BEST PRACTICE COGNITIVE IMPAIRMENT AND DEMENTIA CARE FOR OLDER ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE ATTENDING PRIMARY CARE

GP WEBINAR

Dr Mary Belfrage and Prof Dimity Pond
Acknowledgement of Country

We acknowledge that we are gathered on the traditional lands of Aboriginal and Torres Strait Islander peoples and pay our respect to Elders past and present. We also acknowledge and pay our respect to those of the Stolen Generations and their families.
Let’s CHAT Dementia project

Aims

*Optimised detection and management of cognitive impairment and dementia*

– 5-year project, NHMRC funded, 12 ACCHSs
– Co-design model
– Tailored to local needs and preferences
– Developed **Best Practice Guide**

**RACGP Accepted clinical resource**
In this webinar

- Best practice guide: clinical and cultural aspects of detection and management of cognitive impairment and dementia for Aboriginal and Torres Strait Islander people attending primary care
- Brain health and primary health care throughout the life course
- MBS and PBS aspects of providing care
Poll 1: Who are you?
Poll 2: Where do you work?
Poll 3: How often do you see Aboriginal and Torres Strait Islander patients?
Poll 4: Are you of Aboriginal or Torres Strait Islander origin?
Key considerations

- Cultural context
- Cultural & linguistic diversity
- Diversity of community and health service settings
- Impact of colonisation and subsequent harms
- Principles of trauma informed care

Norman B Tindale
Aboriginal Tribes of Australia
Transactions of the Royal Society of South Australia 64 (1) 26 July, 1940
Background

- Older people and Elders are deeply respected and have important roles in families, Communities and on Country
- The population is ageing
- Dementia rates are high and there is higher onset at younger age
- Most people do not develop dementia and live well to older age
• 1 in 5 people over the age of 50 years has some form of cognitive impairment in this population.

• Alzheimer’s Disease and Vascular Cognitive Impairment common

• Very low rates dementia secondary to alcohol (ie unfounded myth)
Principles of dementia care

• Person & family centred
• Timeliness and responsiveness
• Access to appropriate services
• Regular review of goals of care
• Culturally appropriate and trauma informed care and services
LANCET Commission: 12 Modifiable Risk Factors

Relative risk for dementia

**Early life (<45 years)**
- Less education 1.6

**Midlife (45-65 years)**
- Hearing loss 1.9
- Traumatic Brain Injury 1.8
- Hypertension 1.6
- Alcohol >21 units per week 1.2
- Obesity 1.6

**Later life (age>65years)**
- Physical inactivity 1.4
- Diabetes 1.5
- Depression 1.9
- Smoking 1.6
- Social isolation 1.6
- Air pollution 1.1
Risk factors for dementia in Aboriginal and Torres Strait Islander peoples

Top 5 risk factors 50+ (12 ACCHS)

- Hypertension 53%
- Polypharmacy 48%
- Diabetes 44%
- Current smoker 42%
- History depression 29%

64% have ≥ 4 risk factors

Other

- Childhood trauma is associated with dementia diagnosis (OR 1.6) (NSW urban)
- Head injury (OR 3.7) (remote WA)
Brain health over the life-course

Living well supports ageing well

• Strengthening protective factors and effectively identifying and modifiable risk factors can impact onset and course of cognitive impairment and dementia

• Primary care: antenatal care, developmental tracking, ear health & hearing engagement in learning, mental health and social & emotional wellbeing, social & cultural connection, smoking prevention & cessation, safe alcohol, physical activity, good diet & healthy weight....
Aunty Molly

• Aunty Molly is 68 year old and lives with son Frank

• Diabetes, hypertension, obesity. Aunty was taken from her family as a young child (Stolen Generation).

• Frank is worried as his mother is more forgetful, she is moody, more withdrawn and doesn’t want to go to Elders group anymore. She forgets to take her diabetes tablets sometimes. Aunty doesn’t think she has any memory problems, and becomes upset if the issue is raised.
Detection and diagnosis

Clinical recommendation – *case finding from the age of 50 in Aboriginal and Torres Strait Islander populations* (based on high prevalence)

**Passive**
- Client or family member/friend raises concerns about thinking, memory or confusion
- You or another health practitioner has concerns about thinking, memory or confusion

**Active**
- Assessing risk factors
- Asking questions about thinking, memory and confusion
Annual health check - new recommendation re cognitive assessment ≥ 50 years and over

- Do you have any worries about your memory or thinking?
- Does anyone in your family have any worries about your memory or thinking?

If **yes** to either and/or if health service **staff raise concerns** and/or the **patient has high risk** for cognitive impairment

Then: follow up with cognitive screening and further assessment
Case finding: What might it look like

1. Assessing risk factors
   behaviours lifestyle, chronic illness, stroke, epilepsy, head injury, psychosocial factors

2. Asking questions about memory and thinking
   eg How is your memory? Is anyone in your family worried about your memory and thinking?

3. Staff raising concerns eg missed appointments, appear vague

4. Family or other community raise concerns eg about driving, money

5. Using cognitive screening tools eg clock drawing, KICA, MMSE
How are cognitive impairment and dementia detected?

- Client/family presents with concerns OR
- Concerns are identified through questioning OR
- Client has significant risk factors

- Cognitive screening
- Full clinical assessment
Initial assessment when CI or dementia is suspected or identified

• Informant history: chronicity, change from previous level, functional decline
• Cognitive assessment eg MMSE, KICA, RUDAS
• Exclude depression, delirium
• Review medications
• Dementia screen: FBE, E&Us, LFT, Ca, thyroid, B12, folate
• CT brain
• Consider referral for further assessment eg physician or geriatrician or memory clinic if available.
Personal preferences and decision making

• Introduce conversations about personal preferences early and revisit regularly
• Decision making may be a shared and collective experience

• *Quality of life* may mean different things: See *Good Spirit Good Life* Tool
Living with cognitive impairment and dementia

• Goals of care should support quality of life, maintain function and maximise comfort
• General health and dementia specific care
• Regular review as needs change
• Supported by continuity of care and integrated multidisciplinary case management approach
• Person/family-centred care
Carers and family

• Carers may be:
  – older with complex health needs and are often carers themselves
  – young with own families and complex health and social issues

• Have cultural and spiritual beliefs about changes in thinking or memory

• Often experience poor health and isolation

• Potentially have population risk for cognitive impairment
End of life and advance care planning

Let’s talk
What would happen if you were very sick?
If you become so sick that you couldn’t talk, your family and health worker may need to make decisions for you.
Talking about how this would make you feel and what you want in advance will make their decisions easier and less stressful.

What’s involved?
1. Thinking about you and your family
   Think about what is and isn’t important to you and your family.

2. Thinking about your health care
   Think about where you want or don’t want to be cared for, who you want and don’t want to care for you and the things you do and don’t want.

3. Preparing your discussion
   Prepare for talking with your family, a friend or your health worker.

4. Reviewing your discussion
   Think about how your talk went. What went well and what didn’t go so well?

What’s next?
We have included some other planning activities that may support you and your family.

Aboriginal and Torres Strait Islander Discussion Starter
WORKING OUT WHAT’S RIGHT FOR YOU
dyingtotalk.org.au
My Aged Care & access to PBS medications

• Eligible for enrolment in My Aged Care at 50

• *Close the gap* PBS co-payment for Aboriginal & Torres Strait Islander people
  - Increased subsidy introduced in 2010 to support access to medications
  - Eligibility: self-identify, will support adherence, enrolled in Medicare
  - Once-off registration
  - Register or check registration on HPOS
  - Any PBS prescriber can register a patient
Care planning

• Elements to include in care planning
  – optimising brain health
  – dementia care
  – see resources
### General medical care
- Routine primary care including acute care, immunisation, etc
- Social & emotional wellbeing
- Risk factors & comorbidities
- Oral and dental care
- Medication review
- Encouraging physical activity, social connection and cognitive activity

### Tracking function
**Cognition** (decision-making, finances, safety)
**ADLs** (self-care, driving)

### Risk assessments
- Nutrition & hydration
- Pain
- Falls
- Continence
- Elder abuse

### Monitoring
**BPSD***
- Depression
- Agitation
- Anxiety
- Sleep disturbance
- Aggression
- Wandering

*Behavioural & psychological symptoms of dementia

### Referral
1. Geriatrician/memory service/psychogeriatrician/other specialist
   - Comprehensive assessment/review
   - Advice re general & BPSD management
   - Dementia medication
2. Allied health & nursing
3. Palliative care services
4. My Aged Care enrolment and assessment for access to funded services including Commonwealth Home Support Program (CHSP) and Aged Care Assessment Team (ACAT)
Thank you

Some helpful resources:

– Best practice guide to cognitive impairment and dementia care for Aboriginal and Torres Strait Islander people [BPG & poster](#)
– Care plans
– [Good Spirit Good life](#): Quality of life tool for older Aboriginal Australians
– [Dying to Talk](#): Palliative Care Australia Aboriginal and Torres Strait Islander Discussion Starter
– [Let’s CHAT Dementia website](#)
– Services Australia [CTG PBS Co-payment information](#)
– [KICA tools](#): Cognitive assessment tools for older Aboriginal Australians
– Cognitive Decline Partnership Centre [People with dementia: a care guide for general practice](#)