The Brain Trust Podcast |Episode #7: Early Detection in African American Populations

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;01 - 00;01;34;24

Speaker 2: Raj Shah, MD

Hi, and welcome to today's episode of the Brain Trust Physicians Practical Guide to Alzheimer's and Related Dementias. I'm Raj Shah, your host. I'm a professor and family and preventive medicine at the Rush Alzheimer's Disease Center at Rush University. And today, I'm going to get in my car and head out from Naperville and go to a place that I feel is home, and that's less suburban family medicine residency program in Oak Park, Illinois.

In today's episode of the Brain Trust, we'll be kind of focusing on a really important issue, and that's the diagnosis and early detection of Alzheimer's disease and related dementias in African-American communities. And it's a great honor for me today to be able to go and to visit a dear friend and a colleague and a mentor. Dr. Scott Levin was programed, director of the Family Medicine Residency program at West Suburban and medical staff president at the West Suburban Medical Center.

So, Scott, really an honor to come back and to spend some time at West Suburban in the Family Medicine residency program. And really great to see it. It's hard to believe it's been so many years since we've known each other, but really great to have you today.

00;02;19;13 - 00;02;40;07

Speaker 3: Scott Levin, MD: Scott Levin, MD

Because you are so kind. And I have a beaming smile which our listeners can't see. But your legacy lives on here for sure. And it's always fun when we send residents over, over to us to rotate with you for an elective or something like that. You are an amazing resident and have done amazing work in this field and I'm really excited to speak with you today.

00;02;40;16 - 00;03;02;22

Speaker 2: Raj Shah, MD

Great. Thanks, Scott. And, you know, I think for our audience that covers the entire state of Illinois and maybe further in our practice on our podcast today, I and you know a lot about West Suburban and the Family Medicine program and the communities it serves. But maybe you can give us a little bit of a highlight about sort of the communities served by the family Medicine program at West Suburban Hospital.

00;03;03;04 - 00;03;25;16

Speaker 3: Scott Levin, MD

Oh, of course. Of course. Yeah, well, graduate medical education has now a 51 year history here at West Suburban. You know, Dr. Burdick founded this program in 1971, and served as program director for 20 years. And although our medical center has an Oak Park City name and zip code, many may know that Austin Boulevard is right out my window.

And Austin Boulevard is the kind of the geographic dividing line between the west side of the city of Chicago and then Oak Park. We also have the Belmont Cragin neighborhood just to the north. And so it is an exceptionally diverse community and every which way you would want to define that, that word just to the east in the Austin community is where a large proportion of our patients come from.

It is a wonderful community, but remains underserved and suffers with many of the barriers that many of our family physician listeners know about. One statistic that I'll tell applicants that just still boggles my mind is that when we cross the street, life expectancy goes down by 13 years just by crossing the street.

00;04;13;13 - 00;04;53;00

Speaker 2: Raj Shah, MD

Yeah, No, it's a remarkable place with such a diversity of training. And that is why I was hoping to visit you today, because I remember even from my training days, having such a large African-American community that was getting services through the West Suburban Family medicine residency program and West Suburban Hospital and health system was such a big, important part of my learning and experience, and thus some of the issues that we're dealing with right now when we consider Alzheimer's disease and related dementias, and when we think about it in the short term for the brain trust and sort of our kind of a small tagline or a little logo, we I've tried to create this sort of docs diagnose seeing dementia. So today it's about the docs and how we diagnose dementia early. But really the special

needs that you experience when working with an African-American community. One of the statistics that's in the Alzheimer's Association, facts and figures, the report that comes out every year, usually in January, highlights the different risks that different groups face when dealing with Alzheimer's disease and related dementia.

And our most recent work and, you know, researchers in the field, epidemiologists tend to point to older African-Americans, sometimes being at a two fold increased risk of developing Alzheimer's disease or related dementia compared to older whites. And I'm just kind of curious about when I give that message, when I'm asked to talk with diverse communities, sometimes on the radio that serves the African-American community, the first question that always gets asked is why could this be?

Why could our community be at more risk for develop being Alzheimer's disease? And I wanted to pose that to you. If you had to kind of answer that question for the patient population, that scene in Austin, you know, and the community that you provide to. How would you try to answer that question? And why do you think it might be that the African-American community is more at risk?

00;06;12;22 - 00;06;42;00

Speaker 3: Scott Levin, MD

Yeah, it's a really complicated question, and I think the answer is also multi-layered. One thing that we know it's not due to is genetics. You know, race is not a genetic issue. So if it's not genetics, then when you start to peel back the onion, you talk about access to health care, continuity of health care, trust in health care.

And those three things alone don't necessarily explain Alzheimer's and other dementias, but they certainly play a role. I think how they additionally contribute is all of the co-morbid conditions that might put someone at very high risk, such as uncontrolled hypertension or undiagnosed or uncontrolled diabetes leading to microvascular dementia. Black and brown communities are much more susceptible to those risks.

So we have a really important role to play as family physicians in bringing black and brown populations. The African-American community that lives in Austin and in my example, into the fold.

00;07;32;25 - 00;08;14;09

Speaker 2: Raj Shah, MD

Yeah, And I think you bring up a really good small tip or an issue that, you know, is unique to family physicians caring for people over their entire life course or life span from birth all the way to their older years, is that some of these conditions, like high blood pressure or diabetes that we spent so much energy or clinicians in primary care have to spend so much energy, you know, working their way through and showing quality metrics around are really important, not just for the quality metrics around, you know, controlling that diabetes or controlling that blood pressure, but also because those conditions over time, over decades and decades and decades, eventually leads to situations where you have mixed dementias, where you can have vascular changes along with Alzheimer's disease and bringing on a

diagnosis of Alzheimer's disease or related dementia. So it's it's something I've tried to do a little bit more is to remind medical students, residents that every piece they touch, right, especially around the care at different points in a lifetime can have an impact on how somebody does in their later years.

So, a big recommendation is you're already doing a lot of the right things. And, you know, your daily practice by monitoring, seeing, identifying who's at risk for dementia, by first looking at things such as do they have high blood pressure and is that controlled and do they have diabetes and is it well controlled?

00;08;56;02 - 00;08;57;23

Speaker 3: Scott Levin, MD

Absolutely. Absolutely.

00;08;57;29 - 00;09;22;19

Speaker 2: Raj Shah, MD

Yeah. And I guess that leads me to my next question, which is just as a practitioner or as a family practitioner for so many years in the community, including the Austin neighborhood on the west side of Chicago, what are some of the barriers you've kind of seen or the challenges your patients face and bringing up issues about Alzheimer's disease or concerns about having memory troubles and seeking evaluation?

00;09;22;29 - 00;09;48;24

Speaker 3: Scott Levin, MD

It's I think, comes down to trust. And, you know, along with trust comes comfort. You know, it's not easy for someone to admit in any population that they might be starting to struggle with memory. It might be embarrassing. It might be a threat to autonomy. It might be scary to think about what's my family going to do with me now or next year if I let on.

So as family doctors, having the relationship with the patient over time and also with family members, whether that's a spouse, a significant other, a daughter, son, a grandson, a granddaughter, you know, so that we can use our skills as family physicians to try and mitigate the fear and the mistrust and the discomfort that comes along in the early stages.

Yeah. And that's always been a little bit of a surprising fact to me as we do these public health surveys in Illinois, where we actually call people over age at any age that's over age 18 and ask them about their risk factors for particular conditions. It's called the Behavioral Risk Factor Surveillance Survey. And one component that's been added the last few years has been asking people over age 50 if they notice trouble with their thinking, memory or confusion.

And then if they say, yes, there's more questions around, well, have those memory problems started to affect your day to day activities? And about 20% of people, you know, over age 60, which is quite young as a geriatrician, like my patients are 75, 80, but say that they're having troubles with confusion. And out of that 40% saying it's affecting their day to day routines.

But that's sort of like the diagnosis of dementia in a broad way, right? I'm having problems with my memory and it's affecting my day to day life. But when they're asked, like, have you talked with your primary care physician about this? Only about 30%, 40% say they have. Right. So this gap between knowing something's happening in your body, recognizing it's affecting you, but then feeling comfortable to go to see a primary care physician, your family physician and bringing it up becomes quite a challenge.

Are there been things that you thought about that you know, in your practice to open up some of that trust space where people can more easily bring up these issues, whether it be, say, like asking the question at the annual wellness visit, if they're having troubles with their memory or other techniques to just help people be more open about bringing up these issues.

00;12;04;20 - 00;12;25;29

Speaker 3: Scott Levin, MD

Yeah, sure. And again, when I when I answer these questions, I, I answer them with humility and with a recognition that there there is limited time and there is limits to kind of what we can do. But I think as family physicians, you know, we're all about prevention. We went into this specialty to break the curve, to break a cycle of illness.

And so I would answer that question the same way I would answer a question about any other illness, even, you know, advance directives. You know, the time to talk to someone about an advanced directive is not just before they get intubated in the ICU and the time to talk to someone about potential memory loss is probably not when they've already started to notice something.

And whether you use an age cutoff, you know, 5055 might be a great time as part of a wellness visit to say, you know, I'm glad you're doing well right now in this regard, but I want you to know that this is a safe place where you can feel comfortable telling me if you happen to notice any of X, Y, or Z problems with your memory, finding words, discussing more complex things with family members, doing more complicated tasks, and to bring it up earlier.

And I think, you know, if you forget to do it at one visit, the wonderful thing about family medicine is we have that continuity of care and you can make a sticky note and make sure you talk about it at the next visit. But I think the earlier we bring it up and kind of create the space and the expectation that at some point we might hear about this is a good way to try and get that discussion going.

00;13;43;09 - 00;14;04;07

Speaker 2: Raj Shah, MD

Yeah, and I really appreciate that thought of doing it in sort of the pre-work, right. Like right to work off at least introducing the concept as something that might happen in the future may not, but it could. And that I'm creating this safe space for you to talk. And how about, you know, trying that out and understanding it?

I just wanted to get a sense before I ask about specific, like tools or things that you use sharing maybe an example of a story or an anecdote or an experience where opening up some of those spaces, having those conversations earlier, especially with sort of your African American patients and families, might have led to an easier process, a smoother process, a more belonging process in making a diagnosis of dementia.

Sure, yeah. There are lots of stories, and I'm sure many of our listeners have them as well. But I certainly remember in particular a police officer and then former police officer. I took care of him when he was active on the force and then after his retirement and his wife was a member of our practice and I took care of his kids and actually delivered a child of one of his grandchildren.

And he started to, you know, for lack of a better term, fray around the edges a little bit. He was very high functioning and it was his wife, you know, who let me know about it. And I then was able to talk to the patient about it, and we were able to kind of bring some supportive services in.

And what was a little bit sad about this case, it was was extremely rapid decline. It probably was not Alzheimer's. We in clinically speaking, it might have been more of a Lewy body dementia type scenario because he really declined quickly over maybe 3 to 4 years and then and passed away actually at his home with advanced directives and his family at his side.

And so, you know, I say all this because, you know, in family medicine, we I still aspire to training folks to be true wome to whom the physicians and there is really nothing like the charge of bringing a new life into the world except except having a patient that you've been taking care of for a very long time reached the stage in their life and be able to help them through that.

And when the time comes, you know, be peaceful at home with their family nearby. And I think if family physicians can keep that goal in mind, ultimately it's not about the mean arterial pressure or the hemoglobin A1 c or making the diagnosis exactly at the perfect time, but screening, anticipating and then accompanying your patients as they kind of go through this process.

00;16;39;02 - 00;17;19;00

Speaker 2: Raj Shah, MD

Yeah. Now that's a really great anecdote, Scott, then thank you for sharing that. And just to tell the story of following people throughout the journey, right, Like their entire life span and even when conditions, we don't have great medications or treatments for. I'm sure it meant a lot. And I am curious, you know, the family, even after he passed away, continue to follow, you know, the wife and others with you as their doctor, and then how that also helps the entire family structure, because in so many cultures, especially the African-American community, it is that entire bonding of the family structure that plays such an important role in how they heal, how they deal with issues, how they come to understand when some, as you call it, sometimes like bad things happen to really good people. All right. India is kind of

curious. It really impressive that you're able to follow them through that journey and share that. And I think that's one of the powers that we can offer. And even afterward is right to continue to be there for the family and to be part of their team.

Absolutely. And they do continue to follow with me. And, you know, there aren't numerous examples every day that that fill our tank in health care these days. It is a very difficult environment we practice in. But these are the examples that that definitely can be tank sellers and not tank trainers.

00;17;57;19 - 00;18;30;06

Speaker 2: Raj Shah, MD

Yeah, very good point. And then if I can come back to some of the things about how do we find, you know, some of these experiences, how do we prep them to talk about it with us first, which we talked recently about. But then when the moment comes where they're maybe like a family member saying they're having problems with their memory, you know, how do you go about using tools or tips to kind of document that there might be something going on with the cognition and making some of those earlier diagnostics that this person may have a dementia at this point?

00;18;30;13 - 00;18;54;00

Speaker 3: Scott Levin, MD

Yeah, sure. And, you know, a lot of the tools, as you well know, it may not be the best in certain populations just because of how they're written or certain things that they may assume about the person who's taking the test. So very simply and very short answer is we use the mini cog. That's also kind of what our residents rotating in geriatrics use when they're doing their geriatric assessments.

And, you know, many people know the mini cog is just, you know, asking someone to repeat three words, draw a clock with a time on it. Typically ten after 11, there are some other choices. And then kind of repeating the three words that you asked them to remember back after doing that task. And that's a very sensitive test.

And it takes literally 2 minutes to do that in the office, which I think is what makes it so attractive in that it's not a I'm not disparaging the mini mental status exam or any other longer tool, but those are harder to use. So we use the mini cog and then we also might do you know, some simple mobility tests like a get up and go test and and just kind of see, you know, how many seconds someone might take to get up from their chair, walked across the exam room and then go back and sit down.

Those two things alone can tell us a lot about not only cognition, but but other risks.

00;19;51;19 - 00;20;16;18

Speaker 2: Raj Shah, MD

And then you're hinting at it a little bit with even tools like the mini car, I guess just being aware, right as a clinician that they're not perfect tools and they have some biases towards them about like where in what populations that were developed and tested in. And many of our tools don't include enough African-Americans, Latinos, people from other cultures to get good psychometric properties.

So any thoughts about how you cautioned, like the interpretation of some of those tests where maybe somebody does really well on a mini cog, but you still have an inkling that something's wrong with their memory and what you should do, or maybe they do really badly. On the mini cog. But you think there's other signals to you that you're getting that they might actually be doing okay?

And there's something about the test itself?

00;20;38;19 - 00;21;00;24

Speaker 3: Scott Levin, MD

Yeah, I, I think I would probably defer to you on that for some more tips and tricks. I think if in the first example, I'll just speak briefly about this. You know, if someone did very well on a mini cog, but, you know, I was still suspicious or family was suspicious or the patient was suspicious, then I, I might go to a more elaborate tool. But there isn't one in particular that I could say right now.

00;21;03;19 - 00;21;32;02

Speaker 2: Raj Shah, MD

And that's sometimes where you could use, you know, the other support teams that, you know, like neuropsychologist, even though that might be harder to schedule to do a full battery. But I think I always try to be careful about interpreting some of these tests because I ask things or I know more information about, say, their education level. So if somebody is a college professor in the African-American community, a mini cog, maybe relatively easy to do because we maintain those skills for a long time.

So they might they might do really well on it. Right. But if you talk with their family member and they used to be a math professor or something like that and they can't do basic calculations, it might give you a clue that, you know, that something else is about the test is not really showing that the problems are there.

So I try to like look a little bit more into the test and to really evaluate or maybe use another test or another experience. If I'm not sure the test is matching up with some of these education level or cultural background in the way the test was developed. I also think you got to sometimes remember that when people have low education levels or low health literacy levels, that it might be more difficult.

I actually think the mini cog is going to start having problems because even ten years ago you started seeing what you asked about what you write. People don't draw the clock anymore and all the numbers because nobody has a watch like that.

00;22;24;13 - 00;22;25;01

Speaker 3: Scott Levin, MD

That's right.

00;22;25;06 - 00;22;44;09

Speaker 2: Raj Shah, MD

They just put in the number and the bed occupied. So you know, the challenges of time also cultural experiences are going to influence what we do with these tests. But it's just something we keep in mind because some of the word choices that we make on some tests may not be words that every community uses or is familiar with.

So it's something we we always try to just at least, you know, have that in the back of people's mind that these aren't perfect 100% tests. And if your indication from other sources as a good primary care clinician, family physician, a diagnostic point out to you that something's just not right here just to continue to keep going on and finding out what the solutions are, which, you know, kind of brings us to our final parts of the discussion today, is that, you know, what always amazed me about you and the program at West Suburban in the Family Medicine Program, a residency program, you know, now for over 50 years or more in existence, is that dedication to generating the next level, family physicians that are going to be caring for our communities. And, you know, when it comes to things like Alzheimer's disease and related dementia as well, we don't have a perfect blood test or we don't have a perfect measure. How do you think we should go about in your role, say is, you know, sort of like the long time family medicine residency program director to teach some of these skills, right.

00;23;44;20 - 00;24;06;06

Speaker 2: Raj Shah, MD

Not only how you diagnose dementia, but then how do you stay aware of how that diagnosis has to fit within the cultural framework of the members coming for their evaluation, that pathway, that context might be a bit different in the diagnosis from somebody coming from an African-American community, say, than from somebody coming from a Latino or an Asian community or a white community.

00;24;06;09 - 00;24;31;17

Speaker 3: Scott Levin, MD

Yeah, Raj, those are great points and I so appreciate your words. And it is a tall order. It is a really tall order. Family Medicine is a three year residency program. There's a lot of material to fit in. And so other than the tools and the knowledge, which as a resident learner might need to make the diagnosis, for me, it comes down to three things.

A first and foremost is cultural humility. And you know, from being here, we're almost militant about using the word humility and competence. I still believe that, you know, no one can ever be fully culturally competent, no matter how knowledgeable they are. You always have to approach a patient population and an individual from within that population with a large degree of cultural humility.

And, you know, our learners are often coming with that mindset, but still have a lot to learn. And being able to provide that feedback in a way that doesn't make them feel bad about something they may have said a little bit wrong, even though they had the best intentions in mind. It's delicate. So, you know, our faculty are always learning and exploring and developing themselves and how to provide that feedback to our resident learners in the best way so that they can continue to learn that cultural humility.

And then I think the third thing after cultural humility and giving the feedback is to really be proximate and present within the community itself. So whether that's at orientation, when residents, you know, have a tour through Austin and meet some of the larger stakeholders from the Pastors Association or or teachers or, you know, some food and security establishments, getting the resident learners into the community so that they can be proximate with the people that they're going to be serving.

And I think the rest takes a lot of time and experience.

00;26;12;25 - 00;26;42;08

Speaker 2: Raj Shah, MD

And I really appreciate that message about cultural humility because we just will never know all the experiences possible and we just have to be open and curious and be willing to, you know, participate in those engagements. And I think you brought up a great point about, you know, the family physician being part of the community or being sensing the community and how it works as being an important piece of the training where we're finding that we're trying to develop this in a broader component about dementia friendly communities.

And I'm glad that Austin, as a dementia friendly community and Oak Park is a dementia friendly community and River Forest is a defense friendly community. But, you know, the idea is that we as family physicians are part of that. We're the closest to linking that community in the health care system to then the broader health care system. And if we can keep sharing and talking through and the communities are running into these issues, that makes a big difference.

So as we wrap up for today, I want to again thank Dr. Scott Levin for spending some time with us on our podcast about dealing with how do we get better at early dementia diagnosis in the African-American community. And Scott, it's always a pleasure to talk with you.

00;27;24;06 - 00;27;24;20

Speaker 3: Scott Levin, MD

Likewise.

00;27;24;20 - 00;27;52;14

Speaker 2: Raj Shah, MD

RUSH Oh, yeah. And before we end, I just want to make sure we covered a lot, but our key learning objectives today, which I think we highlighted very heavily, was, you know what is some of the barriers that are experienced by the African-American community and getting an early diagnosis in primary care. And then we talk through what are some of the potential ways family physicians, including residents, can be better at early detection of Alzheimer's disease and related dementia in our populations?

So as we round out for today, I'm going to say goodbye for both Dr. Levine, and I really appreciate you spending time listening to us. And Scott, man, let's go out and grab a cup of coffee down in the cafeteria and catch up.

Speaker 1: Kate Rowland, MD

Thank you to our expert faculty and to you, our listeners, for tuning in to this episode. If you have any comments, questions or ideas for future topics, please contact us at podcast at the Brain Trust dot com. For more episodes of the Brain Trust, please visit our website. The Brain Trust Project dot com You'll find transcripts, speaker disclosures, instructions to claim CME Credit and other Alzheimer's resources as well. Subscribe to this podcast series on Health Care Now Radio, Spotify, Apple, Google Play for any major podcast platform. Thank you again and we hope you tune in to the next episode of The Brain Trust.