Geriatric Assessment Clinic

Established in 1998 as a multidisciplinary approach under the Article 16 regulation of the New York State Office for People with Developmental Disabilities at the regional office, 620 Westfall Road, Rochester, NY, 14620

The total eligible population, as defined in subdivision 22 of section 1.03 of the NYS Mental Hygiene Law, in the Finger Lakes region of Western New York is approximately 12,000

Under a long term agreement with the University of Rochester Medical Center physicians-in-training regularly attend the clinic sessions

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Referrals

Sources:

treatment teams, group homes, family care, treating physicians, family members

Reasons for referrals:

baseline, any functional decline, forgetfulness for routine tasks, ADLs, behavioral changes, agitation, irritability, mood lability, aggression: verbal or physical

Supporting documents

- Individual service or life plan/behavior support plan
- Physical examination, health history, medication history
- Social history/biographical narrative
- Determination of the patient's best level of function, corroborated by a caregiver, who has known the patient for an extended period of time
- NTG – EDSD 'early detection screen for dementia'
- Prior clinical discipline evaluations from OT, PT, psychology, behavior specialist

Changing venues for evaluation procedure to allow private time for patient and caregivers

- All participants assemble in conference room
- MD, OT and Nurse retire with patient to adjacent room
- Psychologist and caregivers remain in conference room
- Psychologist and patient retire to adjacent room
- MD, OT and Nurse visit with caregivers
- Patient returns to caregivers in conference room
- Psychologist, MD, OT and nurse return to adjacent room to deliberate
- The evaluators reunite with patient and caregivers and deliver comprehensive report

Clinic results in numbers

Most recent time period covered is January 2015 - December 2018
Total number of visits was **245 over four years**

93 patients out of the total were seen two or three times

98 Down syndrome patients ranged in age from 39 to 74 years. **32** were diagnosed with dementia (32,6%)

147 non–Down patients, ranging in age from 41 to 89 years revealed **11** instances of dementia, 5 of these vascular (7%)

The **possible dementia** category included 3 more patients with Down syndrome, additionally 1 with LBD, and 1 with FTD

Differential diagnostic considerations

- Multiple confounding factors potentially simulate dementia and may be amenable to specific treatment, specifically:

- Sensory deficits: hearing or visual impairment
- Cycling mental illnesses, foremost depression
- Impact of psychotropic drugs
- Epilepsy syndromes and subclinical seizures
- Untreated sleep apnea
- Chronic comorbidities
- Dementia as a newly arising neurodegenerative process remains a diagnosis of exclusion

Recommendations

Filling a gap in basic work up: Vitamin B 12, TSH

Reevaluation in one to two years to resort to time for clarification of possible or probable diagnosis

Review of medication regimen and possible tapering to determine adverse or beneficial effects

Consultation with community resources: Alzheimer’s Association for training and support of staff

Consultation with clinical disciplines, triggered by flagged items in the EDSD, for cognitive communication supports, environmental changes, safety in mobility, behavior modification for increased cooperation with treatment measures

Comparison of two convenience samples of clinic patients

2002 through 2005			versus	2015 through 2018		
144	Down 51	non-Down 93		245	Down 98	non-Down 147
Dg. of				Dg. of		
Dementia	12	6		Dementia	32	11
Prior diagnosis 42 in primary care approach				Prior diagnosis 4 in primary care approach		
Ref.: James P. Acquilano, Dissertation, February 2006 Capella University established preference for a comprehensive model of geriatric assessment				Primary care physicians, neurologists, psychiatrists now refer for evaluation for dementia for their IDD patients		