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PACE Aging Physician Assessment (PAPA)

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Conflict of Interest: partial salary support from UCSD PACE program

Polling Question #1

Do you believe that there is a need for age-based physician screening?

1. Yes
2. No
3. Maybe

Polling Question #2

If so, when should age-based screening begin?

1. Age 60
2. Age 65
3. Age 70
4. Age 75
5. Age 80

Paradox of Aging

- Physical health and some cognitive abilities decline with aging, while your own impression of how successfully you are aging, mental health, and psychosocial functioning tend to improve
- Positive psychological attributes such as optimism, resilience, compassion, and wisdom do not decline with age, but stay stable or even increase in subgroups of individuals in later life
- Heterogeneity: Some seniors age more successfully than others

Jeste, D. MD: Presentation at Coalition for Physician Enhancement Meeting, November 10–11, 2011

Why screen

- Risk factor affecting competence/performance
  - Quebec data
  - Ontario data
  - Expert opinion
  - Anecdotal experience

Pilots vs. Physicians

- ***National standard***
  - All pilots must maintain currency exam, simulation, and medical exam (frequency of latter varies with age: age 40 = 6 months vs under 40 = 12 months)
- ***No national standard***
  - All physicians must maintain (generic) licensure to practice
  - No health assessment required
  - No assessment of competence, currency, or quality performance required in area/scope of practice

Characteristics of Aging That May Affect Clinical Competence

- ***What we know:***
  - Physical-motor capabilities (dexterity), stamina, energy, strength, reflexes (reaction time), acuity of vision (visuospatial skills) and hearing, immune capacity, propensity for illness
  - Mental memory (short term), diminution of risk taking, impairment of puzzle and problem solving (information processing), reduced ability to adopt new ideas and/or reexamine old ideas

Other Risk Factors That May Affect Clinical Competence

- Poor performance in medical school
- Solo practice
- Lack of hospital privileges
- Lack of ABMS board certification
- Out-of-scope practice
- Clinical volume
- New knowledge/procedural skills
- Fatigue/stress/burnout
- Health issues—mental and physical—may or may not relate to aging

Old vs. Young: Diagnostics

- Old make more accurate initial diagnosis—rely on experience and non-analytic thinking
- Young take longer to make diagnosis—rely more on analytic reasoning
- Problem: 40% of initial complex diagnosis may be incorrect
- Can the older physician be taught to abandon first impressions and use more analytic reasoning?
- Objective peer feedback

K. Eva *Academic Medicine* 2002:77: S1–S6

Unintended Consequences of Age-Based Competence Decisions / Mandatory Retirement

- Contribute to predicted physician shortfall as population ages and their needs for medical care increase
- Loss of contributions of medical wisdom and experience
- Economic losses: society paid for medical education; delaying retirement
- Beware the “law of averages”—old does not necessarily mean incompetent
- Age may be a risk factor, but it is not the only one
- Age Discrimination in Employment Act (ADEA)

Stephen H. Miller, MD, MPH Coalition for Physician Enhancement Meeting, November 10-11, 2011

What Can We Do? – 3 Policies

Hospital/group	Screening commences at age	Frequency of assessment	Areas assessed
Stanford Lucile Packard Children's Hospital	Age 75	Every 2 years	• Peer assessment of clinical performance • History & physical • Cognitive screening
University of Virginia Health System	Age 70	Every year after age 75	Physical and mental capacity (not defined further)
Driscoll Children's Hospital	Age 70	At reappointment	• Physical and mental examinations (described elsewhere) • Proctoring of clinical performance if deemed appropriate

What Can We Do?

- **PACE Aging Physician Assessment (PAPA)**
  - PACE intake form
    - 87 questions
  - History & physical exam
  - Vision, hearing
  - Screen for substance abuse, depression and anxiety
    - PHQ-9
    - GAD-7
  - MicroCog®
  - MOCA®

Data

- 6 participant to date
- Pediatricians
  - 5 general outpatient
  - 1 hospitalist

Age

- 74/9mos
- 74/8mos
- 69/10mos
- 71/11mos
- 71/11mos
- 73/10mos

Intake form

Cultural Background	First language	Medical School	Board Certified	Hours worked per week
White	English	US	Yes	48
Black	English	US	Yes	41
White	English	US	Yes	60
White	English	US	Yes	40
White	English	US	Yes	50
White	English	US	Yes	40

History and Physical
Vision and Hearing

Afib (stable); Hearing (cerumen); Insomnia (medication); ADHD (no medication)	Planned retirement 2015
Hip replacement; HTN (meds, stable); Lipid (meds, stable)	regular exercise
s/p MI (meds, stable); Afib (meds, stable)	regular exercise
Spinal stenosis (mild); HTN(meds, stable)	
Hearing aids; HTN (meds, stable); Lipid (meds, stable)	
HTN (meds, stable); Osteoarthritis	

Screen for substance use

EtOH - 5 drinks per week; small MJ in 60s
EtOH - last 20 years ago
none
none
EtOH - 10 drinks per week
EtOH - 1 daily

PHQ-9

PHQ-9 Scores and Proposed Treatment Actions *

PHQ-9 Score	Depression Severity	Proposed Treatment Actions
0-4	None-minimal	None
5 – 9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10 – 14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15-19	Moderately Severe	Active treatment with pharmacotherapy and/or psychotherapy
20-27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

* From Kroenke K, Spitzer RL, Psychiatric Annals 2002;32:509-521

GAD-7

GAD-7 Scores and cut points

GAD-7 Scores	**Anxiiety Severity**
0 - 4	None-minimal
5 – 9	Mild
10 – 14	Moderate
15 - 21	Severe

further evaluation is recommended when the score is 10 or greater

Spitzer RL, Kroenke K, Williams JB, et al. Arch Intern Med. 2006 May 22;166(10):1092-7

Depression and Anxiety

PHQ-9	GAD-7
2	3
0	0
2	1
5	2
0	0
0	0

Cognitive scores

MOCA	Missed MOCA	MicroCog	MicroCog Note
28	Cube(1), Delayed recall(1)	May Need Further Evaluation	Re-assess 1-2 years, borderline performance, may benefit from time accommodation to optimize performance
28	Delayed recall (2)	Does Not Need Further Evaluation	
30		Does Not Need Further Evaluation	
30		Does Not Need Further Evaluation	
23	Cube(1), Attention (1), Abstraction (1), Delayed recall(4)	Does Not Need Further Evaluation	MOCA and MicroCog don't correlate - Neuropsychologist to review
27	Cube(1), Delayed recall(2)	Does Not Need Further Evaluation	MOCA was able to recall all 5 at a later time

MOCA normal ≥ 26

Summary

1. 74/9 MicroCog, 5 drinks/wk, Hearing (cerumen) ADHD no medication – planned retirement
2. 74/8 – good
3. 69/10 – good
4. 71/11 – PHQ 9 (5), EtoH 10/wk
5. 71/11 – MOCA (23)
6. 73/10 - good

Discussion

Questions?