International Journal of Community Medicine and Public Health
Baoum SO et al. Int J Community Med Public Health. 2023 Jan;10(1):454-458
http://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20223573

Review Article

Safety and effectiveness of dementia care management in primary care

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Received: 07 December 2022
Accepted: 22 December 2022

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ABSTRACT

Globally, dementia affects 47.5 million people, making it a significant health concern. The growing number of people with dementia is posing a challenge to the health care systems. Dementia is a complicated progressive syndrome which is characterized by impairment of cognition, changes in personality leading to impeded daily life activities. Dementia poses burden to patients, their families society and healthcare systems in context of cost and care. People with dementia need intense medical, nursing, psychological, and social support to slow the disease's progression and retain autonomy and social inclusion. Primary care has been shown to be the first point of contact for patients with dementia (PWD), making it an appropriate setting for diagnosis, in-depth needs assessments, and the beginning of dementia-specific therapy and care. The majority of dementia patients are treated in primary care settings and deal with complex medical and psychological conditions. They also suffer from various comorbid diseases along with dementia and take numerous psychotropic medications, including anticholinergics. However, the primary care system frequently fails to recognize their dementia-related symptoms due to certain constraints including time and lack of resources. Hence, the primary care system has to be supported with a variety of resources, such as dementia care managers, access to and coordination with interdisciplinary dementia specialists, and a practical dementia screening and diagnostic procedure, in order to provide better care for these vulnerable patients. The purpose of this research is to review the available information about safety and effectiveness of dementia care management in primary care.

Keywords: Dementia, Primary, Care, Management, Support

INTRODUCTION

Dementia is a major public health issue as by 2050, there will be 131 million patients suffering from dementia worldwide, up from the current estimate of 47 million. The chronic, acquired loss of two or more cognitive abilities caused by brain disorder or injury is referred as dementia. The majority of clinical assessments, differential diagnoses, and dementia management take

place in the primary care setting with appropriate specialist assistance as necessary. The overarching objectives are to lessen agony and concerns brought on by cognitive symptoms and their ancillary symptoms such as changes in mood and behaviour, while postponing the progressive cognitive deterioration. To accomplish the overall objectives, pharmacologic and non-pharmacologic methods are both applied.[1]

Dementia affects 47.5 million individuals globally. The healthcare systems are faced with challenges due to the constantly increasing population of dementia sufferers. To halt the disease's course and maintain autonomy and social inclusion, PWD require intensive medical, nursing, psychological, and social support. It has been determined that primary care is where PWD initially seek help, making it a viable location for diagnosis, thorough needs assessments, and the start of dementia-specific treatment and care. Worldwide primary care systems are not well prepared for these services, though. There is some evidence to support the viability of integrating general practitioner-based dementia care programs into healthcare systems. The scientific data does not yet, however, support the enthusiasm for these programs. Prior to being used in primary care, care management needs to be tested for effectiveness.[2] Many older adults with early symptoms or indicators of dementia first seek care from their primary care physicians. As a result, they are crucial in the diagnosis of dementia. When dealing with patients who have subjective memory issues, they should have a high index of suspicion for this disorder and shall be screened for it. The ideal scenario for primary care physicians is to promptly diagnose dementia and then refer the patient to a multidisciplinary memory clinic or the relevant expert such as geriatric psychiatrist, psychiatrist, geriatrician, or neurologist. Following that, the proper pharmacological therapy can be initiated, and psychosocial interventions can be put in place, but numerous studies have found that the prevalence of dementia in primary care settings is low.[3]

In the primary care context, dementia is grudgingly reported, inadequately recognized, underdiagnosed, and poorly managed. People with dementia have a fundamental human right to accessible, equitable primary care, even if it is accepted that managing dementia with its gradual cognitive, functional, physical, and psychiatric impairments is complex. High care demands, time requirements, and ongoing care are obstacles to providing the best care possible in primary acre setting. As a result, the needs of those with dementia may not be able to be satisfied by the general practitioner alone.[4] PWD have a lot of benefits from primary care physicians as the stress that patients and caregivers experience is greatly reduced when they receive the proper care, treatment, and support, which enhances their capacity to lead fulfilling lives. The practitioner should optimize the patient's chronic illness care in addition to the aforementioned medications to lower the risk of a cardiovascular event. This involves managing hypertension and diabetes mellitus, treating hyperlipidaemia and offering smoking cessation advice. Non-pharmacological therapies ought to be the initial line of treatment for dementia sufferers. Non-pharmacological intervention can be a beneficial supplement to pharmacological treatment in extreme situations. In order to help patients and caregivers manage the disease, primary care physicians can provide quick and practical advice during their brief clinic consultations, which is helpful because they are frequently time-constrained.[5] The purpose of this research is to review the available information about safety and effectiveness of dementia care management in primary care.

LITERATURE SEARCH

This study is based on a comprehensive literature search conducted on November 29, 2022, in the Medline and Cochrane databases, utilizing the medical topic headings (MeSH) and a combination of all available related terms, according to the database. To prevent missing any possible research, a manual search for publications was conducted through Google Scholar, using the reference lists of the previously listed papers as a starting point. We looked for valuable information in papers that discussed the information about safety and effectiveness of dementia care management in primary care. There were no restrictions on date, language, participant age, or type of publication.

DISCUSSION

A persistent and permanent deterioration in cognitive abilities, such as memory, language, and reasoning skills, characterizes dementia and is severe enough to impair day-to-day activities. Dementia prevalence was estimated to be 46.8 million people worldwide in 2015, and it is expected to quadruple to 75 million people by 2030. In primary care, treating people with dementia is still difficult. Diagnosing dementia and managing it can be challenging in the context of a busy primary care clinic. However, in order to provide comprehensive and individualized care, the family physician may diagnose and treat the simple cases alongside the patient's other chronic illnesses. Primary care physicians should inform the patient and family first about the dementia diagnosis if possible. Additionally, the disease's side effects, such as behavioural problems and difficulty in daily tasks, should be discussed with them. As dementia is permanent and gradually progresses from the mild to the moderate and severe phases, expectations should be carefully handled.[5] Dementia patients visit the hospital three times more frequently than people their age, and many of these visits are for ambulatory-care-sensitive diseases. To improve health outcomes and avoid needless emergency room visits, dementia care requires high-quality, well-integrated medical and social services; however, numerous studies have shown that dementia care in primary care practice settings is of poor quality, with physician adherence to quality indicators ranging from 18-42%.[6]

Evidence from literature

The majority of dementia patients are treated in a primary care setting. In primary medical setting, the prevalence of dementia is 2% in patients 65 to 69 years old, 7% in patients 70 to 79 years old, and 17% in seniors of age 80 years and older. Less than one-third of these patients have dementia identified through the primary care system, as reported by the various research studies. PWD have a variety of behavioural and psychological symptoms, are prescribed a number of medications, including psychotropic medications, and frequently seek medical attention. More over 20% of these PWD receive at least one medicine that is definitely anticholinergic, while less than 10% receive cholinesterase inhibitors as a prescription. Unfortunately, the complex medical and psychiatric requirements of PWD have an impact on not only their own care but on the wellbeing of their caregivers. As a result, improving primary care for dementia patients will necessitate more financial, educational, and social resources.[7]

Results of a systematic review showed that when compared to memory clinics, primary care physicians' care improved caregiver mental health and resulted in lower hospital and memory clinic expenses. Clinical outcomes or costs were not affected differently by primary care physicians -led care with specialist consultation help than they were by standard primary care. With regard to neuropsychiatric symptoms, caregiver burden, anguish and mastery, and healthcare expenses, primary care physicians -case management collaboration models showed the most promise. Compared to memory clinics, integrated primary care memory clinics had less evidence of enhanced quality of life and cost-effectiveness.[8] Findings of an exploratory study revealed that about 59% of the patients who had dementia according to the geriatric assessment team had a diagnosis of dementia listed in their primary care reports. None of the 12 individuals with mild cognitive impairment who received a geriatric assessment team diagnosis received a primary care diagnosis. The most frequent justification for a referral to the geriatric assessment team was memory loss. On all quality indicators of dementia, there were statistically significant differences between the primary care and the geriatric assessment team, with the primary care using fewer diagnostic and functional assessment tools, paying less attention to wandering, driving, medicolegal, and caregiver issues, and using fewer community supports. On the assessment and care indices, community care and the geriatric assessment team had higher congruence. Hence, in primary care, dementia care and management is still difficult.[9]

Clinicians in primary care should be aware that dementia increases the probability of important risk factors for medication-related adverse events, such as improper prescribing, advanced age, problems with adherence, drug interactions, comorbidity, and polypharmacy. Despite this, limited study has been done on the factors that lead to medication errors and adverse drug responses in PWD, as well as their prevalence and clinical repercussions. Due to the involvement of numerous health and social care workers, medication errors may be more frequent in PWD; the primary-secondary care interface may be especially dangerous. Due to cognitive impairment, PWD may be less likely to question a medicine change, be less aware of possible side effects, and know whether monitoring is necessary, making it more difficult for them to spot potential medication errors. The burden on physicians and caregivers to maintain safe medication administration is increased by this cognitive impairment and the resulting lack of capacity.[10]

Khanassov et al stated that PWD have a variety of needs and expectations, some of which have not yet been fully realized including early diagnosis of dementia. Based on their medical and social requirements, PWD and their caregivers need a range of interventions. However, the care received by PWD and their families in many nations is routinely criticized for being dispersed and not being person-centred. There are various dementia patient-centred care approaches, however they are not always used in primary care such as case management. Results further revealed that participants expressed satisfaction with the primary care practices' availability of care and the quality of their medical care. However, PWD and caregivers still had unmet needs.[11] Dreier-wolfgramm et al described that primary care physicians, nurses, and social workers make up the bare minimum of care teams. Involvement from additional medical specialties may be required for a given intervention. The majority of the time, care team members got specialized training, although this training did not always use an interprofessional education approach. Interprofessional education training programs should at the very least cover the following core subjects to ensure successful profession-to-profession collaboration including early diagnosis, post-diagnostic support, advanced care planning for patients and caregivers, and efficient collaborative care. To measure the effect on collaborative practice, the interprofessional education programs for dementia should be broadened and broadly adopted especially in primary care setting.[12] Findings from Burns et al demonstrated that in the long-term management of the dementia patient, modest primary care interventions may be useful in lowering caregiver stress and burden. They further stated that caregiving-related interventions that exclusively target care recipient behaviour may not be as effective at lowering caregiver stress.[13]

Lack of active collaboration between physicians and the numerous family-friendly community resources is one of the most frequently disregarded aspects of primary care management of dementia. Numerous physicians claim that they are unaware of the resources that are available, are uncomfortable with family education and dementia counselling, and only rarely send patients to social services. Thus, despite evidence that combining primary

dementia care with these services can lower the rate of nursing facility admissions, raise caregiver satisfaction with care, lower caregiver melancholy, and enhance the quality of care, community options are frequently neglected. Numerous initiatives for physician education and quality improvement have been created to address these issues. Implementation of guidelines, care management assistance, academic detailing, and practice redesign are a few examples. These treatments have had different degrees of success; nonetheless, a significant challenge is how to involve primary care physicians while addressing dementia in a long-term and economical way.[14] It has been demonstrated that when it comes to the treatment of dementia, general practitioners are frequently overworked or fall prey to a number of fallacies and guidelines are frequently ignored. For instance, drug prescriptions frequently contain mistakes. The fact that PWD are typically older people is a challenge because they have a higher risk of multimorbidity and polymedication. Primary care physicians might benefit from taking dementia-specific training courses in this situation. involve and organize a range of medical specialists. Other structural issues with primary dementia care exist. Multi-professional and multimodal care are required due to the complexity of the clinical picture. Individualized and stepwise therapies are required since needs differ significantly between people and over the course of the disease.[15]

Petrazzuoli et al concluded that different rules about who is responsible for what in dementia management appeared to have an impact on primary care physicians involvement in dementia assessments and investigations. Additionally, primary care physicians who were permitted to give dementia medications reported being more involved in dementia work-up than primary care physicians who were not.[16] The patient-caregiver dyad as well as the healthcare system may gain greatly from the direct integration of case management into the primary care context, in accordance with the most recent research. The process of advanced care planning can be facilitated by the case management, which can also reduce the incidence of neuropsychiatric dementia symptoms, depressive symptoms, hospital admissions, and duration of stay. Caregivers can also gain from a reduction in stress and depression. After six months, there are fewer patients who are institutionalized thanks to case management, which also reduces caregiver stress. After implementing case management for six months, there is also a decrease in the utilization of hospitals and residential care facilities. Early implementation while cognitive decline is modest, including all stakeholders, and creating a positive connection between the primary care physicians and patient-caregiver dyad are all necessary to facilitate successful case management and advanced care planning.[17] Despite of being the immediate contact with the patients, primary care settings have several obstacles for the provision of safe and effective management for PWD, advocating the need of further research to focus on the development of effective management strategies for PWD in primary care setting context and also add to the literature since the available studies are quite limited in this aspect.

CONCLUSION

The provision of high-quality assessment and care for PWD primarily involves primary care. Although, to improve the management of PWD in primary care, challenges and obstacles faced by primary care physicians in this context must be addressed timely. Additionally, awareness and education of primary care physicians regarding the early diagnosis and management of the dementia is need of time.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

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Cite this article as: Baoum SO, Al-Ibrahim AM, Alharthi MT, Almohamad AA, Althobaiti AH, Alsagr WH et al. Safety and effectiveness of dementia care management in primary care. Int J Community Med Public Health 2023;10:454-8.