Senior PsychCare
4314 Yoakum, Houston, Texas 77006
Medical Director: Leo J. Borrell, MD
District Manager: Jason Lacy
Regional Manager: Beryl Shorter
Ph: 713-850-0049 **Fax:** 713-850-0036

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Senior Minutes

A Better Quality of Life for Seniors, Our Staff and Others

SENIOR PSYCHCARE
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THE ADAVANTAGE OF PSYCHIATRIC INVOLVEMENT IN GERIATRIC CARE

Much has been published about the substantial increase in the number of Senior Citizens in the United States. The increase is greatly attributed to the aging of the baby boom generation and the change in the mortality rate. There has also been a rise in the number of the elderly persons with behavioral disorders. Due to underlying medical and neurological diseases, there will be older adults developing late-onset psychiatric disorders. There is an extreme shortage of health care professionals who are skilled in treating these types of behavioral disorders. Numerous studies have show that the primary care physicians, who provide the elderly much of these mental health care, have received very little training in geriatric psychiatry. Because of this, elderly people are not being accurately diagnosed or treated effectively. According to a primary care physicians' survey, 20% of primary care physicians admitted to be "not very knowledgeable" about mental health care issues in the elderly, and another 66% feld they were somewhat knowledgeable." How does this shortage of geriatric psychiatrists impact the treatment of an illness seen typically in the elderly such as Alzheimer's Disease (AD)?

Because numerous advances in the treatment of this disease have been documented, cholinesterase inhibitors (e.g., tacrine [Cognex], donepezil [Aricept], and rivastigmine [Exelon]) showed to have symptomatic treatment of the cognitive deficits for a period of time. There has been an approximate one-year delay in nursing home patients, according to long term studies with tacrine. The need to delay institutionalization is imperative due to the rise in the number of patients with Alzheimer's Disease. What is the differential outcome of patients with Alzheimer's Disease being treated solely by a primary care physician versus those also being treated by a geriatric psychiatrist? What are the differences in the cognitive outcome of patients from each cohort? Are generalists different than specialists in the prescription of cognitive enhancers or in the utilization of health care services versus geriatric psychiatrists significant facilities? In the treatment of Alzheimer's Disease by primary care physicians versus geriatric psychiatrists significant issues have surfaced. While hospitalization rates (38.7% primary care patient versus 14.8% psychiatric patients) and use of home health aides (45.2% versus 18.5%) were significantly different in the pilot study, primary care patients had a substantially higher institutionalization rate in the two -year follow up study (30% versus 4.6%). In patients treated only by a primary care physician, there was decreased use of donepezil (45.5% versus 76.5%). A significant difference was revealed in the prescription of donepezil (35% versus 64%). This may reflect an incomplete understanding of reasonable expectations of the medication by either the primary care physician or the caregiver.

The percentage of psychiatric patients receiving donepezil may reflect continuous reinforcement by the physician and case manager. The clinical dementia rating (CDR) of the primary care patients had deteriorated significantly more than the CDR of the psychiatric patients at the one-year mark. Greater cognitive decline has also been associated with increased hospitalization. The rise in utilization of home health aides by the primary care patients may also be a function of greater global impairment compared to the psychiatric patients. A comprehensive intervention for enhanced treatment in the primary care setting may be indicated. There also exists a need to analyze physician knowledge, attitude and behaviors regarding the diagnosis and treatment of Alzheimer's disease. Significant differences in institutionalization, cognition and donepezil prescriptions emerged during the two-year follow up in this comparison of two different models of care. Primary Care intervention trials can be useful in assessing differences in outcomes after an educational intervention in order to determine if a collaborative care model is efficacious. Additionally, the assessment of the positive implications (both direct and indirect) of this

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type of intervention would be necessary. A similar study has been initiated recently at Robert Wood Johnson Medical School. It is a study of collaborations between geriatric psychiatry and several primary care sites. Most of the individuals with AD have a person with dementia is twice as high as the cost of caring for the average Medicare patient. Patients with dementia are 10% to 30% of nursing home admissions. To address this shortage of geriatric specialists, it will likely involve both educational and financial incentives to enhance the pipeline of individuals who are exposed to geriatrics early their training and professional development.

A Study: Advantages and Disadvantages of Patients Being Told They Have Dementia

Patients After The Dementia Diagnosis

Until recently it has been assumed that by the time a person can be diagnosed with dementia, they are too far gone to understand what dementia is because they have usually lost most of their senses. Therefore, the medical profession has believed it best to withhold the diagnosis from the patient as they believed them beyond the understanding and unable to help themselves. Doctors reveal the diagnosis only to the family who take control of the patient's life afterward. But more than likely, decision made by a family, no matter how loving the relationship would not have been what the patient wanted if they still had their senses.

Since there are patients diagnosed with dementia who still have some of their senses most of the time, should they be told of disease that will eventually rob them of their minds for the rest of whatever they have of their lives? Or should they be left blissfully unaware of the diagnosis to not rob them of what little hope remains, even if the hope is unwarranted? Can these patients help themselves in the progression of the disease before the disease makes it quite clear that they cannot? The answer by patients in varying degrees of dementia is that they should be told of the diagnosis in order to plan how to spend the rest of their lives on their own terms.

Patients Before the Diagnosis of Dementia

Dementia is first suspected of a person due to their bizarre or unfamiliar behavior with the most obvious symptom being abnormal memory loss. Behavior such as turning on the car, going back into the home and forgetting the car was turned on (leaving the car on all night) can be amusing at first and non-threatening.

But as the disease progresses, when behavior involves not recognizing people who were once very well known or when found repeating the same question without realizing it had been asked only minutes before more than once, the realization that sometime is wrong can be frightening and devastating to the dementia-stricken person while becoming more and more bewildering to others present as symptoms continue to develop.

When a situation occurs with a loved one, there will be understanding for the dementia-stricken person. This may impede diagnosis even when there is traumatic awareness that something is wrong, such as insisting on trying to drive off in the wrong car, would frighten family members. Often no one mentions anything about an episode, despite being acutely aware that all is not right, just in case it is an isolated episode.

On the other hand, episodes with strangers have no loving understanding. A person might start eating food off a stranger's plate at a restaurant. This can produce an exclamation such as the common impatient question—"are you crazy or something?" Responses from strangers can be more traumatic for the stricken person along with compounding more caring responses from loved ones. At this point, the afflicted person might withdraw and become isolated to avoid pity or ridicule. Eventually, they become afraid to ask for help. Then they lose the ability to know to ask for help.

It is usually when the person is forced to seek medical attention by a loved one or a stranger has them arrested that they are diagnosed. Until then, early detection is virtually impossible. But even if it were possible, it would be useless as there is no cure and nothing that will slow the progression of the disease at this time. There are many things the patient with dementia can do until the disease takes full charge.

Medical Director: Leo J. Borrell, MD

Corporate Offices:

San Antonio: 1380 Pantheon Way Ste. 240, San Antonio, Texas 78232

District Manager: Lee Jones

Regional Manager: Charles Henderson

Ph: 210-366-8035 **Fax:** 210-496-1901

Dallas:

District Manager: Spencer Dunn

Regional Manager: Soni Rao

Toll Free: (800) 806-0465 **Toll Free Fax:** (800) 318-0120

For additional information please visit our website:

www.seniorpsychiatry.com