

The Brain Trust Podcast | Episode #5: Early Detection Implementation in Health Systems

Transcript

Speaker 1: Kate Rowland, MD

Welcome to the Brain Trust, A Physician's Guide to Diagnosing Alzheimer's Disease and Related Dementias. Brought to you from the Illinois Academy of Family Physicians. I'm Dr. Kate Rowland, family physician, member of the IAFP and faculty at Rush University. Funding for this podcast series was provided by a grant from the Illinois Department of Public Health. The goal of the Brain trust in this podcast series is to educate and empower the primary care clinician in the early detection, diagnosis and management of Alzheimer's disease and related dementias.

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Thank you for joining us as we empower each other and provide training on the early detection of Alzheimer's disease and related dementias. And now today's episode.

00;01;08;03 - 00;01;39;02

Speaker 2: Raj Shah, MD

Welcome again. This is Dr. Raj Shah at Rush University Medical Center and part of the geriatric member interest group for the Illinois Academy of Family Physicians. Today, I've taken a longer road trip and I've found my way up north to Milwaukee, Wisconsin, for today's episode of The Brain Trust A Physician's Practical Guide to Alzheimer's and Dementia. And in this episode, we're going to talk about the early detection and implementation of methods in health systems.

And I'm really lucky to be able to come out here today on this wonderful day to spend time with Dr. John Brill, who is the VP of Population Sciences and research for Advocate, Aurora Health and past president of the Wisconsin Academy of Family Physicians. So, John, thanks for hosting me today at Advocate Aurora Health. So, we can talk a little bit about health systems.

00;02;01;29 - 00;02;24;25

Speaker 3: John Brill, MD, MPH

Oh, thank you, Raj. It's great to be with you. And I'm so glad you offered this opportunity. Wonderful.

Speaker 2: Raj Shah, MD

So I think just we're encouraging people to know a little bit more about the different health systems that are working in the spaces to improve early detection, especially with primary care and family physicians and health care systems. So can you tell me a little bit more about your organization, the Health System Advocate, Aurora Health.

00:02;25;20 - 00:02;54;03

Speaker 3: John Brill, MD, MPH

Thanks Raj. Advocate Aurora is a vertically integrated health system serving eastern third of Wisconsin and greater Chicagoland. Two things that I think are unique to our system for our region at least, are that we have a pluralistic model where we have a fairly large employed medical group, especially in the Wisconsin side, but also a large, aligned group in particularly in Chicago and comprised largely of small clinician practices.

So, we've had to learn how to work well with both types of care delivery. The other piece is that we have gone very far down the value-based care journey and have a high percentage of our Medicare patients enrolled in Medicare Advantage plans, including some that we own or are fully capitated for as well as the largest Medicare shared savings plan in the country.

00:03;17;25 - 00:03;43;14

Speaker 2: Raj Shah, MD

And as a family physician, you play this important system role as the VP of Population Sciences and Research can kind of tell me about, you know, your thoughts as being a family physician and taking on this role in population health and population sciences and research for advocate Aurora, and especially how it might have helped you and some of the engagement around how a system approaches the early detection and diagnosis of Alzheimer's disease.

00:03;43;28 - 00:04;11;19

Speaker 3: John Brill, MD, MPH

Yeah, well, I think family medicine is very natural to move into the areas of population and community and public health. I do have a degree in public health, and I've worked for state and local health care departments as well. But I think my most important experience has been educating family physicians. So worked in our academic programs as a residency and student program director for several years before moving into the population health area.

In my current role, I really think of my role philosophically as trying to help our physicians, especially our primary care physicians, to offer high value care, to stay healthy and engage themselves, and to try to meet the aims of value, patient experience and better outcomes that we're all trying to achieve.

00:04;35;27 - 00:05;00;02

Speaker 2: Raj Shah, MD

Great. And you know what really impresses me?

Thinking about being in medicine for 23 years and just seeing that the major changes and shifts that have happened and how we deliver health care in the United States. So, you know, at a time when I had started with my training or going to medical school, majority of family physicians and primary care physicians were in their own private practices or with small groups managing closely with their communities.

And now, you know, if you think about the environment, we're in, it's these large health systems where primary care family physicians are faculty employees of that system and are trying to work to achieve the best goals in population health for their communities. And it just always makes me wonder, like, how do we understand a little bit more with this big shift the roles and responsibilities on both sides, especially around sort of early detection and diagnosis of Alzheimer's disease.

So we want our our family physicians, our primary care physicians to be in the front line, recognizing when somebody is having cognitive problems, making a diagnosis early because there's such a large frontline group that sees a lot of adults at risk for developing a dementia. But now they're in this big system that has a lot of priorities that they have to deal with.

And the health system, it kind of coordinates sort of what our energy has to go. And so I thought, you know, one thing I wanted to just bring up was how do you how do you sense we have to advocate or how do health systems have to advocate to support primary care physicians in making an early diagnosis of dementia?

00;06;11;05 - 00;06;28;10

Speaker 3: John Brill, MD, MPH

That's a great question and it's not a new one. As I was preparing for this, I was looking at some of the national literature going back decades and people were talking about how hard it was to diagnose dementia in primary care. You know, 40 years ago at the very beginnings of family medicine. So it's not a new problem.

And certainly our health care systems haven't solved that. But I do think that there are a number of things that we can talk about that can make that very difficult diagnosis more effective and more efficient and less hard, really, for the family and patients and the clinician.

Speaker 2: Raj Shah, MD

Great. And I think that's a big issue that we have to keep working on, and that's part of our learning objectives today that we're going to be going over, which is how do we describe sort of the barriers for greater early detection of Alzheimer's disease and related dementias in health systems?

And then how do we kind of figure out the right tools and techniques that will be solutions to allow for greater capabilities in that space? So, I think what interested me a little bit in my background reading about what was going on with advocate Aurora Health is this recent announcement from the Davos Alzheimer's Collaborative that you as a health system are going to be part of some very innovative and intriguing work about how a health system can maybe reduce some of those barriers.

So maybe we start first by talking through what you're sensing, you know, in a health system leader role. What are some of those key barriers that primary care physicians advocate, Aurora, or are the big health systems facing and being able to make this diagnosis?

00;07;52;24 - 00;08;32;28

Speaker 3: John Brill, MD, MPH

Yeah, and maybe I'll start. I'm sure you can relate to this, Raj, but I think my own experience is with diagnosing dementia. The typical scenario is you walk in to see one of your established patients for their follow up on their diabetes and blood pressure, etc. and there's somebody new in the room, a family

member or friend. And at some point during the discussion, that person will say, Doctor, I'm really concerned about so-and-so as memory. And you experience a lot of what the British call those heart sink moments because, you know, everything else is pretty much going to go to the side and then very frequently, family physicians, I think, feel very unsupported and how to take the time to do that screening, how to make that diagnosis, how to get support in establishing a diagnosis.

And those are all things that I think the health care system can be very helpful with and with the DAVIES Grant, I want to call out doctors Darren Gilman and Mike Malone, who are really been the leaders in that initiative and have been kind enough to include me in some of the planning. So a few of the specific steps that we've been doing to try to make the diagnosis of dementia more effective and available for family physicians are modifying the annual Wellness Visit Health Risk assessment to include a question about memory.

It's not required, but it's relatively easy thing to add, and certainly at least can introduce the conversation. And it makes it easy to say that this is something I ask all of our patients rather than I'm singling you out because I'm worried about your memory. The other piece that I think is really important is incorporating some sort of standard instrument into the annual wellness visit.

The requirement from CMS is you know, direct observation, and I think it's a little bit almost ridiculous that it's in there that way because it basically comes down to, you know, a checkbox or no observation of cognitive impairment by direct observation. And it's pretty meaningless and not very useful or effective at all. And it really just doesn't do justice to the program.

00;09;49;27 - 00;10;16;01

Speaker 2: Raj Shah, MD

Can I just add a component to that because I definitely agree that's been a problem in the field, right? Because somebody that comes in, even in the more moderate stage of having a condition like Alzheimer's disease is social enough, right. That they can have a conversation in 5 minutes with a physician, especially as a physician is not really aware that something might be going on and asking sort of yes or no questions that the person can walk right through and be fine.

So sometimes observation is a bit hard, right? So, so this idea of, yeah, like a tool and using one of the sort of available case finding or screening tools could be helpful. But we know from a health system perspective, we worry a little bit about these tools because some of these tools have licenses with them and they cost money to use if you implement them in your system and you could get penalized if you don't appropriately get their licenses.

So I was just kind of curious like how Advocate has been kind of supporting that? Does it leave it to each primary care physician to say, use whatever you want with your instrument? Or are you guys thinking more like system wide? We'll look at all the instruments. We get a team together and we pick one and we get people trained on that one.

00;10;57;02 - 00;11;20;26

Speaker 3: John Brill, MD, MPH

What you just mentioned is exactly the process that we're currently working through. And you're right, the mini mental status exam or M.S., is probably the best example of a copyrighted product that is being much more aggressive about enforcing the copyright uses. So that one, although it's in some ways kind of the gold standard, it's not very available and really pretty problematic to use.

Fortunately, there are a couple of other instruments, including the mini cog and the mouse memory impairment screen that although they're copper copyrighted, the owners have given permission for their use in clinical applications. If a corporation's using them for research or something, they do require a fee, but they have generally agreed that if you or I are using them to screen our patients in clinical practice, that's fine. And appropriate use, but probably also good to get your compliance and legal department to weigh in on that so that you don't get yourself in any trouble there.

Speaker 2: Raj Shah, MD

Yeah, and I definitely end it, but I do think that's going to be I felt that that's been an important issue as I've interacted with primary care physicians is that they're looking for support from their institution to say, Hey, what instrument should I use that you're going to be comfortable with and I'm going to be comfortable with to really document that somebody may be having cognitive impairment after listening to them or their family.

I have some objective measure in the chart and that kind of brings around well, as we were saying before, sometimes this feeling of time, right? Like it takes time to set out aside to do some of this early case finding capabilities, even in an annual wellness visit that's sponsored by Medicare. So I think you were mentioning to me a while back ago, you know, just the problem in primary care is there's so many things that are important, you know, that are on their list to cover with a patient that you just can't do it in a full day.

Right. Or, you know, with everything for each patient. But but any thoughts that has been going on at advocate Aurora about how do you carve out that time for that physician right to feel that value or maybe add other players into the mix and the team base situation that they can capture some of it and the physician can interpret it and then take the next steps. So any any work there that you've been thinking through?

00;13;08;11 - 00;13;35;25

Speaker 3: John Brill, MD, MPH

Yeah, several pieces that fit well with that. One is trying to use time outside of that available in the office interview. So using the online portal to ask questions about either the patient themselves and or their caregivers about concerns on dementia, we all know that one of the inherent problems with diagnosing dementia is that almost by definition the patient's history is a little problematic.

And so certainly it's important to get information from caregivers, but those are always readily available. And you also have to take caregivers words with a little bit of a grain of salt. So getting some of that information offline, either through the Medicare HRA or screening quizzes specifically related to dementia or caregiver screening tools related to dementia can be really helpful.

Another thing that we know is that physicians and primary care docs just don't feel super comfortable making the diagnosis of dementia. And so one of the things that we're working on as part of the Davis grant is a smart built into the H.R. That will suggest standard questions provide decision support for labs when to do imaging and what kind of imaging when to think about some of the new laboratory tests that are available and something that I'm really excited about that I think is pretty innovative.

It is sort of an artificial intelligence calculator to help provide something like your symptoms are consistent with a probable diagnosis of Alzheimer's. So, you know, there's no one simple test for Alzheimer's. That's one of the problems with making the diagnosis. So, in general, I think most family physicians are going to use it to get to the point of I have a pretty strong clinical suspicion of Alzheimer's. How would you feel about seeing a specialist to verify that or and you come back and see me and set up a specific visit where we can go into a little bit more depth on that.

00;15;10;16 - 00;15;33;16

Speaker 2: Raj Shah, MD

It brings to mind an article I just read a few months ago about some work that was done in Europe, in France and in England where they looked.

They're just different systems, right, because they're all integrated into sort of national systems. So they have more access to broader data. But they were actually looking at what was being recorded in the problems of primary care patients that eventually got diagnosed with dementia versus those that didn't. And they were even able to find patterns about common conditions that people were bringing up early.

And it wasn't just memory loss. They were bringing up things like constipation and other issues that seemed to then predict who was more likely to develop. So, I, you know, some of those system approaches to looking at sort of the broader data that the system is collecting about the person to support the primary care office could be helpful as long as you know they're vetted and we're testing that they actually do help without you reducing the risk of harm and exclusion.

But it's a definite interesting area that, you know, people are looking into to support primary care. Right? Debatable. A bit easier to work their way through. And then I think you were getting to something, John, that was always what I've heard sometimes too as well, especially early. The person's pretty functional. They're doing a lot of things in their home.

They're still part of their communities. If I make this diagnosis now, what do I do next? I like a little bit of a feeling like I'm going to say this word to them, like they have Alzheimer's disease based on criteria. But then I'm not really sure what I can do to help them next. How are health systems kind of creating that ecosystem, that environment, that connection with community, so that primary care doctors making that diagnosis can then help to follow in the journey of that patient over time in their family and making sure they're supported.

00;16;51;03 - 00;17;13;14

Speaker 3: John Brill, MD, MPH

Yeah, a few things that dealt with that. Raj I think one is a lot of health systems are integrating community resource directories into their HER. So there's a number of those out there and birth is

probably the best known and most widely used, but that can be very helpful. One of the things about diagnosis of Alzheimer's as they're uncertain, what does this mean?

Am I going to be able to carry on? Am I going to be able to drive? Who's going to take care of my spouse? All these things that are going through people's heads. And so connecting them with community resources and support groups can be really effective. Another is some of the more practical things. We know that dementia and sort of declining functional ability go hand in hand.

So looking at where you live, is this going to work for you or, you know, should you start looking into alternative places to live or adaptations that you can make to your home that will make it safer and more easy for you to get around? Third is seeing what other community resources you might be available, for example, in the Medicare Advantage world, applying for the G-SNAP or dual eligible special needs program can bring a lot of additional resources and support to patient and family, including in some cases, money for personal care workers and other resources that aren't generally available through Medicare.

So those are some of the reasons why I do think it is really important to make a diagnosis early. Even if we all know that the pharmacotherapy for dementia has been pretty disappointing, frankly, and not anywhere near where we hope it can be someday. But there are still a lot of things that doctors can do to make the lives of their patients and families better.

00;18;31;20 - 00;19;05;27

Speaker 2: Raj Shah, MD

Yeah, no, definitely. And I really appreciate that concept of starting to wrap around services and connection and using even some of the health system contracts. Right. And the value based or the value care type of contracts to say, hey, we can maybe use some of our resources a little bit better to provide things in the community, maintain people in their community, make sure they're in their appropriate environment, in their community so that they can maintain their function and not have to necessarily have sort of inadvertent or potentially preventable hospitalizations or E.R. visits along the way.

So that's always a good thing that we've done. And I do appreciate the efforts there and thinking through that a little bit more in the health system. I did want to touch base a little bit on the health system side. You know, as a health system leader and you're working with the other VP's and SVP's and CEOs about decision making around prioritization.

And I'm just kind of curious, even though we might, you know, physicians personally have a sense like we have to deal with Alzheimer's disease, it's usually the fifth or sixth leading cause of death from a public health point of view, creates a lot of suffering for people and their families to have to go through it as caregivers. But I'm just kind of wondering about the rationale for a health system.

I think you were starting to kind of bring that up early around some of the ways funding for health care is moving in the United States that, yeah, you know, health systems really need to think about this, you know, as a as an area that affects a lot of people and might actually allow for meeting those triple aims or quadruple AIMS of health care around quality and value and experience.

00;20;14;19 - 00;20;43;04

Speaker 3: John Brill, MD, MPH

Yeah, that's a great question. And I think if you're going to appeal to the sort of the left brain of the of the organization, some things that are important to point out are that delirium and dementia are two of the reasons for very extensive length of stay. So, if you can get screening in place when people enter the hospital, even if it's on a fee per service basis, they're getting paid as a DRG in most cases.

And so extending lengths of stay is avoiding long lengths of stay is something that hospital administrators will definitely get behind. Additionally, a lot of systems are involved with episodic payments, including the bundled programs there. Again, we're getting paid on a DRG and also getting significantly penalized for readmissions that happen up to 90 days later. So we know that patients that go into the hospital that experience delirium rarely get back to their baseline in terms of cognitive functioning.

And so although delirium and dementia are not identical, they are very closely related and sort of synergistic finally in a managed care environment. And that's where a lot of our work is. It's a pretty easy sell in that we know that dementia care is in itself very expensive, medications are very expensive and it also very consistently contributes to costs of other medical conditions.

So if you have a patient with heart failure and dementia, it's not double the cost. It's four times the cost. So making that argument that it's really helpful to get patients diagnosed early, get on treatment, complete advance directives so that can have care provided that's most consistent with their wishes, as well as hopefully avoiding very long, expensive hospitalizations.

00;22;05;12 - 00;22;22;25

Speaker 2: Raj Shah, MD

I think you listed out some really key pieces because I just keep hearing this statement with any new program, especially to health system leaders and those in finance is, you know, what's our return on investment, Right? Like, what's it going to cost us to get this thing up and running? And then, you know, are we going to actually recoup that later on?

And I think some of the arguments you're bringing on that, you know, if we can identify people early on that have dementia, maybe we can support and wrap around some services in a very efficient way that will then help prevent some of those costly, you know, preventable type of hospitalizations that could occur. How has that been resonating in general or talking with other colleagues around the country?

Does that seem to be some a pattern that people recognize, appreciate, see value in?

00;22;46;05 - 00;23;18;12

Speaker 3: John Brill, MD, MPH

I think it is. It's always a little difficult to gather the data in a way that shows all the different segments of spending differentiated well enough to make that argument. So getting the data is probably the hardest

part. Once you have the data in place, I think it's fairly self-evident that spending to decrease dementia complications is a good investment that will save the organization money.

00;23;18;23 - 00;23;45;29

Speaker 2: Raj Shah, MD

Great, going back to sort of the environment in the physician's office, I wanted to see how health systems are approaching this, because sometimes it is that a physician feels like, okay, I make the diagnosis or I need to make this diagnosis and I'm kind of alone doing it. But we're moving towards sort of a team based approach where the family physician is the lead of that team, of individuals working together to take care of a population and a group of patients, right.

That are coming into that space from the community. How any advances or word of advice that you can give to, you know, family physicians practicing in health systems around how can they build together a team or how can the the health system support a team that will help to kind of divide the work and to be able to support that person and their family?

00;24;08;14 - 00;24;31;09

Speaker 3: John Brill, MD, MPH

Yeah, a couple of things. Well, this is a good place to put in a plug for teaching medical students and other learner because they can be great additions to the team and ability to spend some time going through these assessments is a great learning experience for them and oftentimes it's a little bit easier to take from a family and patient experience perspective when it's coming from a younger person who's learning.

And it seems to me like it's just better accepted than if I'm trying to do some of these assessments and they might be feeling like they're disappointing me, or there's just a lot of stigma attached to the diagnosis of dementia. Another piece that I think is really helpful that we're working on is those tools for specialty consultation. We all know that psychiatrists are, for example, so backed up now, especially with the greatly significant increase in mental health issues related to the pandemic that it can take months to get in.

So one program that we've been piloting in Hope to expand is an E council idea where a primary care physician can do a virtual consultation with a specialist to run a case by them. So it might be as simple as an email or a video call or time that they set up to grab coffee, even. And it's a billable procedure for both of them.

So there are some revenue incentives to do that. And it also helps save a lot of time in terms of getting things together, saves patient, having to do a separate office visit doesn't work for everything, but for this kind of situations where a lot oftentimes it's just more a matter of not quite having the competence to definitively make a diagnosis that e-counsel can be really helpful.

00;25;53;07 - 00;26;15;04

Speaker 2: Raj Shah, MD

That's great. Yeah. No, I think those connections that make it anywhere easier to work with a broader team, especially for particular issues, right? That you need some help can make a big difference and hopefully for even the patients so that they don't feel like they have to set up another appointment that's going to take a year to get into or six months to get into and work their way through.

And I guess, you know, in as we kind of wrap up for today's session, I wanted to get a sense from you a little bit about some words of advice around, you know, what, you've done a great deal of work in your role and with others that advocate Aurora to support this engagement around the early diagnosis of dementia and primary care in family medicine.

And I just wonder, you know, as you think about other family physicians who end up in leadership roles at other health systems, because family physicians just know so much about the breadth of an experience, they end up naturally going into leadership capabilities. You know, what would you kind of encourage your colleagues to think about? As, you know, maybe they're early in the process, testing it out with their health systems about what are the important issues in primary care that we have to think of from a population health health system perspective, What would kind of come to mind that you would say, hey, you know, this is sort of what you may want to advance around or the early diagnosis of dementia.

00;27;10;24 - 00;27;36;23

Speaker 3: John Brill, MD, MPH

o I think that, you know, that's the ultimate question, right? So I would say one is talk to and listen to your colleagues. So all of us know that practice is very local and the barriers and challenges that I might be experiencing working in central city of Milwaukee might be very different than those of my colleagues working, seeing patients in the Miracle Mile in Chicago.

So trying to understand, you know, what are the barriers where can we help? What problems are you running into and doing some thinking about what are the best ways to work through those. The other, and you alluded to this too, is having both. I think the right brain and the left brain and arguments ready to go. One thing about dementia is that it's so prevalent that almost everyone has had some personal experiences with a family friend or caregiver or parent or grandparent that has had dementia.

So it's not too hard to get people to recognize how difficult and emotional and challenging that situation can be.

And then third, I think is having a smart team. I think more and more we realized we just can't do it all ourselves. And we were talking earlier about the article that came out in the Journal of General Internal Medicine recently that said it would take 27 hours a day, 365 days a year to take care of all of the evidence based problems that primary care doctors do.

And it goes down to 9.3 hours a day. If you use a team based care approach, which will do a lot. But in a legal system like, you know, within the realm of possibility. Right?

Speaker 2: Raj Shah, MD

Definitely. Great words of advice. And I really appreciate you taking time out of your busy schedule and your role and leadership at Advocate Aurora Health and teaching us a little bit about your perspectives on service and our health system leader role.

What health systems can do to support family physicians making earlier diagnoses for dementia. So I appreciate your time and studying with us today on this work with the Brain Trust and our podcast. And we'll be on the road again, either Dr. Eukesh Ranjit or I to talk with our next individual working in family medicine that's making a difference and the early diagnosis of dementia. So thank you for your time.

Speaker 3: John Brill, MD, MPH

Thank you. Raj

Speaker 1: Kate Rowland, MD

Thank you to our expert faculty and to you, our listeners, for tuning into this episode. If you have any comments, questions, or ideas for future topics, please contact us at podcast at theBrainTrust.com. For more episodes of the Brain Trust, please visit our website, TheBrainTrustProject.com You'll find transcripts, speaker disclosures, instructions to claim CME Credit and other Alzheimer's resources as well.

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