Panel Discussion on Memory loss

Dianne McIntyre: Primary Care
Melissa Andrew: Geriatric Psychiatry
John Puxty: Geriatric Medicine
Driving Change: The Dementia Tsunami

<table>
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<tr>
<th>Year</th>
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Estimated Total Costs

YEAR OF PROJECTION

TOTAL HEALTH SYSTEM COSTS AND OUT OF POCKET CAREGIVING COSTS ($ MILLION) TO PERSONS WITH DEMENTIA (CONSTANT $ CDN) 2010

- 2011: 8,331.60
- 2016: 9,664.20
- 2021: 11,255.50
- 2026: 13,460.60
- 2031: 16,366.80
Common Terms used

- Normal Age-related Memory Changes
- Mild Cognitive Impairment (MCI)
- Dementia (Diagnostic and Statistical Manual of Mental Disorders [DSM] IV)
- Minor and Major Neurocognitive Disorders (DSM V)
Memory and “Normal” Aging

- Typically, older adults need more time to process information.
- Increased distractibility
- May have difficulty coming up with names spontaneously (retrieval).
- For healthy older adults, these changes represent more inconvenience than significant functional impairment. A number of strategies can compensate for these changes.
- In fact, older adults tend to have much better semantic memory than young adults (perform better on tasks of vocabulary & world knowledge).
Mild Cognitive Impairment (MCI)

MCI causes a slight but noticeable decline in cognitive abilities. Symptoms include:

- Memory complaint
- Objective memory impairment
- Normal general cognitive function
- Intact activities of daily living

10-20% of people with MCI progress to dementia; after 10 years 20% of those with MCI are NOT demented.
Definition of Dementia (DSM IV)

The diagnostic criteria includes:

- **Presence of** memory impairment
  - plus at least one of: aphasia, apraxia, agnosia or executive dysfunction
- **Associated with** a decline from previous cognitive functioning
- **And** functional impairment usually affecting IADLs (this differentiates dementia from MCI),

It's important that other causes of worsening cognition, particularly delirium or depression, are considered before making a diagnosis of dementia.
DSM 5 and “Dementia”

- Alternative terms of minor and major neurocognitive disorders
- The DSM-5 details six cognitive domains which may be affected in both Minor and Major NCD. These cognitive domains (and their associated warning signs/red flags) include:
  - **Complex attention** - involves sustained attention, divided attention, selective attention and information processing speed
  - **Executive ability** - involves planning, decision making, working memory, responding to feedback, error correction, overriding habits and mental flexibility
  - **Learning and memory** - involves immediate memory, recent memory (free recall, cued recall and recognition memory) and long term memory
  - **Language** - involves expressive language (naming, fluency, grammar and syntax) and receptive language
  - **Perceptual - Motor - Visual perception, praxis** - involves picking up the telephone, handwriting, using a fork/spoon
  - **Social cognition** - involves recognition of emotions and behavioural regulation, social appropriateness in terms of dress, grooming and topics of conversation
DSM 5 and “Dementia”

- Minor is decline in neurocognitive performance, usually with cognitive tests within 1-2 S.D’s of norm (3rd-16th percentile) and while not interfering with independence but requiring greater effort of compensatory strategies.

- Major is a decline in neurocognitive performance, typically involving test performance in the range of two or more standard deviations below appropriate norms (i.e. below the third percentile) and are sufficient to interfere with independence (IADL’s).

- Includes exclusion criteria of presence of delirium or deficits attributable to other mental health issues such as depression or psychosis.
Upper Canada Family Health Team
Memory Clinic

- The Upper Canada Family Health Team (UCFHT) offers a Memory Clinic at two sites—Gananoque and Brockville
- Based on Dr. Linda Lee’s model for Memory Clinics in Primary Care
Memory Clinic

• Dr. Lee is a family physician from the Centre for Family Medicine (CFFM) Family Health Team and the Director of the CFFM Memory Clinic (located in Kitchener/Waterloo)
• Members of our Memory Clinic Teams received extensive training from Dr. Lee and her colleagues
• The Memory Clinic Team members participate in ongoing training and development through annual Booster Days that are organized through the CFFM
Memory Clinic

• The Memory Clinic operates twice a month in both Gananoque and Brockville
• Four patients are assessed at each clinic
• The appointments are a combination of either initial or follow up appointments
Memory Clinic

• Each Memory Clinic Team is comprised of a physician, nurses, social workers and a member of the Alzheimer’s Society
• The Memory Clinic provides an inter-professional approach to providing early diagnosis and treatment for problems associated with memory loss
• For many of these conditions, early diagnosis and treatment can help to maintain independent living and quality of life for as long as possible
Memory Clinic Home Pre-Screen

- Unique to the Brockville site of the UCFHT
- An RPN completes a home visit
- Purpose of this visit is to explain the memory clinic appointment, assess for the patient’s safety in the home and to make any necessary referrals prior to the Clinic appointment date
Preparation for Appointment

• Prior to the Memory Clinic appointment, patients are required to complete investigative procedures.
• These procedures include:
  • Blood work--HbA1C, glucose, TSH, Creatinine, electrolytes, Vitamin B12, CBC and Lipid profile if cardiovascular indicators
  • Urinalysis
  • ECG
  • CT scan of the head
Memory Clinic Appointment

- The patient and a family member will meet with a team of nurses, social workers, a representative from the Alzheimer’s Society and the physician for a comprehensive assessment.
- Each appointment lasts approximately two hours.
- During this time, the patient and family member complete the Intake forms with the nurse and Social Worker.
- The patient completes the cognitive testing with the nurse and the Cornell Scale for depression.
Cognitive Testing

- MoCa
- Trails Testing
- CLOX
- Intersecting pentagons
- Executive function tests—months of the year backwards, Go-No-Go and Luria
- Animal Lists generation
Memory Clinic Appointment

- While the nurse is completing the cognitive testing, the Social Worker meets with the caregiver or family member privately to gather further information about the patient’s condition.
- During this time the family member completes the Cornell Scale for depression about the patient from their perspective.
- The Social Worker also assesses for caregiver issues and administers the Zarit Burden Interview
- If required the Social Worker will also complete the Frontal Behaviour Inventory (FBI)
Memory Clinic Appointment

• Results are then reviewed as a team
• Physician discusses results with the patient and family member, along with involved team members
• Patients are given a written care plan with the recommendations to take home with them
• Member of the Alzheimer’s Society will stay with patient and family member following this discussion to answer questions and provide information about the recommended resources
• Recommendations are sent to the patient’s family physician
### Upper Canada Family Health Team
#### Memory Clinic Care Plan

<table>
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<th>Date:</th>
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<tr>
<td><strong>Your Memory Clinic Team:</strong></td>
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<tr>
<td>Dr. Pajot, Dr. Tyler, Jane Banbury, MSW, RSW (Social Worker); Nicole Kirkby, Reg. N (Registered Nurse); Dianne McIntyre, Reg. N, RScN (Registered Nurse); Janice Feltham, MSW, RSW (Social Worker); Lisa Livingston, MSW, RSW (Social Worker); Sean McFadden, BA (Alzheimer’s Society)</td>
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**Recommended Changes to Your Medications:**

- ☐ Medications to be Blister Packed

**Recommended Plan:**

- ☐ Bloodwork
- ☐ Imaging (CT or MRI)
- ☐ EKG

**Driving Recommendations:**

- ☐ Not Applicable
- ☐ No Driving Concerns at Present
- ☐ Ministry of Transportation Notified
- ☐ Recommend On-Road Driving Assessment
- ☐ Recommend that you NOT Drive

**Referrals:**

- ☐ Alzheimer’s Society
- ☐ Home Care
- ☐ Community and Primary Health Care
- ☐ SMILE
- ☐ OT Assessment
- ☐ Medic Alert Safely Home
- ☐ Sleep Study
- ☐ Geriatric Mental Health Community Team
- ☐ Other

**Other Information:**

In order to maximize your health, safety and independence, you are encouraged to stay socially active, eat a healthy diet and increase your physical activity, all of which help to improve brain health. You are also encouraged to follow the recommended guidelines for alcohol consumption: No more than 10 drinks a week for women, with no more than 2 drinks a day most days. No more than 15 drinks a week for men, with no more than 3 drinks a day most days.

**Next Appointments:**

Please make appointment to see your family doctor in 2 weeks and **BRING THIS SHEET WITH YOU**.

You will be contacted in enter # of mos months for a follow up appointment with the Memory Clinic Team.

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*If you have any questions about your memory clinic appointment please contact us at 613-423-3333 ext 211*
Population Served

- Upper Canada Family Health Team is comprised of two Family Health Organizations
- The Thousand Island FHO
  - Lansdowne, Seeley’s Bay and Gananoque
  - Nine Physicians
  - 11,868 patients
- Brockville FHO
  - Seven sites throughout the city
  - Seventeen physicians
  - 25,731 patients
Common Profile

- Majority of patients are living independently either in their own home or apartment
- Underlying co-morbidities including hypertension, diabetes, dyslipidemia and stroke
- Either the patient or one of their family members or friends have noticed changes in the patient’s memory
Referrals (Brockville Site)

48 referrals Nov. 2017 – April 2018

• Ages
  • Below 65  5
  • 66 – 75  11
  • 76 – 85  25
  • 86 and over  7

• Gender
  • 32 Females
  • 16 Males
Referrals

- Referrals to the Memory Clinic are completed by either the patient’s Physician or Nurse Practitioner.
- This is due to the implications that poor test results can have on the patient’s current lifestyle.
- Patients are generally referred because either they themselves, a family member or someone else has noticed changes in the patient’s memory.
Challenges for the Memory Clinic

- Family physicians not ordering required work-up (bloodwork, CT scan, ECG)
- The “Driving” issue
- Voluntary—sometimes family members want the patient to have memory testing and the patient declines
- Patient not bringing a caregiver with them to the Memory Clinic appointment
- Patient or Family physician not following up on recommendations
- People living independently and not agreeing to assistance (i.e., referrals for home service)
Challenges for the Memory Clinic

- Ensuring appropriate time delay when scheduling appointments for patients who have suffered a stroke before coming to Memory Clinic
- Age of some of the referred patients
- Patients diagnosed with multiple complex conditions
- For these cases, patients may need to be referred to a specialty service such as the Geriatric Mental Health Community Team, Providence Care – Geriatric Medicine Clinic in Kingston or Elisabeth Bruyere Hospital in Ottawa
Opportunities in Our Setting

- Member of the Alzheimer’s Society present at the appointment to provide education, information and support
- All patients are contacted within two to four weeks following the appointment
- Interdisciplinary team approach
- Ongoing follow up appointments with the Memory Clinic for continuing assessment, intervention and support
Opportunities in Our Setting

- Referrals are made for community resources within few days of appointment
- Complex patients referred to Health Links
- Family physician receives report by end of the day
- Protects patient/doctor relationship re: driving
Geriatric Psychiatry
Seniors Mental Health Outreach
• Outreach team serving Kingston area
• Houses and apartments, retirement homes, long term care
• Similar teams based in Napanee (L&A) and Bellevile (HPE)
How it Happens

• Triage including all available investigations

• Case Manager (RN, OT, SW) make initial visit

• Assume primary liaison role

• Most receive 2nd visit with psychiatrist
• Shared care model with primary care
• Link to community-based supports
• Avg 6 months
Who?
Who?
Miss B

- 87 year old, never married, living in the home that she was raised in
- No relatives
- First home visit -> 3 neighbours appear
- All providing various forms of support
- A friend out of town = POA
• MoCA- 19/30

• Risks identified; neighbours all becoming concerned

• Coordinated efforts of neighbours – nutrition, medication monitoring; some paid supports
• With additional supports, Miss B lived for 2 years before suffering a CVA

• Neighbours coordinated trip home

• POA applied for LTC
•Ultimately 2 neighbours drove her there and settled her in
Mrs C

• 81 year old widow (x20 y)
• Lived alone, drove an orange Mustang
• Referred by CCAC (SELHIN) for “suspiciousness”
Mrs C

• Refused entry to all supports; some refused to enter due to her verbal barrage
• Suspicions = convinced care providers were stealing
• Plan was to move to Europe. Had managed to renew her passport despite MoCA 13/30.
• Neighbours begged us to do something re
• Advised her not to drive. Surprisingly she agreed.
• Now, no groceries. Walked to store occasionally.
• Monitored: nutrition, hygiene
• Tried risperidone but inconsistent
• Waiting for a crisis
• Extended time in her home ~ 8 mo
• Ultimately no food, no supports
• Sister in Arizona agonized over the decision
• Not accepted for admission to LTC
• Form 1 to hospital -> BSTU -> LTC
Mr & Mrs E

• Live in retirement home because house was “too much”
• Mr has dementia (mixed)
• Mrs has significant health concerns
• Mr has made 2 attempts to “escape” RH at night -> “needs Form 1”
• Irritable, doesn’t always recognize her, “what’s a man doing in my bed?”
• Shadows her all day
• Sleep disrupted, Mrs exhausted
• At least 3 trips to ER
• Risperidone 0.5mg qhs
• Work with staff to understand
• Support / education for wife + + +
• No more ER
• Facilitated planned move to higher level of care
Strengths

• Assess & monitor risk
• Caregiver support & care strategies
• Medication recommendations
• Flexibility
• Accessibility
• System navigation & support
• Big “O” Outreach
Challenges

• Getting shared care right
• “Cadillac” service
• Long term follow up
• Non-professional caregivers
• LTC availability
Thank you!

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Geriatric Memory Disorders Clinic at Providence Care Hospital

Dr John Puxty
puxtyj@providencecare.ca
Outline

- Current population served
- Service Description
- Challenges
- Opportunities
Clinic Intake

● Triage based on intake info

● Options:
  ▪ General Geriatric Medicine Clinic
    • Usually >75 with “common presentation” +/- comorbidities
  ▪ Seniors Day Rehabilitation
    • Usually >75 with functional issues and cognitive problems
  ▪ Geriatric Memory Disorder Clinic
    • 55-74 years with memory concerns
    • Atypical dementias: PPA, Fronto-Temporal, PD+
    • High functioning individuals with dementia
    • Complex presentations of younger patients often with previous head trauma or psychiatric issues or learning disabilities
    • Cultural minorities
Geriatric Memory Disorder Clinic Process

- **Frequency**
  - Usually new patients 2-3 per clinic with 1-2 clinics weekly
  - Follow-ups 4-6 per clinic with 2-3 clinics

- **Interdisciplinary assessment by nurse and geriatrician**

- **Nurse:**
  - Flags keys issues
  - Clarifies medication profile
  - Office Cognitive tests
  - Counselling

- **MD:**
  - Modified Comprehensive Geriatric Assessment
  - Targeted history of cognitive issues inclusive of risk factors
  - Review co-morbidities and medications
  - Further targeted assessments of language, attention, executive and memory domains
  - Detailed neurological assessment and targeted systems review
  - Assesses and interprets functional impact of cognitive deficits
  - Determines need for further investigation
  - Schedule follow up visit for further feedback and counselling
Geriatric Memory Disorder Clinic Process

- First follow up visit
  - Ideally 4-6 weeks (but delays re neurodiagnostics common)
  - Share and discuss all findings
  - Discuss need for further neuropsychiatric testing
  - Suggest probable diagnosis and prognosis
  - Agree treatment plan between patient and caregivers
  - Identify and discuss strategies to reduce risk factors
  - Address proactively issues of POA and Driving

- Subsequent visits usually graduate from 3/12 to once a year with focus on shared care
Geriatric Memory Disorder Clinic Challenges

- Nurse and MD have other roles and demands on their time with an impact on wait times
- Limited access to other members of health professional team
- Delays in neurodiagnostics
- Limited access to further neuropsychometry testing
- Approximately 25% of case would benefit from involvement of psychiatry and neurology
- Distance patient/families have to travel
- Missed educational opportunities
Opportunities

- Parallel Recruitment in Neurology, Geriatrics and Geriatric Psychiatry
- Proposed creation of Regional Integrated Cognitive Assessment and Management Program
- Increased linkages with primary care led memory disorder clinics
- Developed of Regional Memory Disorders Knowledge Exchange Network
- Provincial Dementia Strategy: central intake
Clinician Role in Dementia

- careful assessment, identification of all contributory factors and probable diagnosis
- communicating the findings and diagnosis and discussing probable natural history and treatment options
- responding to common questions and concerns
- optimizing of cognitive, medical and functional status and reduction of ongoing risk factors,
- developing an anticipatory care plan sensitive to ethico-legal issues that includes monitoring, mobilization of patient and caregiver supports and adjustment of strategies
- considering use of cognitive enhancers
- collaborating with other health providers and community agencies
- identifying of psychiatric co-morbidities
- monitoring for and anticipating common issues and concerns (driving, delirium, depression, disruptive behaviors, sleep disruption etc)
- consulting with other specialist services as needed