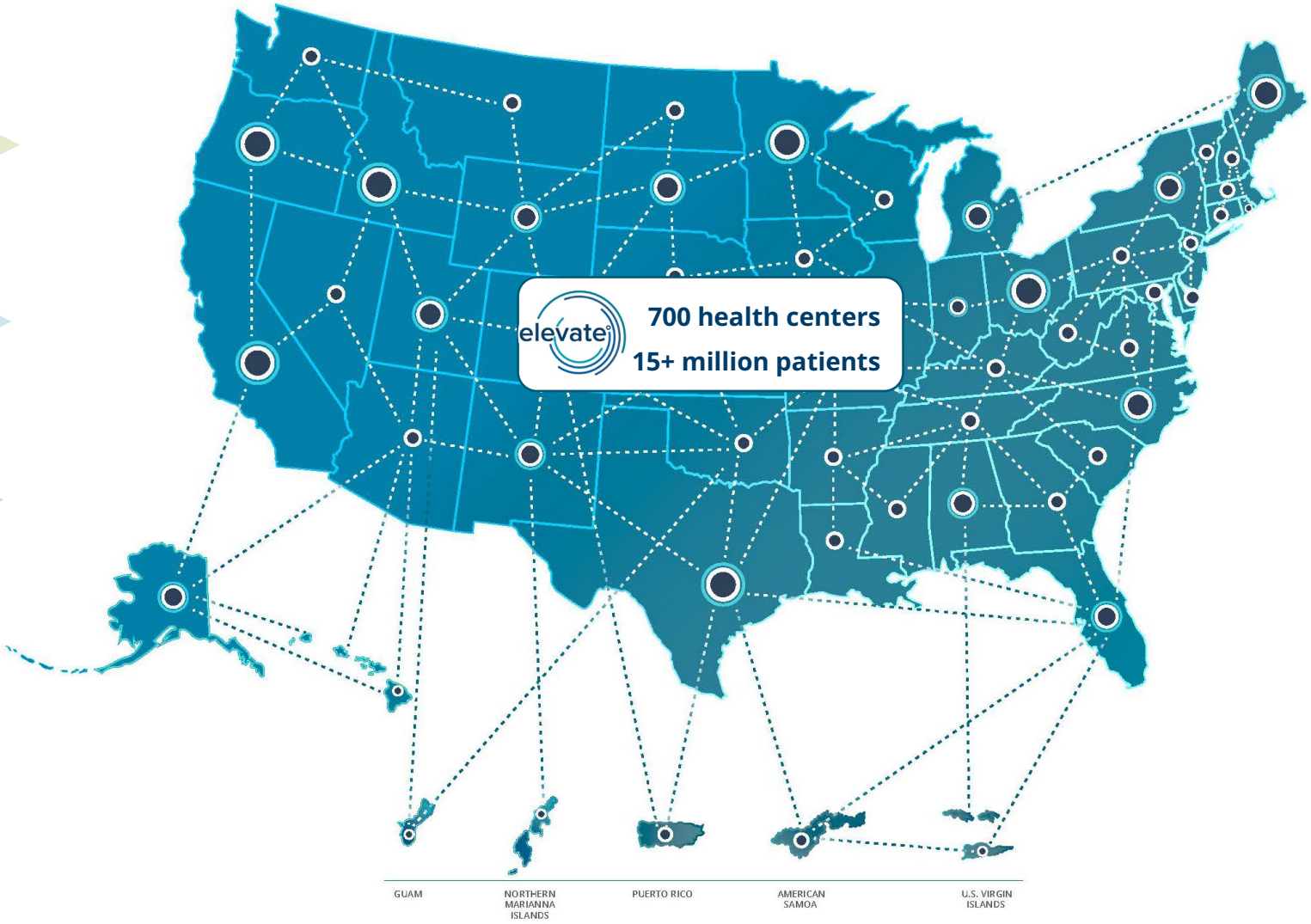
Infrastructure: the components, including health information systems, policies, and payment structures, that build the foundation for reliable, high-quality health care

Care Delivery: the processes and proven approaches used to provide care and services to individuals and target populations, such as evidence-based care and social drivers of health

People: the stakeholders who receive, provide, and lead care at the health center, as well as partners that support the goals of high-value care

Elevate National Learning Forum

Guided application of the Value Transformation Framework



Featured Expert:

Dr. Nicole Purcell, DO, MS

Senior Director, Clinical Practice

ALZHEIMER'S ASSOCIATION®

Dementia
A Clinical Perspective

Nicole Purcell, DO, MS

May 3, 2023

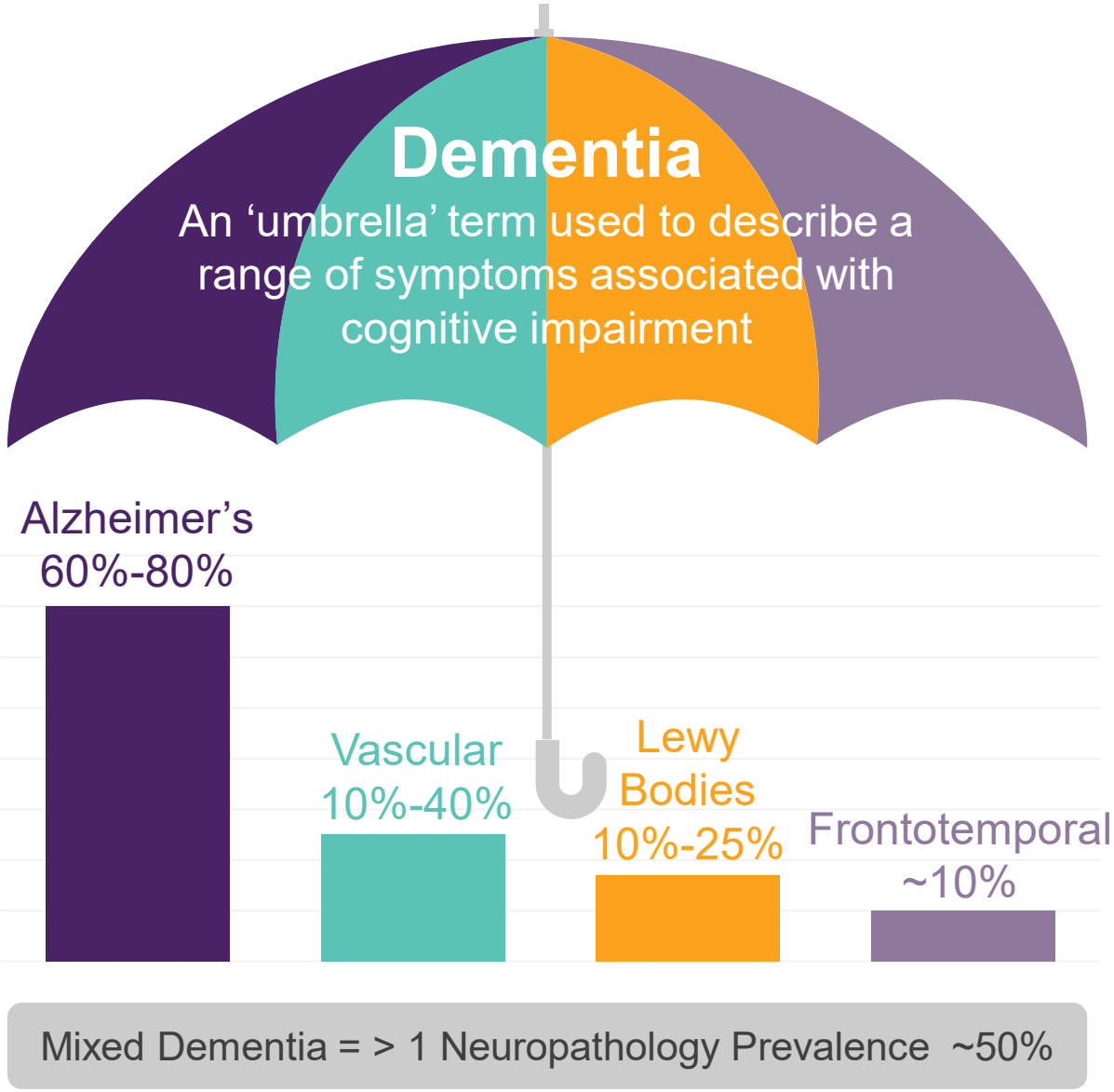
ALZHEIMER'S ASSOCIATION®

Our Time Today

- Understand the epidemiology of dementia
- Explore the benefits of early detection and diagnosis
- Identify common risk factors for cognitive impairment
- Differentiate between normal and abnormal aging
- Differentiate between other dementia syndromes

Dementia is a Syndrome

- Dementia is a collection of symptoms related to cognitive decline
- Can include cognitive, behavioral and psychological symptoms
- Due to biological changes in the brain
- Alzheimer's is most common cause
- Mixed dementia is very prevalent
- Some causes of cognitive decline are reversible and not truly dementia



Mixed Dementia = > 1 Neuropathology Prevalence ~50%

More than 6 million Americans are living with Alzheimer's.

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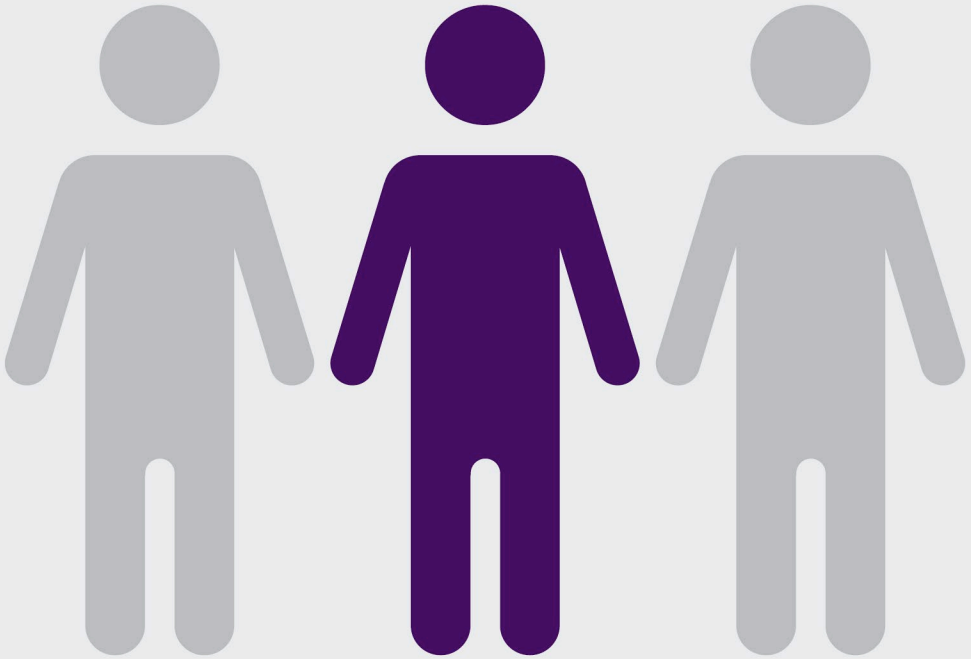
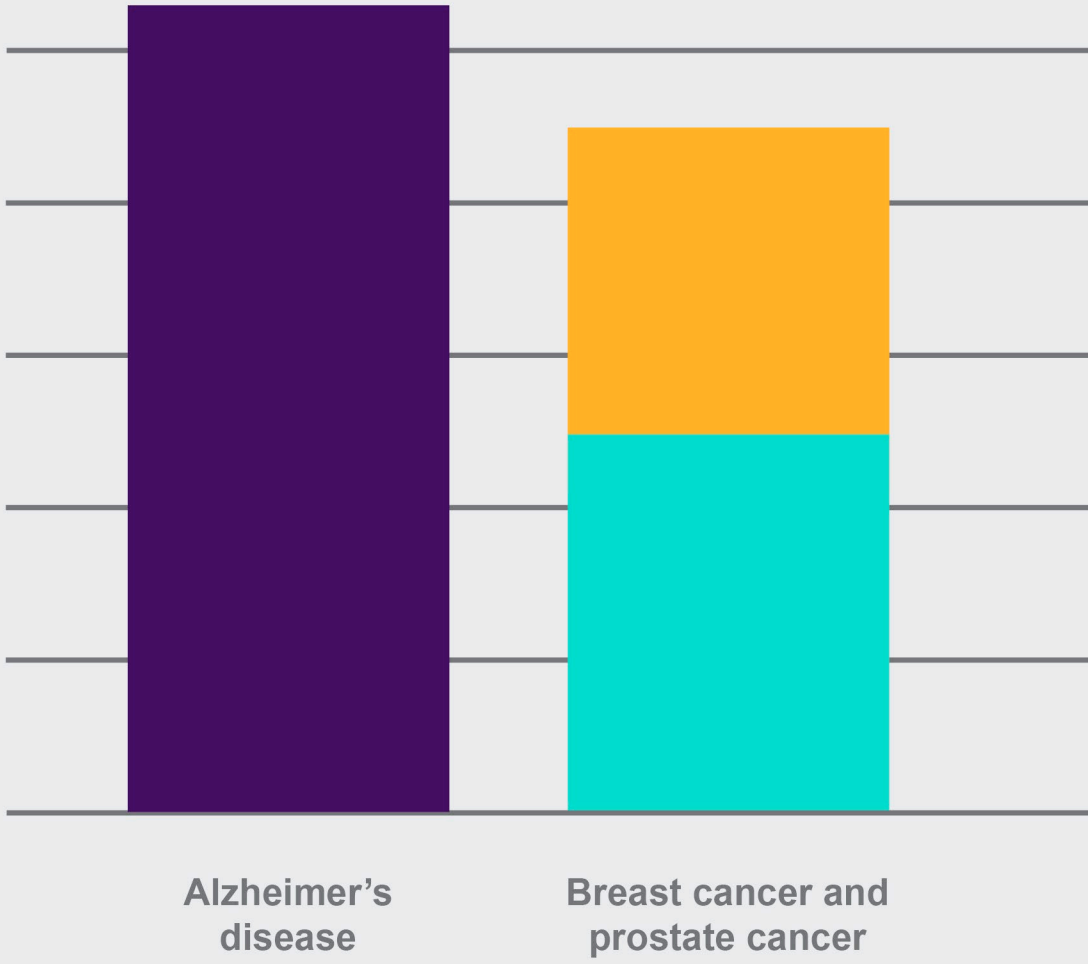
About 1 in 9 people ages 65 and older have Alzheimer's disease

Percentage of people with Alzheimer's dementia increases with age. People younger than age 65 can develop Alzheimer's, but it is much less common.



1 in 3 seniors dies with **Alzheimer's** or another dementia.

Alzheimer's kills more people than breast cancer and prostate cancer **combined.**



Almost **two-thirds** of Americans with Alzheimer's are women.

Older Black Americans are about **twice** as likely to have Alzheimer's or other dementias as older White Americans.

alzheimer's association®

Genetic factors do not account for the difference in racial groups

Social determinants of health may impact some or all of these risk factors

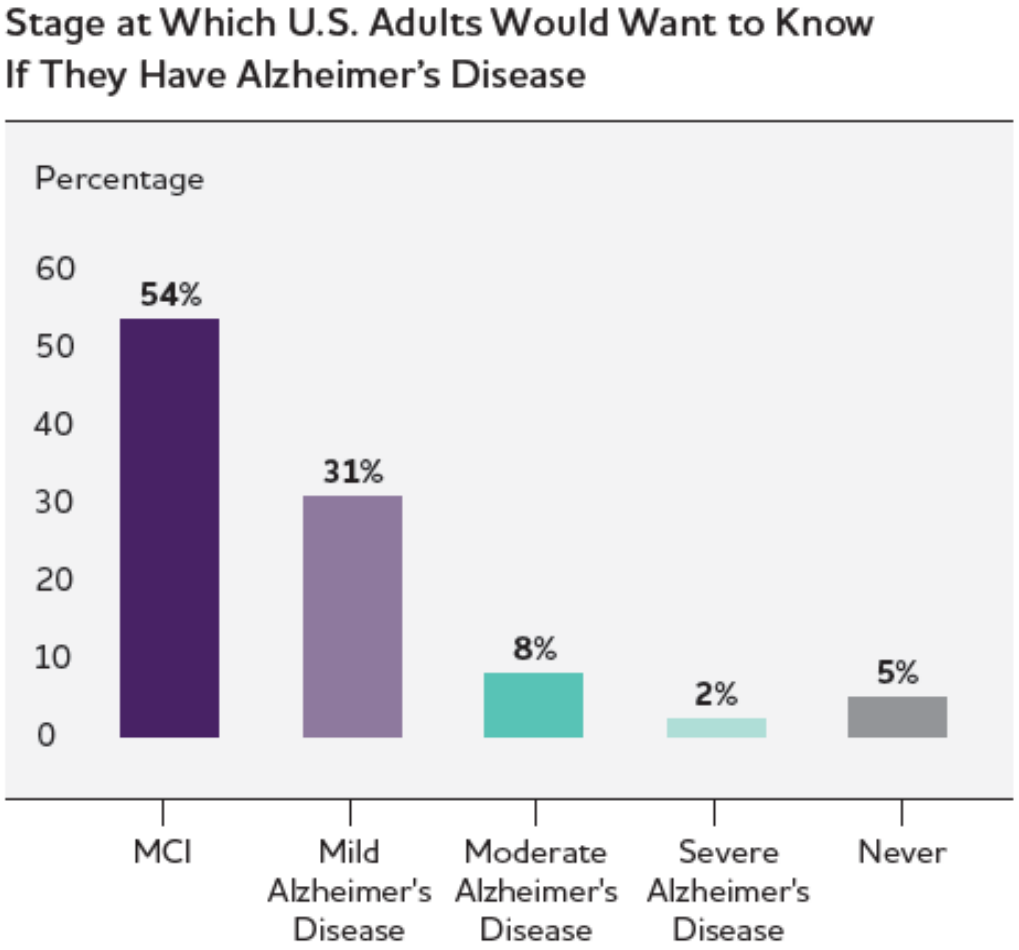
98% of primary care physicians feel it's important to diagnose MCI

96% of primary care physicians feel it's important to assess patients 60 and older for cognitive impairment

But report that they conduct assessments for just 48% of these patients.

- Most frequently cited challenges when making an MCI diagnosis:
  - Difficulty differentiating normal aging from MCI
  - Difficulty interpreting patient reports of daily functioning
  - Lack of specialists and facilities to perform diagnostic testing
  - Patient reluctance to pursue follow-up testing
  - PCP reluctance to diagnose a condition that has limited treatment options

- Nearly half of Americans (47%) worry about developing MCI in the future
- Asian (54%) and Hispanic (52%) Americans are more likely to worry than Native (47%), White (45%) and Black Americans (44%)
- A majority of Americans would want to know if they had Alzheimer's disease early



Benefits of Early Detection

- Addressing modifiable risk factors may slow progression of dementia in those who have MCI due to Alzheimer's disease

- Evaluation for other causes of cognitive impairment.
- Better management of comorbid conditions through medication adherence and compliance with care plans

- Reducing anxiety about symptoms
- Opportunity to participate in clinical trials
- Opportunity to discuss treatments and new medications

Benefits of Early Detection

Safety assessments

- Driving
- Home environment
- Elder abuse

Advanced care planning

- Identification of trusted individuals who can make decisions and advocate on the person's behalf
- Participation in care and living decisions
- Address legal and financial matters
- Develop lasting relationships

Cost savings

- Patient
- Caregivers
- Health care system

Modifiable Risk Factors

WILL affect risk of cognitive decline **and** dementia

- ✓ Education
- ✓ Traumatic Brain Injury

WILL affect risk of cognitive decline and **MAY** affect risk of dementia

- ✓ Midlife Hypertension
- ✓ Physical Inactivity
- ✓ Midlife Obesity
- ✓ Diabetes
- ✓ Smoking
- ✓ Poor Sleep

MAY affect risk of cognitive decline

- ✓ Balanced Nutrition
- ✓ Cognitive Engagement

Others You May Hear About

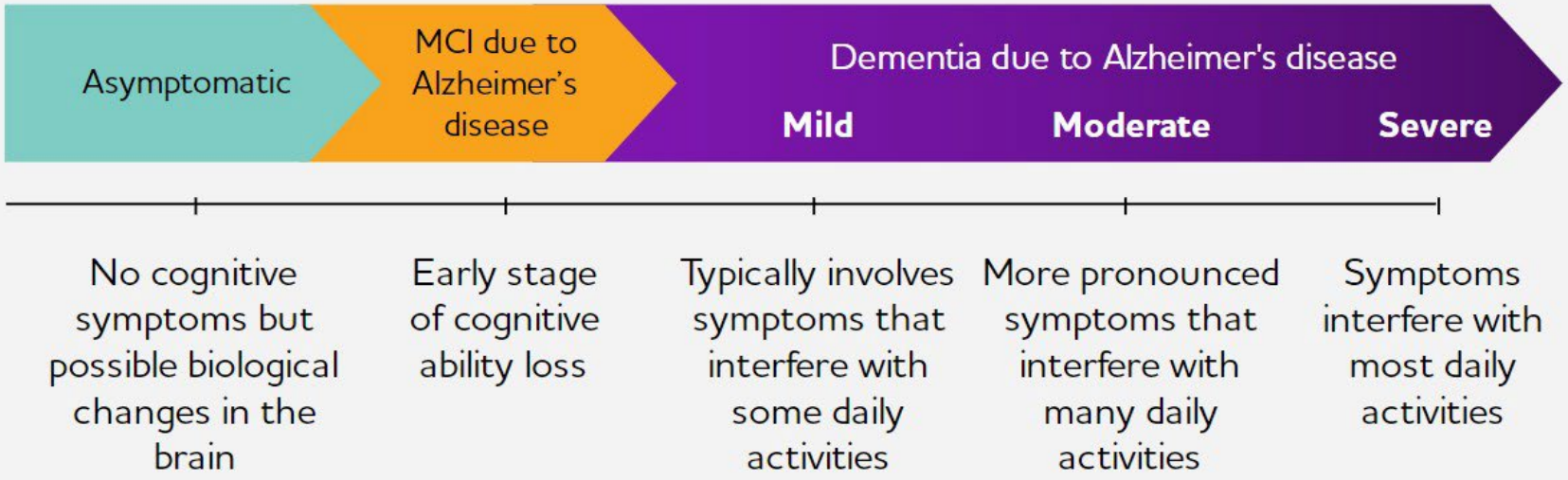
Lower Level/Unclear Evidence:

- Hearing loss
- Air pollution
- Depression
- Hyperlipidemia
- Alcohol abuse
- Moderate alcohol use
- Social engagement

Unmodifiable Risk Factors for Cognitive Impairment

- Increasing age
  - Strongest risk factor
- Family history
  - Risk increases with the number of first-degree relatives, and to a lesser extent, second-degree relatives
- Genetics
  - Deterministic genes: <1% of all Alzheimer's; 50/50 risk of AD
    - Dominantly inherited mutations in amyloid beta precursor protein (APP) gene, presenilin 1 (PSEN1) gene and presenilin 2 (PSEN2) gene
    - Trisomy in Down syndrome — individuals develop Alzheimer's at an earlier age; by age 40 most have significant levels of amyloid and tau
  - Risk genes:
    - APOE-e4 is linked to increased risk of developing Alzheimer's disease
    - May be dozens of similar genes

Alzheimer's disease is a continuum



Normal Aging

Typical age-related changes:

- Forgetting names or appointments but remembering them later
- Making occasional errors when managing finance
- Vision changes related to cataracts
- Sometimes having difficulty finding words
- Misplacing things but successfully retracing steps to find them
- Making poor decisions or mistakes intermittently
- Occasionally uninterested in family and social obligations
- Becoming irritable with change in routine

Mild (or Early) Stage of Alzheimer's Disease

- Most individuals function independently.
- May require assistance with activities of daily living (ADLs) to maximize independence and safety.
- May continue to drive and work.

Mild (or Early) Stage of Alzheimer's Disease

Common Cognitive Symptoms	• Misplacing items and losing the ability to retrace steps • Forgetting appointments • Forgetting to take medications or pay bills • Difficulty coming up with the right word or name • Trouble remembering names when introduced to new people • Difficulty performing tasks in social or work settings • Forgetting material that was just read • Losing or misplacing a valuable object • Experiencing increased trouble with planning or organizing
Behavioral or Psychiatric Symptoms	• Depression • Anxiety • Social withdrawal • Irritability • Sleep maintenance

Moderate Stage of Alzheimer's Disease

- Harder to complete multi-step tasks
- Confused or disoriented more easily
- More problems with memory and language

Moderate Stage of Alzheimer's Disease

Common Cognitive Symptoms	• Difficulty navigating familiar environments • Problems preparing meals • Problems with simple calculations • Difficulty with devices (phone or computer) • Disoriented to date or location • Obvious difficulty finding words • Poor judgment • Mild apraxia
Behavioral or Psychiatric Symptoms	• Irritable mood/lability • Aggressive behaviors • Occasional delusions • Increased anxiety • Rare hallucinations • Wandering • Insomnia
Other Symptoms	• Decreased appetite with weight loss • Incontinence • Occasional myoclonus • Mild extrapyramidal symptoms (bradykinesia) • Rare seizures

Severe (or Late) Stage of Alzheimer's Disease

- Limited language capability with global aphasia
- Require around-the-clock care with apraxia of tasks
- Impaired gait and balance
- Poor recognition of family members
- Hallucinations
- Incontinence is common
- Dysphagia with aspiration; contributes to death

Vascular Dementia

Course	• Based on location and extent of cerebrovascular event (CVE) • Can be stepwise decline
Presentation	• Temporal relationship between CVE and onset of cognitive impairment • Subcortical ischemic vascular disease: dysexecutive function
Associated Features	• Personality and mood changes • May exhibit parkinsonian features
Most Common Risk Factors	• Hypertension • Dyslipidemia • Diabetes • Smoking • Atrial fibrillation • Amyloid angiopathy

Dementia with Lewy Body

Course	• Insidious onset with gradual progression
Presentation	• Fluctuating cognition and functional impairment with parkinsonian • Cognitive symptoms start shortly before or concurrently with motor symptoms
Associated Features	• Falls, syncope, autonomic dysfunction • Nearly 50% have severe neuroleptic sensitivity
Most Common Risk Factors	• Genetic risk identified but no family history in most cases

Parkinson's Disease Dementia

Course	• Insidious onset with gradual progression
Presentation	• Cognitive decline is usually later, >1 year after motor symptoms
Associated Features	• Apathy • Anxiety • Depression • Hallucinations • Delusions • Personality changes • Rapid Eye Movement (REM) sleep disorder • Excessive daytime sleepiness
Most Common Risk Factors	• Clinical predictors of dementia (age, male sex, greater motor symptoms, hallucinations, REM sleep disorder and vascular risk factors)

Frontotemporal Dementia

Course	• Insidious onset with gradual progression
Presentation	• Behavioral variant: behavioral disinhibition, apathy, loss of sympathy or empathy, perseverative stereotyped speech, compulsive/ritualistic behavior, hyperorality, dietary changes • Language variant: loss of word memory, including speech production, word finding, comprehension, grammar
Associated Features	• Extrapyramidal symptoms may be present in later stages • Majority present between ages 56 to 65
Most Common Risk Factors	• Up to 40% are familial • Occurs in patients with motor neuron disease • Brief cognitive assessments often normal

Thank You!
Q & A

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Featured Expert:

Soo Borson, MD

Co-Lead, BOLD Public Health Center of Excellence on Early Detection of Dementia

Professor of Clinical Family Medicine, Keck USC School of Medicine

Professor Emerita of Geriatric Psychiatry, University of Washington School of Medicine

Disclosures

Creator and developer of the Mini-Cog, a first-stage dementia screening tool developed for primary care and freely available in many languages on mini-cog.com.

Current funding: Centers for Disease Control and Prevention, National Institute on Aging, National Institute of Minority Health and Health Disparities, and Keck USC Department of Family Medicine.

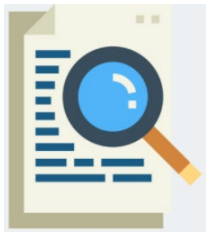
Collaborations: Division of Health Systems Research and Implementation Science, Kaiser Permanente Southern California; AltaMed; Presbyterian Homes; researchers at several academic institutions.

Honoraria: for her work as Deputy Editor of the Journal of the American Geriatrics Society, on clinical advisory boards for Roche Genentech, Biogen, and Eisai, for content created for Medscape, and advisory services to California's Dementia Care Aware, a web-based dementia detection and care training model for primary care clinicians.

BOLD Public Health Center of Excellence on Early Detection of Dementia

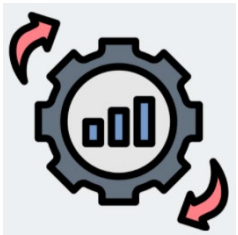
Mission, Vision, and Actions to Increase Early Detection

Finding evidence-based strategies for early detection and better care for older adults with dementia and their care partners



Collect and widely share ways to improve detection

Co-create solutions with national partners



Promote change within stakeholder organizations nationwide

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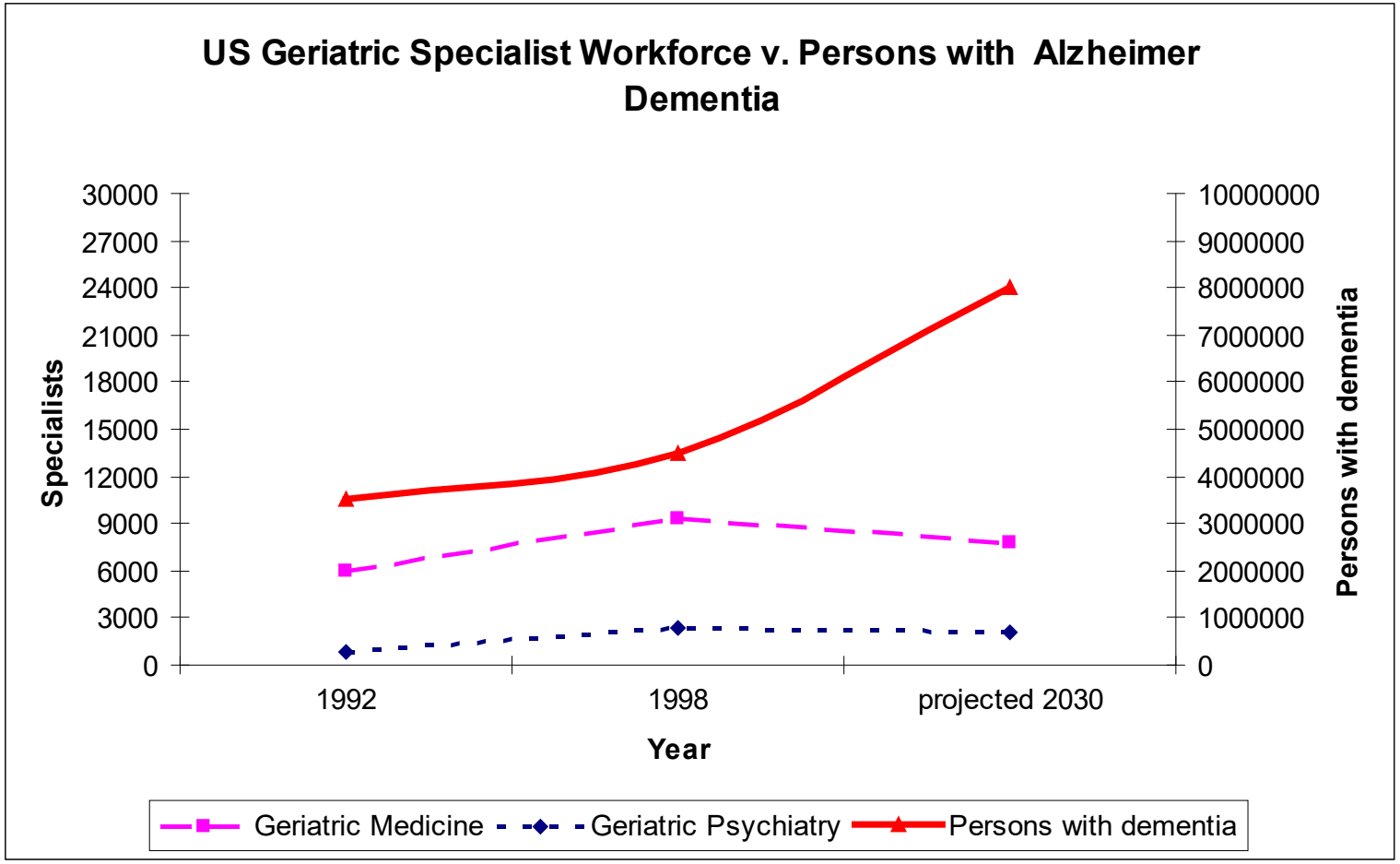
PUBLIC HEALTH CENTER OF EXCELLENCE
EARLY DETECTION OF DEMENTIA

NYU Langone Health

DETECTING DEMENTIA IN PRIMARY CARE:

why, how, and who can do it?

Why primary care?



Primary care is primary!

PRIMARY CARE PROVIDERS

85% of first diagnoses, 80% of care

- "We do it all, birth to death"
- Late and low dementia detection
- Under-developed care framework

MEMORY DISORDER SPECIALISTS*

15% of first diagnoses, <10% of care

- Access issues, consult model
- Disease vs person focus
- Variable relationship with primary care

* *neuro, geri, psych*

Yang et al. *J Am Med Dir Assoc* 2016; Drabo et al. *Alzheimer's Dement* 2019

Missed new diagnoses

Medication errors

Unnecessary crises

Caregiver stress, poor health

Accidents/injuries

Acute confusion/delirium

The WHY of Detection: Health Consequences of Dementia

Poor chronic disease control

Under-, over-, and wrong treatment choices

Surgical complications

Discontinuity of care

Complications of family stress

Preventable hospitalizations, complications, readmissions

Dementia increases preventable hospitalizations

	NEW DEMENTIA	NO DEMENTIA	EFFECT
N	494	2525	16%
Age at enrollment	78 (6)	75 (6)	p = 0.0001
Length of F/U (yrs)	9.6	8	No difference
% w/any admit	86%	59%	++
% with at least one preventable hospitalization	40%	17%	Adj rate ratio 1.78 (1.38-2.31)

2/3 of preventable admissions were for CHF, pneumonia, or UTI. Admits for dehydration and duodenal ulcer occurred *only* among persons with dementia. Higher risk in poorly controlled diabetes, esp for UTI and dehydration.

Phelan E et al. JAMA 2012; Zaslavsky O et al , J Gerontol 2021

- Make the decision
- Build it into your workflow – e.g., Annual Wellness Visit
- Start the conversation – a “check up from the neck up”
- Break the ice – ask about symptoms - individual, family/friend concerns
- Take a history
- Use a detection tool – direct and/or proxy test, ideally both (anyone can do it)
- Assess independent activities of daily living
- Talk about results
  - If no concern or impairment detected, encourage active reporting
  - If impairment detected: discuss choices for further evaluation – one size doesn’t fit all

Dementia-capable health care

- Surveillance: individuals: watch for signs – listen for clues; health systems – use electronic health data.
- Develop an active detection strategy.
- Ask about memory concerns – take a history!
- Assess both cognition and everyday function.
- Engage care partner(s) as members of your team.
- Assess needs across multiple domains* – patient and partners.
- Plan proactively, manage risks intentionally.
- Attend to continuity – relationships are key!
- Optimize staff roles and participation.
- Use multiple modes of care – face to face, remote, in groups.

*Six domains of care: cognitive; emotional, behavioral, spiritual; medical, functional; care partner capacity and readiness; health related social needs; delivery system capacity.

The BOLD Public Health Center of Excellence on Early Detection:

How We Can Help

- Early detection toolkit for clinicians and health care systems
- Strategic advice on becoming dementia-capable
- Technical assistance to clinicians, teams, health care systems
- Connection with members of our partner network

BOLD Public Health Center of Excellence

Early Detection Toolkit for Health Systems

BOLD
PUBLIC HEALTH CENTER OF EXCELLENCE
EARLY DETECTION OF DEMENTIA

Early Detection of Dementia Toolkit - Health Systems

Toolkit Overview
What Is Dementia
Early Detection Overview
Pre-screening
Cognitive Screening Overview
Post-screening

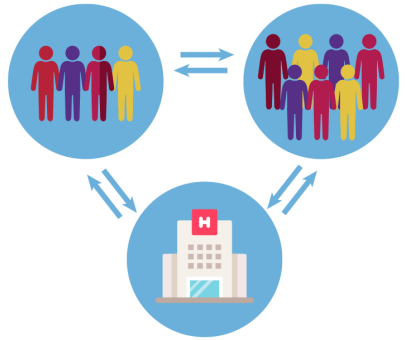
TABLE OF CONTENTS

Toolkit Overview 03
What Is Dementia 04
Early Detection Overview 06
What is early detection? 07
Why is detection important? 08
Should routine dementia screening be conducted? 09
Red flags/indicators for screening (e.g., missed appointments) 11
Ecological Model of Dementia Detection Stakeholders 12
Dementia screening and normalizing discussions around brain health 17
Pre-Screening 19
Navigating pre-screening conversations 20
Building trust 21
Feelings matter: Use positive framing and pay attention to your body language 22
Words matter: Prepare short, simple statements 23
Examples of pre-screening statements 24
Cognitive Screening Overview 26
Post-Screening 26

EARLY DETECTION OVERVIEW

- What is early detection?
- Why is detection important?
- Should routine dementia screening be conducted?
- Red flags/indicators for screening (e.g., missed appointments)
- Ecological model of dementia detection stakeholders

Ecological Model of Dementia Detection Stakeholders



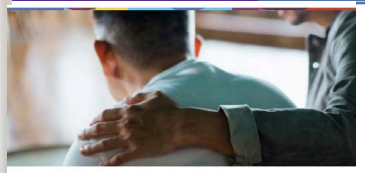
Where is dementia detected?

Dementia can be detected wherever affected people are – at home in the kitchen, in the supermarket, at the bank, on the bus, at the park, at the food bank, in the senior center, during a blood draw for lab tests – but a clinician is needed to make a medical diagnosis of dementia and identify what conditions and factors, reversible or permanent, are causing it.

This section covers the roles that health systems, communities, individuals, family, and friends can play in dementia detection.

Post-screening | Cognitive Screening Overview | Pre-screening | Early Detection Overview | What Is Dementia | Toolkit Overview

Building trust



Feelings matter: Use positive framing and pay attention to your body language.

What are screeners?

Screeners or screening tools are used to predict the likelihood of cognitive impairment. Screening tools can detect early changes in cognitive functioning, and can also be used to monitor changes in cognitive functioning over time. There are two types of screening tools:

Performance-based screening tools are administered to patients.
Examples of performance-based screening tools include:

- Mini-Cog
- Saint Louis University Mental Status Examination(SLUMS)
- Function-based screening tools are administered to informants (e.g., care partner, family member, close friend)
- 8-Item Informant Interview (AD8)
- Quick Dementia Rating System (QDRS)
- Functional Activities Questionnaire (FAQ)

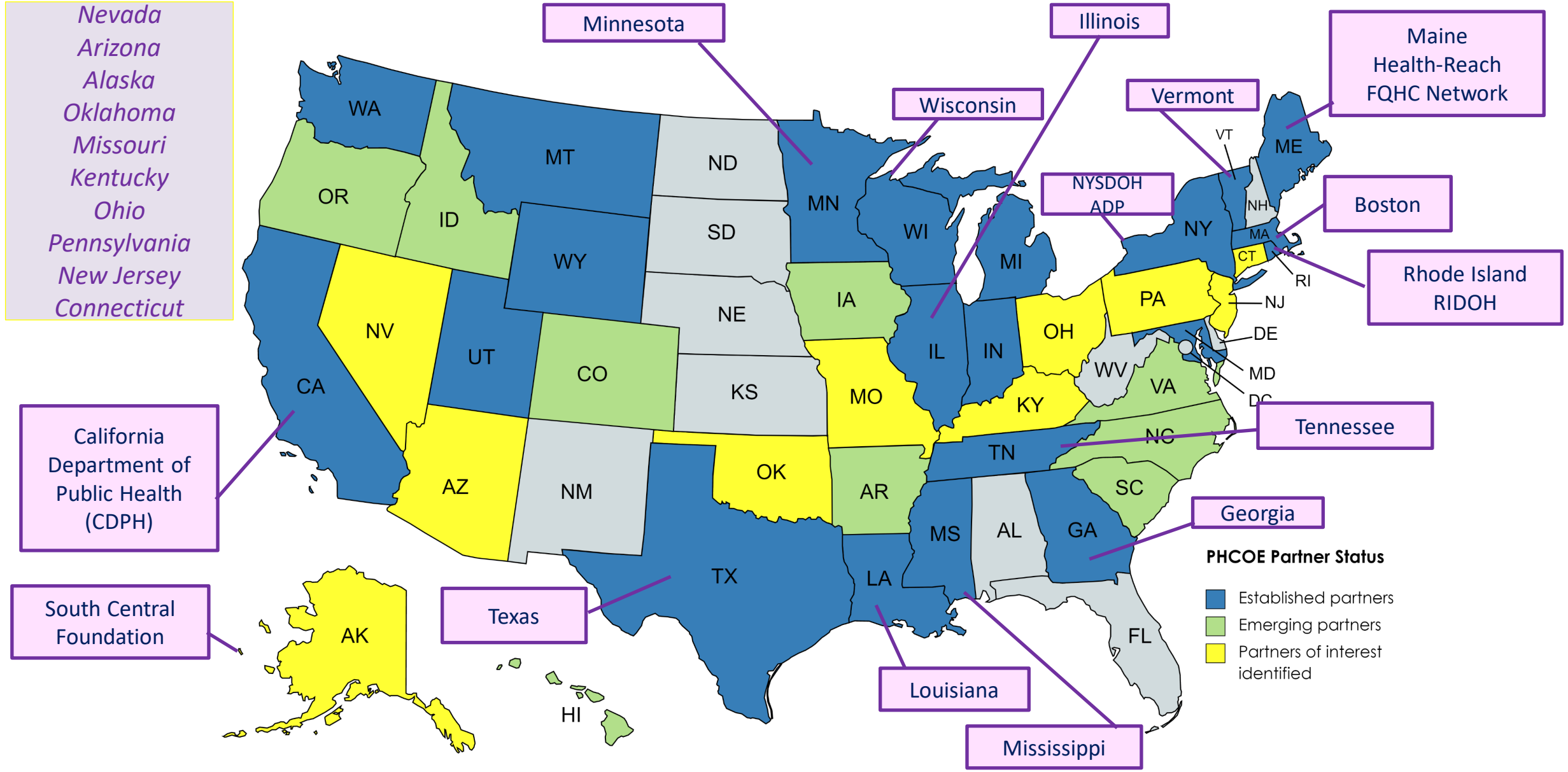
Navigating post-screening conversations

Screening for cognitive impairment is a crucial first step to ensuring patients' overall health.

Detailed conversations with patients about their lives and their day to day activities provide context for cognitive screening and establishes an important partnership in ensuring best opportunities to maintain health. Supporting brain health is vital to overall health, regardless of the results of any screening activity. In the event of a positive screening test, continuity of care is essential and often helps to "complete the story". This work is never completed on one visit as there will always be more. This is a journey for both primary care providers and these patients and their families. Primary care is exactly the vehicle for such a journey because this is always about relationships between patients, their families and providers. When impairment is detected, having readily available information to refer to other resources (e.g., community-based organizations, state or local resources) is a critical element of ongoing care.

Our National Partner Network

Nevada
Arizona
Alaska
Oklahoma
Missouri
Kentucky
Ohio
Pennsylvania
New Jersey
Connecticut



HBI Collaborative

Multi-component approach to fully integrate dementia, cognitive health and caregiving into public health practice

HBI Collaborative

Find us online

- About the HBI Collaborative
- Participating Members
- Contact Information

hbicollaborative.org

Get in Touch!

QR CODE FOR **NEWSLETTER SIGN-UP**

Contact our team by emailing NYUBOLDCenter@nyulangone.org to submit a request for resource sharing or to join our national partner network

QR code for technical assistance form

Featured Expert:

Barak Gaster, MD
Professor of Medicine
Director of the Cognition in Primary Care Program
University of Washington

Early Detection and Prevention

The Role of Primary Care

Cognition in Primary Care

82-year-old woman comes to see her PCP for annual wellness visit.

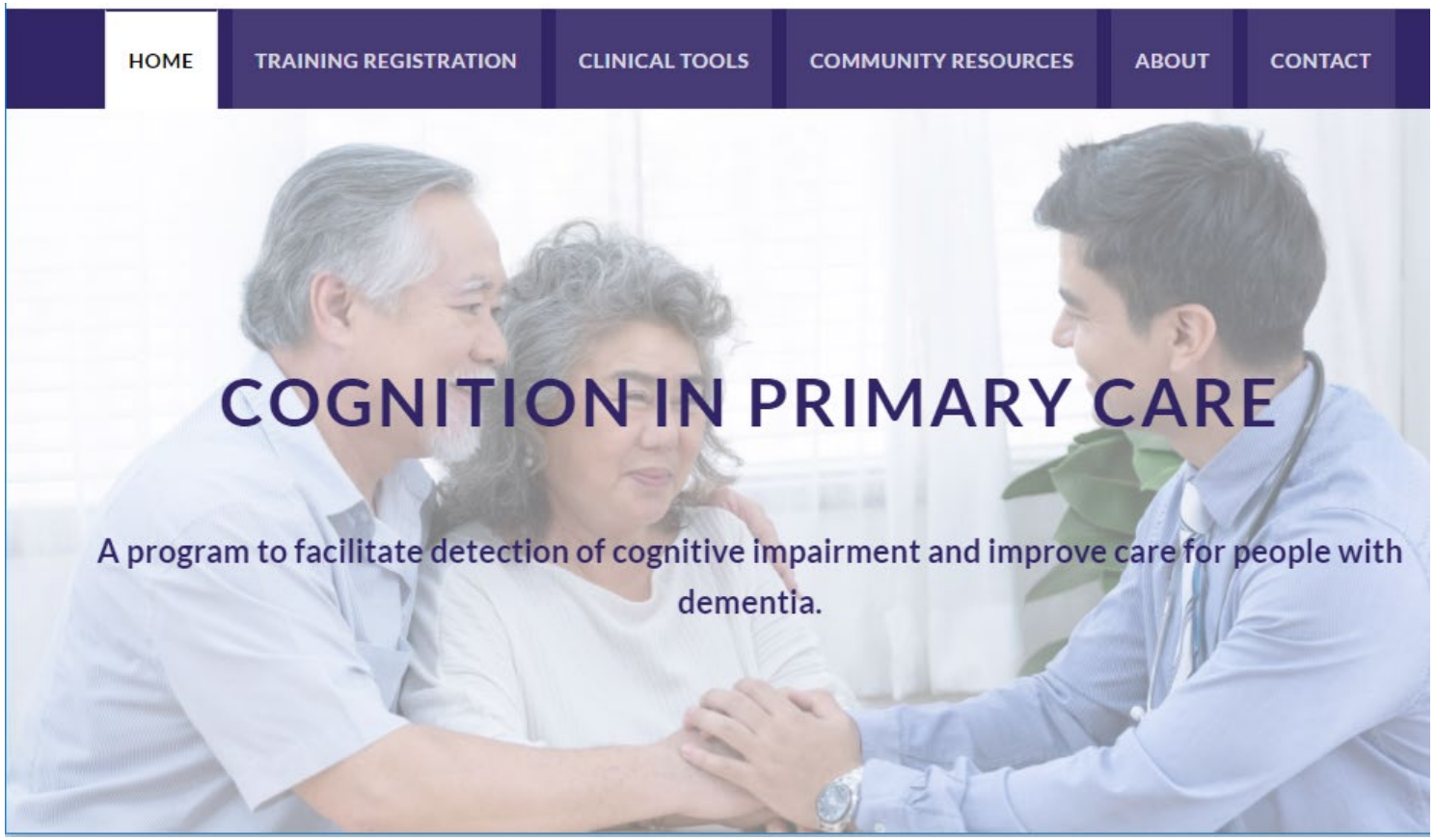
Generally, very healthy.

She happens to mention, “I‘ve been worried about my memory.”

Primary Care needs/ wants a path forward

- Don’t just reassure. “Don’t worry, it’s normal.”
- Can’t refer all to Memory Clinic. Lack capacity.
- Not practical to do a cognitive assessment then and there. Lack of time.
- **<u>Solution</u>: Schedule a follow-up visit for cognitive evaluation**, *family member also*.

A model to efficiently perform cognitive evaluations



Dementia: primary care disease

- We’re on the front lines.
- Patients trust us.
- Specialists hard to access.

- Goal: a structure to evaluate cognition: improve care: helps us, helps the system.

Better Care from Diagnosis

- Better communication, support, family involvement.
- Makes care easier, less chaotic.
- Take steps to improve **brain health** now: treat sleep apnea, treat hearing loss.

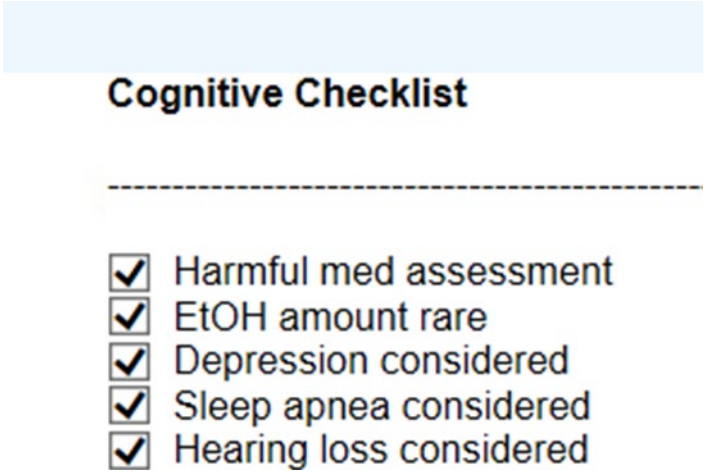
The Need for Education

Make a diagnosis of cognitive impairment

Set a plan for a newly diagnosed patient

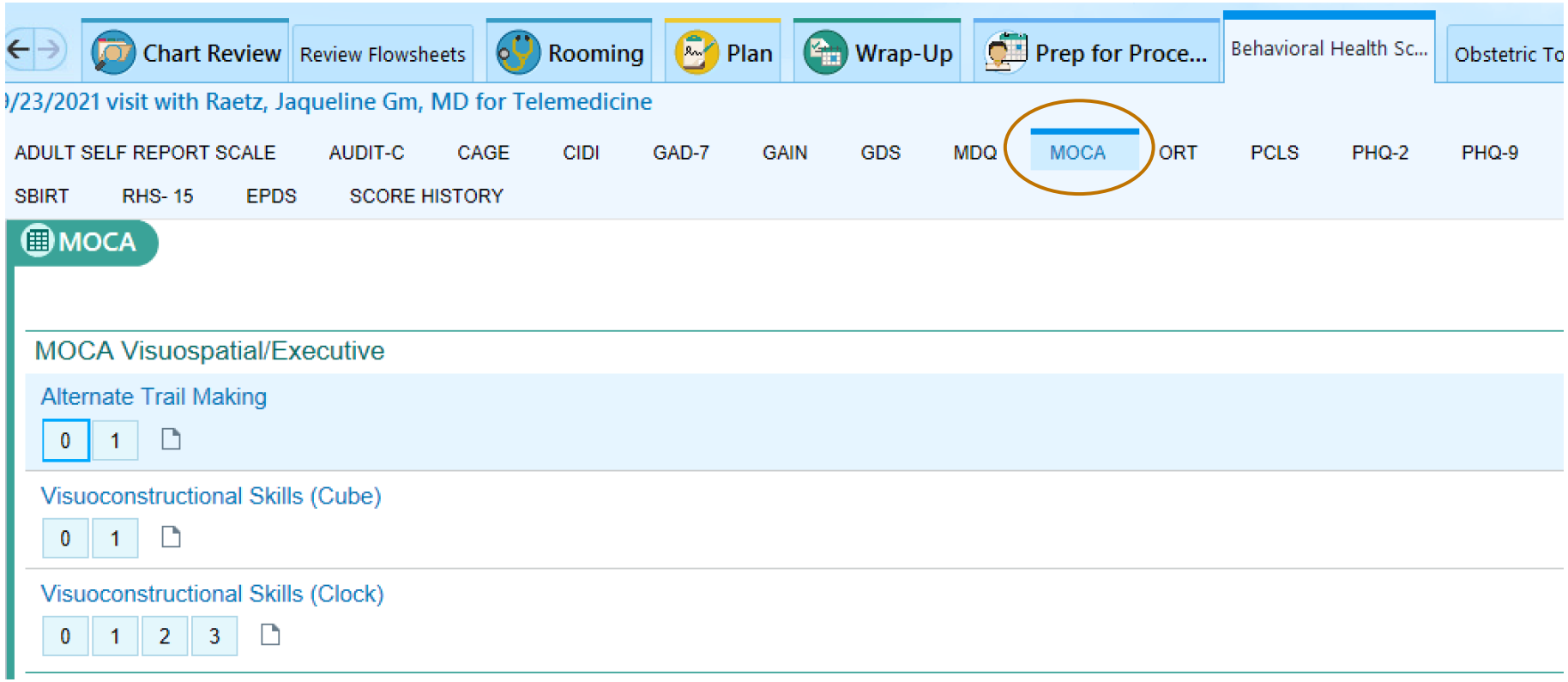
With simple tools to use in practice

- Structured framework for evaluation.
- Brain health checklist for prevention.



Cognition in Primary Care

Enter MoCA results: Behavioral flowsheet



AD8

A brief observer interview to detect dementia.

Neurology 2005;65(4) 559-64

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)		

Cognition in Primary Care

Set the next steps:
A plan for the newly diagnosed

- Difficult-conversation (“serious-news”) communication model.
- Guidance on when to refer to specialist, and what are key education and support resources to provide.
- Interventions to maintain Brain Health.

Cognition in Primary Care

Brain Health – Checklist

- ❑ **Alcohol**: Limiting to 0-1 drinks will help your thinking.
- ❑ **Medications**: Avoid sedating and anticholinergic meds.
- ❑ **Contributing Conditions**: Sleep apnea, hearing loss.
- ❑ **Exercise and socialization**: Daily walks with a friend.

Cognition in **Primary Care**

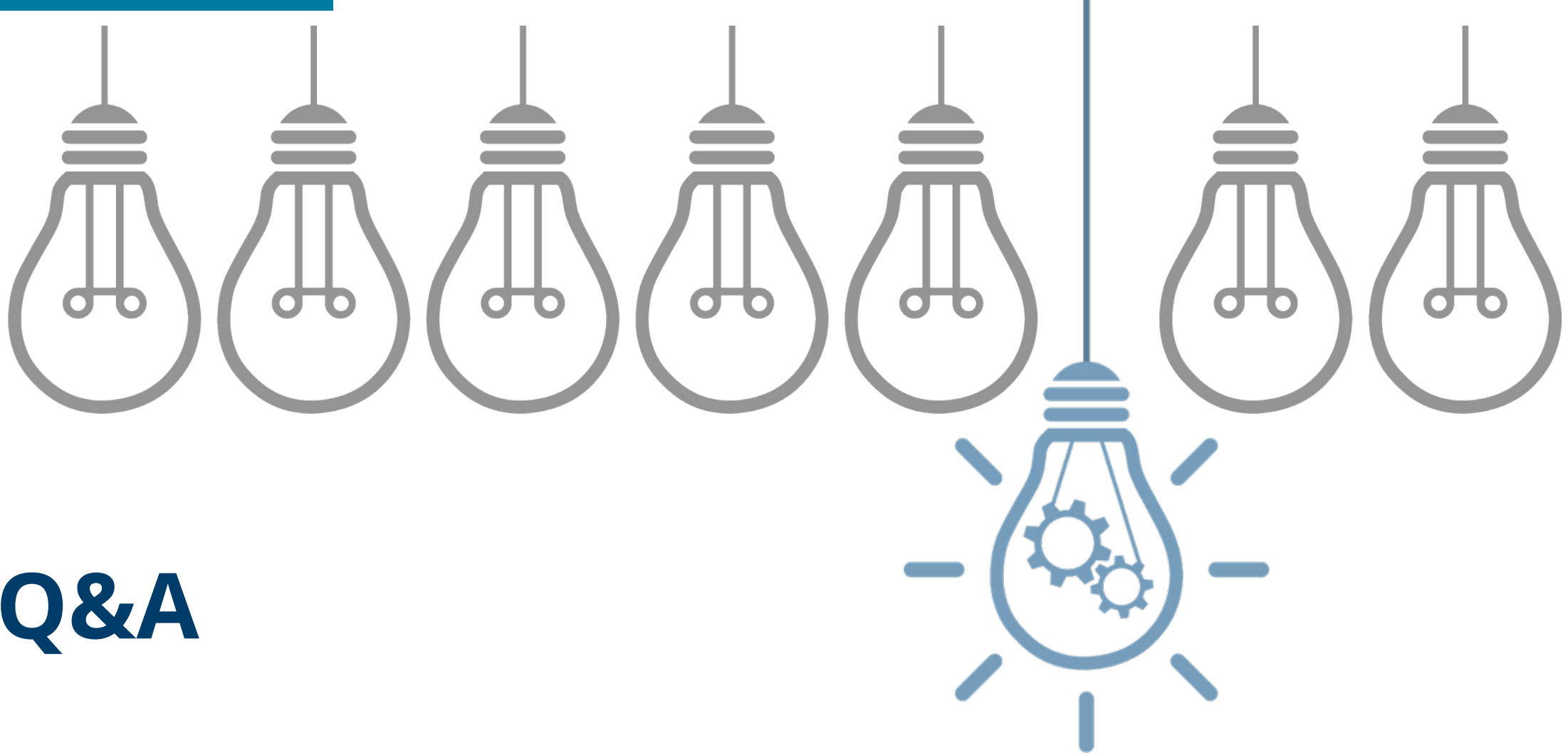
Using the GSA KAER Toolkit, a workable model for primary care:

- Earlier detection of impairment.
- Better care.

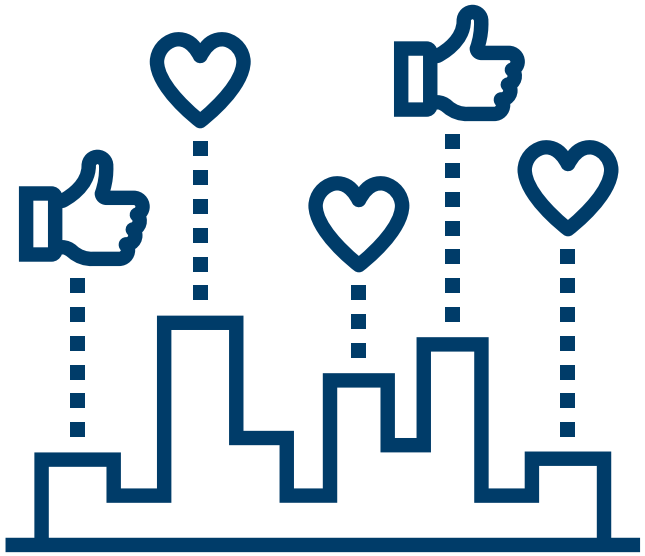
Cognition in Primary Care

We Can Make a Difference

- Training and tools, easy to share.
- Design by primary care, for primary care.
- PCPs want knowledge, and they need tools to assess cognitive impairment.
- Path to make a difference in early detection, take steps to promote a healthy brain.



Q&A



Provide Us Feedback

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SHARE YOUR FEEDBACK

Don't forget! Let us know what you thought about today's session.

Next Webinar:

May 17, 2023
1:00 – 2:00 pm ET