Geriatrics Journal Club

The effect of a disease management intervention on quality and outcomes of dementia care: a randomized, controlled trial

Presentation by George Bergus, MD:


Background

Dementia is common and associated with high social and economic costs. While not preventable at this time, institutionalization can be delayed with caregiver assistance and support. But many caregivers do not make use of available resources.

This paper reports on a trial of application of the chronic care model to dementia. The interventions included: Care managers at health care centers and community agencies to enhance collaborative care, formal communication procedures between health care and community agencies, provider education (5 sessions related to dementia care), care giver self-management support, and ongoing and automatic followup.

Methods

This is a cluster randomization trial involving 18 clinics in the San Diego area including academic clinics, fee for service clinics and health maintenance clinics. Clinics were matched and then randomized.

Patients were eligible if they were age 65 or older, had a prior diagnosis of dementia or had been prescribed a cholinesterase inhibitor AND had an informal caregiver age 18 years or older

Outcomes: Primary outcomes involved adherence to 23 different dementia guidelines focusing on assessment, treatment, education/support, and safety. fourteen were assessed by chart review and 9 by care giver interview.

Secondary outcomes focused on actual receipt of services, use of cholinesterase inhibitors, patient health related QOL measured by HU13 which is a validated visual analog scale, care giver health related Quality of Life measured by EuroQol-5D which is a time trade off instrument, and care giver social functioning.

Due to multiple comparisons a p value of 0.0125 or less was considered significant.

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The effect of a disease management intervention on quality and outcomes of dementia care: a randomized, controlled trial
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Results

A total of 308 pts (170 usual care, 238 in intervention group) mean age about 80, about 55% females, about 60%
married of living with someone, about 75% Alzheimer disease.

Care givers mostly women (69%) mean age 65. 55% spouse of pt with dementia, 40% child or in-law of pt. 70%
lives with demented person

Intervention group had higher adherence to guidelines (64% VS. 33%, P<0.001) There was better adherence for 21
of the 23 guidelines and in all 4 categories of guidelines

Patients in the intervention group had less decline in HRQOL over the following 18 months. Care givers re-
ported a higher health care quality at 12 and 18 months. They had better confidence in care giving at 12 and 18
months, and better social support at 18 months. Care giver HRQOL did not differ.

Discussion

Care management nearly doubled adherence to guidelines and had favorable impact on patients and their care givers.

Care managers cared for 50 patients and their caregivers. More time on recent enrollees and then dropped off. The
economics are such that in fee for service this approach to care is not economical.

Which patients benefit the most from a Geriatricians’ Care? Consenus among Directors of Geriatrics Academic Programs

Presentation by Gerald Jogerst, MD:


Introduction:

Expert reports estimated that the U.S. needed 9,700 geriatricians in 2000 and there currently are 7,128 certified geri-
atricians. By 2030 the U.S. will need approximately 36,000 geriatricians.

The question asked is: given the limited availability of geriatricians how should geriatricians’ specialized clinical
skills be deployed?

The article reports the results of a U.S. national survey of Directors of Geriatrics Academic Programs (DGAPs) ask-
ing “Which patients would benefit the most from a geriatrician’s care?”

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Which patients benefit the most from a Geriatricians’ Care?

continued from page 2:

Methods
Cross-sectional study, conducted in the Winter of 2007 including all 145 allopathic and osteopathic medical schools.

Survey Instrument
Modified from a 1988 unpublished survey and listed three practice situations: primary care, consultations, and care in the hospital. Several clinical conditions or characteristics particularly benefited from a geriatrician’s care were listed (age, functional state, medical complexity, including end-of-life care and geriatric conditions).

Final questionnaire had an open-ended question and was 15% of a general survey posted online to all geriatrics academic leaders at U.S. medical schools.

Used standard statistical methods were conducted.

Results
Response rate was 74.5% (108/145).

Public schools & medical schools with geriatric medicine fellowships were more likely to complete the survey.

1) Primary Care by a Geriatrician (Table 2, p.1798)
   - 75% or more considered benefit from geriatrician’s care for patients 85 & older, had moderate or severe functional impairment, complex conditions required end of life or palliative care or were frail or had a geriatric syndrome.

2) Consultative Care by a Geriatrician (Table 3), less consensus
   - 75% or more considered benefit for patients with severe functional impairment, complex biomedical, psychomedical problems and patients with a geriatric syndrome or frailty.

3) Hospital care by a Geriatrician (Table 4) (similar to responses for primary care) and included patient requiring post-hospital placement.

Open-Ended Question Comments:
Discussed three areas: knowledge, approach to care and the health system (planning of care transitions, effective use of community resources.)
Which patients benefit the most from a Geriatricians’ Care? (continued from page 3)

Discussion:

- High consensus among academic geriatric medicine leaders on benefits of geriatricians’ care for the most complex & vulnerable older adults.
- 2002 survey of the actual clinical practices of fellowship-trained geriatricians shows little evidence of a targeted focus on a subset of older adults.
- The academic perspective may differ from that of physicians practicing outside of academia.
- So comparison made with unpublished 1988 study from UCLA which surveyed family physicians & internists asking them about indications for a geriatrician’s services.
- Greater than 2/3 rated complex biomedical & psychomedical problems as an indication
- Greater than ½ rated severe functional socioeconomic, family & ethical problems
- Community-based primary care physician views (20 years ago) are similar to DGAP’s.

Conclusions

This study offers the beginnings of a consensus statement where geriatricians should be positioned in a coordinated continuum of care for an aging population.

Next Journal Meeting: March 27, 2009

Presenters: Kevin Glenn, MD Robert Wallace, MD Natalie Denburg, PhD

MARCH 2009

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EDITOR:
Jeanette M. Daly, RN, PhD
(319) 384-8995

EDITORIAL ASSISTANT
Amy Miranda
Research Secretary