The Aging Practitioner
(or is 70 the new 50?)

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Chair, Provider Wellness Committee
Medical Staff Affairs
Presbyterian Healthcare Services
www.phs.org
The Beloved Doctor

• Many older docs are a treasured part of the medical staff:
  – an “institution”
  – a wealth of knowledge and wisdom
  – beloved by patients, staff and colleagues.

• And maybe giving great medical care...?
The Case of Dr. Tom
Demographics

• 42% of the nation's 1 million physicians are older than 55 and 21% are older than 65, according to the American Medical Association.

• Up from 35% and 18%, respectively, in 2006.
Presbyterian’s Medical Staff

Providers Age Analysis

September 29, 2014

11:30:39 AM
Presbyterian’s Medical Staff

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Count</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 29 &amp; Under</td>
<td>48</td>
<td>2.71</td>
</tr>
<tr>
<td>Ages 30 to 39</td>
<td>396</td>
<td>22.35</td>
</tr>
<tr>
<td>Ages 40 to 49</td>
<td>467</td>
<td>26.35</td>
</tr>
<tr>
<td>Ages 50 to 59</td>
<td>452</td>
<td>25.51</td>
</tr>
<tr>
<td>Ages 60 to 69</td>
<td>334</td>
<td>18.85</td>
</tr>
<tr>
<td>Ages 70 &amp; Over</td>
<td>73</td>
<td>4.12</td>
</tr>
<tr>
<td>Not Assigned</td>
<td>2</td>
<td>0.11</td>
</tr>
</tbody>
</table>

Provider Count: 1,772
Average Age: 49.77
Now, the depressing part: What happens as we all age?

- Physical skills decline
- Cognitive skills decline
  - At highly variable rates
- Increased risk of being a victim of the “4 D’s”
  - Dementia, depression, drugs and drink
- And, for physicians, the farther we are from residency/fellowship training, there is the increased risk of deteriorating knowledge/skill base
An opinion (or argument) from every point of view

http://www.fsphp.org/AssessingLateCareerPhysicians-Norcross.pdf
Sang O-Rhee. Factors determining the quality of physician performance in patient care. Med Care 1976; 14 (9):733

• Study of 454 U.S. physicians in 18 specialties examining predictors of quality of physician performance

The study found that
1) physician specialty;
2) type of medical school;
3) time in practice;
4) type of ambulatory care setting; and
5) type of hospital

_all had both separate and joint effects_ on quality of care

• All 5 predictors explained 20% of the variance in care
• Physician in practice from 6 to 15 years provided the highest quality of care
• Physicians in practice 16 years or more provided intermediate quality of care
• Physicians in practice from 1 to 5 years provided the lowest quality of care!
Relationship between Presence of Alcohol Abuse/Dependence and Major Medical Errors (Oreskovich, FSPHP’14)

Positive Symptoms of alcohol abuse or dependence by AUDIT-C (N=1100)

- Major medical error last 3 months:
  - Yes = 10.9%
  - No = 89.1%

p=0.0011

No Symptoms of alcohol abuse or dependence by AUDIT-C (N=6109)

- Major medical error last 3 months:
  - Yes = 7.9%
  - No = 92.1%
Mild Cognitive Impairment symptoms in physicians

• Prescription errors
• Late payments
• Irrational business decisions
• Loss of skills
• Office staff concerns
• Dissatisfied patients
• Unsatisfactory peer review
• Patient injuries and lawsuits
What does evidence-based literature tell us?
Diagnostic Algorithm for Amnestic and Nonamnestic Mild Cognitive Impairment.

1. Report of cognitive impairment by patient
   - Change in condition:
     - Not normal
     - Not dementia
     - Decline in cognition
     - Preserved functional abilities
   - Memory impairment
     - Yes
       - Memory alone
         - Amnestic MCI
     - Memory and other cognitive domains
     - Single nonmemory domain
       - Nonamnestic MCI
     - Multiple nonmemory domains
## Screening for Cognitive Impairment in Older Adults

**Clinical Summary of U.S. Preventive Services Task Force Recommendation**

<table>
<thead>
<tr>
<th>Population</th>
<th>Community-dwelling adults who are older than 65 years and have no signs or symptoms of cognitive impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendation</strong></td>
<td>No recommendation.</td>
</tr>
<tr>
<td><strong>Grade</strong></td>
<td>I statement</td>
</tr>
<tr>
<td><strong>Risk Assessment</strong></td>
<td>Increasing age is the strongest known risk factor for cognitive impairment. Other reported risk factors for cognitive impairment include cardiovascular risk factors (such as diabetes, tobacco use, hypercholesterolemia, and hypertension), head trauma, learning disabilities (such as the Down syndrome), depression, alcohol abuse, physical frailty, low education level, low social support, and having never been married.</td>
</tr>
<tr>
<td><strong>Screening Tests</strong></td>
<td>Screening tests for cognitive impairment in the clinical setting generally include asking patients to perform a series of tasks that assess 1 or more cognitive domains (memory, attention, language, and visuospatial or executive functioning). The most widely studied instrument is the Mini-Mental State Examination. Other instruments with more limited evidence include the Clock Drawing Test, Mini-Cog Test, Memory Impairment Screen, Abbreviated Mental Test, Short Portable Mental Status Questionnaire, Free and Cued Selective Reminding Test, 7-Minute Screen, Telephone Interview for Cognitive Status, and Informant Questionnaire on Cognitive Decline in the Elderly.</td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td>Pharmacologic treatments approved by the U.S. Food and Drug Administration include acetylcholinesterase inhibitors and memantine. Nonpharmacologic interventions include cognitive training, lifestyle behavioral interventions, exercise, educational interventions, and multidisciplinary care interventions. Some interventions focus on the caregiver and aim to improve caregiver morbidity rates and delay institutionalization of persons with dementia.</td>
</tr>
<tr>
<td><strong>Balance of Benefits and Harms</strong></td>
<td>The evidence on screening for cognitive impairment is lacking, and the balance of benefits and harms cannot be determined.</td>
</tr>
<tr>
<td><strong>Other Relevant USPSTF Recommendations</strong></td>
<td>The USPSTF has made recommendations related to several of the risk factors for cognitive impairment, including counseling on tobacco cessation, alcohol use, healthful diet, physical activity, and falls prevention and screening for high cholesterol, hypertension, and depression. These recommendations are available at <a href="http://www.uspreventiveservicestaskforce.org">www.uspreventiveservicestaskforce.org</a>.</td>
</tr>
</tbody>
</table>

For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, please go to www.uspreventiveservicestaskforce.org.
Global Cognition Scores in Survivors of Critical Illness.

**Predicting the risk of mild cognitive impairment in the Mayo Clinic Study of Aging. Neurology 84: April 7, 2015**

<table>
<thead>
<tr>
<th>Men &amp; Women</th>
<th>Risk Score Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-reported memory concerns</td>
<td>5</td>
</tr>
<tr>
<td>Ever Dx’d Alcohol problem</td>
<td>3</td>
</tr>
<tr>
<td>Stroke Hx</td>
<td>2</td>
</tr>
<tr>
<td>Diabetic, Age at Dx &lt; 75</td>
<td>19</td>
</tr>
<tr>
<td>Age at Dx 75-84</td>
<td>9</td>
</tr>
<tr>
<td>A.Fib Hx</td>
<td>2</td>
</tr>
<tr>
<td>APOE-4 carrier</td>
<td>8</td>
</tr>
</tbody>
</table>
### Men only, without APOE

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Risk Score Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI $\geq 30$</td>
<td>4</td>
</tr>
<tr>
<td>Never married or widowed</td>
<td>9</td>
</tr>
<tr>
<td>Slow gait, $&lt;0.9$ m/s</td>
<td>9</td>
</tr>
<tr>
<td>Anxiety, BAI $\geq 8$</td>
<td>6</td>
</tr>
<tr>
<td>Depressed, BDI $\geq 13$</td>
<td>3</td>
</tr>
<tr>
<td>Short test of mental status</td>
<td>0 – 39</td>
</tr>
</tbody>
</table>

### Women only, without APOE

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Risk Score Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midlife dyslipidemia</td>
<td>6</td>
</tr>
<tr>
<td>Short test of mental status</td>
<td>0 - 51</td>
</tr>
</tbody>
</table>
Factors affecting policy and screening

• Americans with Disabilities Act
• Age Discrimination
• HIPPA
• Employment contracts are not the same as the Medical Staff credentialing process
• “Safety Sensitive”
“Safety Sensitive”

• Examples of Safety Sensitive Workers
  – Power company employees, especially nuclear power
  – Defense contractors
  – Public servants in law enforcement and fire areas
  – Airline pilots (even private)
  – Attorneys and Judges
  – Healthcare workers
  – Employees of pharmaceutical companies, especially manufacturing
  – Politicians (?)
“Safety Sensitive”

Four Qualities of Safety Sensitive Workers

1. A responsibility to the public
2. The need to balance the individual’s right to privacy with the public’s need for safety
3. One group, healthcare workers, has the potential to divert abusable substances from the workplace
4. Safety sensitive workers who are placed in roles of authority as part of their profession have problems adopting the “patient” role
Future policy recommendations for screening:

- Screening must be part of routine process and not reactive or “for cause”
- It should reflect overall consideration of healthcare workers as “Safety Sensitive”
- It cannot be elective
- It must be objective
- Screening instruments must be developed which are evidence-based
- When risk is identified, objective third parties should provide further screening and direction
Future policy recommendations for screening:

• Non-discriminatory with respect to age, should begin with initial credentialing, regardless of age, and repeat through each re-appointment
• HIPPA compliant
• ADA compliant
• Provision of dignified pathways for transition to employment which protects patients while preserving the value inherent in the experienced practitioner
If a problem is identified......
Policy Statement on Assessment:

CPPPH Policy Statement on Assessment:

• Core Elements:
  – History & Physical
  – Peer Assessments
  – Observations from others in the clinical setting
  – Assessment of cognitive function
CPPPH Policy Statement on Assessment:

• The Wellbeing Committee should provide a list of **two or more qualified** evaluators for each element of the assessment process from which the evaluee may choose.
CPPPH Policy Statement on Assessment:

*Qualifications appropriate for those chosen to conduct the screening include these elements:*

• Experience: at least three years’ experience in practice in his/her respective specialty
• Previous experience assessing physicians is desirable
• For neuropsychological screening assessment, evidence of specialty training in cognitive and neurological disorders and testing
• For screening for substance use disorders, demonstrated knowledge and understanding of addiction, treatment and recovery
• **No conflict of interest or duality of interest with evaluatee or referring entity**
• Licensure: licensed health care professional with current unrestricted license with no disciplinary history within the previous five years
• Demonstrated ability to provide reports on time, with sufficient and appropriate information to support peer review action
CPPPH Policy Statement on Assessment:

Qualifications appropriate for those chosen to conduct additional testing and evaluation are discussed in Guidelines for Evaluations Of Health Care Professionals [CPPPH 2013] and include these additional elements:

• Specialty or subspecialty certification or equivalency
• Previous experience assessing physicians is desirable
• Demonstrated ability to provide reports that describe the nature of any decrements in performance and describe how such decrements or vulnerabilities might affect the ability to perform the tasks required for the evaluatee’s practice and privileges
Some resources:

• FSPHP.ORG
• PACE (San Diego)
  – http://www.paceprogram.ucsd.edu/
• CPEP (Denver)
• Menninger (Houston)
• Provider Wellness Committees
Thank you!!

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