# Empowering Primary Care Management of Alzheimer's Disease (AD) Post Diagnosis: Person-centered care in a changing landscape

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Theresa Sivers-Teixeira, MSPA, PA-C
Department of Family Medicine
Keck School of Medicine of University of Southern California
siverste@med.usc.edu

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- I have no conflicts to disclose.

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# Objectives

- Explain the imperative for primary care PAs to manage post-diagnosis Alzheimer's disease across the spectrum of disease burden.
- Identify goals of primary care management of Alzheimer's disease and major components of clinical care
- Describe person-centered approach to primary care management of Alzheimer's disease.
- Recognize appropriate candidates for recent pharmaceutical interventions and summarize potential benefits and risks associated with these therapies

# Why is this topic important to primary care?

- **Aging #1 risk factor** for Alzheimer's Disease
- People living with Alzheimer's Disease (PwD) are **hospitalized more** than older adults without AD
- 95 % of persons living with dementia (PwD) have at least 1 **chronic disease** and acquire more with AD progression
- **Emerging biomarker detection & new treatments** – PAs will need to know which patient may qualify as well as risks & benefits of treatment
- Most primary care **PAs do not feel comfortable managing** or co-managing AD or related dementias

## Goals of Person-centered Primary Care of PwD

- Whole person approach- treating the person not a disease
- Chronic disease management
- Evidence-based medicine guided by what is/has been most important to the patient
- Enhance and maintain quality of life throughout disease progression
- Strengths based approach-adaptations to preserve autonomy and dignity

# Aligned with Age-Friendly Care (4 M's)

- What **M**atters most to PwD*
  - Know and respect cultural values and norms
- **M**edications
  - Reduce polypharmacy, deprescribe high risk medications, ask about side effects
- **M**obility
  - Optimize functional mobility, reduce fall risk
- **M**entation (3 D's)
  - Detecting & Managing depression, delirium, dementia

# Components of managing AD in Primary Care

- Optimize Function & Quality of Life
- Manage Chronic Disease
- Promote Positive Behavioral Health
- Optimize Medication Theory
- Assess Safety & Driving
- Assess for Elder Mistreatment (EM) & be alert to risk for EM (mandated reporter)
- Facilitate Advanced Care Planning & End of Life Care
- Assess Care Partner Needs
- Refer to Community Services and Supports

# Timing & Teams

*You can't do it all at once!*

*You can't do it all alone!*

# Optimize Function & Quality of Life

## Know What Matters to the PwD

- What gives your life meaning/purpose?
- What brings you pleasure?
- Current and past values?
- Who are the people in your life you most trust?

## Assess ADL & IADLs

- Functional Assessment Questionnaire (FAQ)
- AD8 brief informant assessment (AD8) by trusted person often identified as CG)

## Assess mobility

- Ask about falls/near falls in last 2 month
- Timed Up & Go (TUG)

# Promote Positive Behavioral Health

## Screen for depression & anxiety

- Geriatric Depression Scale (GDS)
- Tell me about your mood? Changes?
- Ask key trusted informant about mood?*
- Social isolation?

## Observations *(changes)*

- Apathy
- Engagement
- Body language

## Agitation/behavior changes

- ***Rule our delirium first!***
- Caregiver Coaching (Caregiver Tip Sheets)
- Caregiver support
- Medication- consider with caution only after other options failed

# Medication Managment

- Reduce polypharmacy
- Ask about side effects (risk vs benefits)
- Deprescribe high risk medication for patients with AD (Current Beers Criteria)
  - Avoid anticholinergics, muscle relaxants, opioids, hypnotics, antipsychotics….
- Simplify when possible- educate on tools to organize medications
- When starting medications start low and go slow

# Medication for AD

Cholinesterase inhibitors for *mild to moderate dementia*

*Does not reverse cognitive decline

* Discontinue if no reduction of sx or GI distress (shared decision making)

- **Donepezil (Aricept)**
  - 5 mg,10 mg tab PO daily
  - Start at 5mg x 4 weeks, can increase to 10 mg
- **Galantamine**
  - Extended release 8 mg, 16 mg 24 mg tab or liquid 4 mg/mL
  - Start 4 mg PO bid, can increase to 8 mgx in PO bid
  - If is interrupted by > 3 days retitrate to from 4 mg
- **Rivastigmine**
  - 1.5 mg, 3 mg, 4.4 mg, 6 mg tab
  - Start 1.5 mg bid for 2 weks and increase by 1.5 mg/dose q 2 weeks
  - Rivastigmine transdermal (Exelon)
    - May use if other options cause GI distress, not covered by all insurers

# Medication for AD

- Glutamate blocker
- May help slow decline in memory & thinking skills.
  - Memantine:
    - In liquid or tab form taken 1-2 times daily
    - Start at 5 mg PO daily and titrate up to 20 mg
      - Increase by 5 mg/day no more frequently than q wk
      - Max dose 10 mg bid

  Side effects may include dizziness, headache, confusion, hallucinations, agitation & constipation.

# Advanced Care Planning/End of Life Care

- **Anticipatory guidance** on disease progression
  - Overtime decreasing function will require more care
  - **Identify trusted people** to help you
  - **Legal/Financial matters-** appointment of trusted people to manage finances & medical decision making when needed when unable to make a decision for self
  - **Advanced Care Plan for Healthcare**
  - Consider **POLST when disease is more severe**
  - **Consider Hospice for end stage dementia-** more resources, often unable to leave home

# Assess Safety

## Still driving?

- Ask if still driving-recent hx of accidents?, lost?
- Consider OT specialty referral to assess driving
- Resource for PwD &
  - **Family Conversations About Alzheimer's Disease, Dementia & Driving**

## Home Safety

- Home environment- adaptations as disease progresses:
  - Fall risk, supervision at home need, ability to be on own, Has the stove ever been left on?

# Safety- Elder Mistreatment

- **50% of PwD experience mistreatment**, most often by a trusted person
- **Types of mistreatment:** financial*, emotional*, physical, sexual, neglect, medication misuse
- **Increased risk** with:
  - PwD increased dependence, social isolation
  - CG overwhelmed, financially dependent on PwD, substance misuse, social isolation

# What you can do:

Screen patient *without* CG present

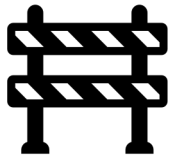
- Screens on PwD are sensitive and specific
  - Not delirious, able to respond

Educate yourself and caregivers preventing abuse & detecting suspected abuse

- National Center on Elder Mistreatment (brief practical education, multiple languages)

- Always keep elder mistreatment on your differential

- Report suspected mistreatment to Adult Protective Services



# Elder Mistreatment Screening & Response Tool (EMSART)

- Brief Screen (Yes or No)
  - Has anyone close to you harmed you?
  - Has someone failed to give you the care that you need?
  - Has anyone forced you to sign papers or used your money against your will?

*If any positive there is a more in depth screening in link

National Collaboratory to Address Elder Mistreatment

Link to NACEM

# Caregiver/Trusted Other

Must also maintain & preserve quality of life

- Encourage all to participate in CG Support group & CG Education (available remotely)
- CG Burden Screening
  - Positive
    - Refer to Social Work, advise to discuss with own PCP, Respite Care, Community Resources, Encourage self care, Other caregivers: paid or unpaid
    - Private Geriatric Care Managers for those that can afford service

# Team-Based Care Primary Care

- Interprofessional Referrals

  - **Behavioral health-** caregiver burden, family conferences, advanced care directives, depression
  - **PT-** optimize physical function, reduce fall risk,
  - **OT-** driving assessment, adapting meaningful activities, modification of activities to maintain sense of purpose, home modification "dementia friendly"
  - **Social work-** community referrals, social intake, help with completing forms for resources,
  - **Community Health Worker** Programs
  - **Specialists-** Geriatrician, Gero-psychologist, Memory Neurology, Gero-pharmacist * *complex cases, unusual progression*

# Effective Referrals

- Why are you referring? Dx, data
- What question/concern do you have?
- Any previous work up?
- What have you tried?
- Include problem with dx code in note with plan
- *A warm hand off increases effectiveness of referral*
  *(call, note via email, EHR message)*

# Educate Your Clinical Team

## Effective communication with PwD & CG

Front office, scheduler, follow up, reminder calls, referrals

- Who to contact for appts/reminders
- Remind to bring trusted family or friend with them

Clinical teammates: MA, LVN, Care Manager…

- Huddle to identify PwD on schedule
- Educate in effective screening
  - CG & informant screens can be done by phone or while waiting, already connected with any community resources?
  - TUG, fall screen, GDS can be done before seen by you
  - Education & warm hand off to community resources & referrals can be done post visit in person or in follow up call

# How to manage:

- If possible, schedule multiple appointments out as far as template allows.
- As disease progresses continue to cover primary care components. Needs and care plan will change as more chronic issues related to the disease emerge

# Disease Progression Needs Shift in Plan

- What worked 6 months ago may not work now
  - Reduced function>increased dependence
  - Increased caregiver burden > burnout, PwD safety
  - Increased safety risks
  - Behavioral changes

Like any other chronic disease when uncontrolled, adapt your plan. Consider appropriate referrals

# What to know about monoclonal antibody treatment for AD?

~~aducanumab~~, lecanemab, donanemab

Goal: slow progress of AD by reducing specific beta amyloid proteins

- Efficacy- *small* effects cognitive scores or changes in function in studies *so far*
- Biomarkers
  - *Large* effects on multiple biomarkers
    - Amyloids dramatically reduced on PET scans

# Adverse Events

- Adverse Events that generally resolve early in treatment:
  - Infusion reactions at site,
  - cerebral edema on imaging (mostly without sx),
  - Microhemorrhages on imaging

## Black Box Warning

- Amyloid-Related Imaging Abnormalities (ARIA)
  - Usually early in treatment & then resolves
- ***Homozygous APOE E4 carriers*** **have a higher risk of intracerebral hemorrhages some of which have been fatal have occurred in this group. Rare.**

**15% of AD patients**

# Challenges

- Complex procedures
- Barriers to access
- Threats to effective treatment
  - Missed doses, non-compliance, drop out, infusion visits, lack of assessments, extra MRIs
- Small clinical effects
- Benefit considerations rely on plaque reduction & clinical management

More trials needed. Now recruiting people without cognitive impairment biomarker +

# Would I qualify for lecanemab?

- Early AD?
  - Mild impairment
  - MRI scan < 4 microhemorrhages
  - PET scans
  - General good health? Ambulatory?
  - 55-80
- Living at home? Partner?
- Twice monthly infusion visits?
- Travel, time, effort, commitment?
- Can I afford this?
- Insurance Copays? Medicare? Medicare Advantage?

**USC**

# A few words about serum biomarkers

- AD dx could only be confirmed with a PET scan or CSF (lumbar puncture) that demonstrated a high level of specific amyloid proteins consistent with AD pathology
- NEW blood based biomarkers
  - Identify these beta amyloids 40/42 and phosphorylated tau proteins p181 & p231
  - Not all people who are found to have these markers develop AD
  - Amyloid ratio, combined with a person's age and APOE phenotype may indicate a amyloid probability score low, intermediate, or high consistent with AD

# Debate whether they should be used in primary care

- Larger studies are needed especially in diverse populations
- Global Alzheimer's Association working group and American Geriatric Society advise against use of these test in primary care
- Suggest cautious initial use in specialized memory clinics
  - If you have a high risk patient family hx, known APOE E4 risk the recommendation is to refer to a memory clinic

# Thank you!

**Feel free to contact me for more resources or any other information or encouragement you might need.**

**Theresa Sivers-Teixeira**
**siverste@med.usc.edu**

# Resources

- National Resources
  - https://www.alz.org/help-support/i-have-alz/know-what-to-expect/just-diagnosed
- ACT on Alzheimer's Clinical Provider Practice Tool
  - https://actonalz.org/sites/default/files/documents/ACTNAT-Provider-ClinicalPracticeTool.pdf
- Video Tutorials
  - https://actonalz.org/sites/default/files/documents/ACTNAT-Provider-ClinicalPracticeTool.pdf
- After a Diagnosis
  - https://static1.squarespace.com/static/559c4229e4b0482682e8df9b/t/561f2778e4b05fb7f59240d4/1444882296205/DFA-Tools-AfterDiagnosis.pdf
- EHR Decision Support Tools for Alzheimer's and Related Dementias
  - https://static1.squarespace.com/static/559c4229e4b0482682e8df9b/t/57714bdcf7e0ab72f1ab3f14/1467042781285/DFA-Tools-EMRManual.pdf
- National Institute on Aging- Alzheimer's Disease and Related Dementias: Resources for Professionals
  - https://www.nia.nih.gov/health/alzheimers-dementia-resources-for-professionals
- Caregiver Tips Sheets https://www.alzheimersla.org/wp-content/uploads/2023/07/Caregiver-Tip-Sheets-all-English-Spanish-07-14-23.pdf
- Screening, Evaluation and Management of AD and Related Dementias https://championsforhealth.org/wp-content/uploads/2021/09/Alzheimers-Project-Booklet-v11-082221-Web.pdf
- Dementia Care Aware Cognitive Health Assessment https://www.dementiacareaware.org/wp-content/uploads/2024/04/Dementia-Care-Aware-Cognitive-Health-Assessment.pdf
- Alzheimer's Association Find state and local resources in your area