

Primary Care Provider Attitudes and Practices Evaluating and Managing Patients with Neurocognitive Disorders



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INTRODUCTION

The prevalence of dementia, a neurocognitive disorder (NCD), is expected to triple in the next 30 years. Accurate diagnosis of NCDs determines prognosis, anticipatory guidance, and symptomatic treatment, and is necessary to identify cases with reversible underlying conditions.¹ Primary care providers (PCPs) are typically the first to recognize that a patient may have a NCD (including mild cognitive impairment or dementia). However, PCPs frequently do not evaluate further, and when they do, they often refer to specialists rather than testing and diagnosing within their practice. Both PCPs and patients commonly report trouble accessing specialists, and more than half of patients do not follow through with referrals.^{2, 3} While PCPs have identified systems-level barriers to the assessment of their patients with NCDs, including lack of resources and inadequate time to educate patients and families after a diagnosis of dementia, data on actual PCP attitudes and evaluation and management practices are sparse.⁴ Understanding PCP practices and practice barriers may guide efforts to support their evaluation and management of these patients. We surveyed a national sample of PCPs to characterize their attitudes and practices with respect to the evaluation and management of NCDs.

METHODS

We surveyed the first 100 PCP respondents who met eligibility criteria from a proprietary database of 5 million panelists. Respondents were eligible if they identified as primary care practitioners and evaluated more than 10 patients over age 55 per month. The cross-sectional survey measured clinical practice characteristics (Table 1) and confidence, attitudes, and behaviors related to the diagnosis and management of NCDs. Providers' demographic data and outcome measures were summarized using descriptive statistics.

RESULTS

Sixty-four percent of PCPs reported high confidence in the general medical care of patients with neurocognitive complaints, but only 23% were highly confident in providing a prognosis and stage appropriate care for patients with NCDs (Table 2). When PCPs suspect a NCD, 54% referred their patients to a specialist for a full neurocognitive workup (cognitive assessment, neuroimaging, labs) and 35% referred patients for comprehensive neuropsychological evaluation, for at least 75% of their patients. Thirty-five percent implemented standardized cognitive screens in at least 75% of their patients. Only 20% of PCPs reported high confidence in their ability to interpret cognitive testing results. Twenty-four percent reported discomfort interpreting MRI results. Only 21% of PCPs were highly confident that they correctly recognized when a patient had a NCD, while 13% were highly confident in making a specific diagnosis. A quarter of PCPs identified lack

Table 1 Characteristics of 100 Primary Care Providers' Practices

Variable	Value
Practice setting: <i>n</i> /109* (%)	
Academic	15 (13.8)
Accountable care organization/HMO	9 (8.3)
Community health center/federally qualified health center	15 (13.8)
Private practice/private group practice	64 (58.7)
Other	6 (5.5)
Self-described medical specialty: <i>n</i> /100 (%)	
Family medicine	41 (20.5)
General medicine	5 (2.5)
Internal medicine	44 (22.0)
Primary care	10 (5.0)
Mean years in practice, post residency <i>m</i> (SD)	18.9 (10.4)
Types of formal training in NCD care: <i>n</i> (%)	
CME credits	70 (52.2)
Professional education through community groups (e.g., Alzheimer's Association)	28 (20.9)
Fellowship	10 (7.5)
Other	3 (2.2)
Never received any formal training in this area	23 (17.2)
Estimated no. of patient providers currently manage with Mild cognitive impairment (SD)	27.6 (27.8)
Dementia (SD)	23.1 (26.4)

*Providers could identify multiple practice characteristics

Table 2 Primary Care Providers' Attitudes and Behaviors

Variable	PCPs
	(n = 100) %
Medical care and management	
Highly confident in managing the general medical care of patients with cognitive complaints	64
Highly confident in providing a prognosis and stage appropriate care for patients with NCDs.	23
General referrals	
Referred more than 75% of patients with suspected NCDs to a neurologist or other specialist for a full dementia evaluation	54
Referred more than 75% of patients with suspected NCDs to a specialist for neuropsychological testing	35
Cognitive screening and neuropsychological testing	
Performed cognitive screening in more than 75% of their patients with suspected NCDs	35
Highly confident in interpreting cognitive test results	20
Imaging	
Lack familiarity or have discomfort interpreting MRI results	23.5
Diagnosis	
Highly confident in correctly recognizing when a patient has an NCD	21
Highly confident in making a specific NCD diagnosis	13
Identify lack of familiarity with diagnostic criteria for NCD syndromes as a strong barrier in their clinical practice	26
Practice competency	
Moderately to extremely likely to treat more patients with NCDs rather than referring them to specialists if decision support tools were available.	76

of familiarity with diagnostic criteria for NCDs as a barrier in their clinical practice. Seventy percent of PCPs reported that they would be moderately to extremely likely to treat more patients with NCDs rather than referring to specialists if decision support tools were available.

DISCUSSION

While PCPs carry the principal burden of assessing and caring for the majority of patients with NCDs, there is often a significant delay between symptom onset and diagnosis.^{1, 4, 5} Furthermore, continuity of care for patients with NCDs is a major problem that can lead to delayed diagnosis and impede clinical care and advanced care planning decisions.¹ Our findings offer a starting point to address this problem by identifying practice barriers that PCPs face, aside from commonly reported systems-level issues such as time and reimbursement.⁴

Our study suggests that PCPs lack confidence in their ability to engage in key aspects of the neurocognitive evaluation, including implementation of screening, interpretation of standard diagnostic procedures, and ability to provide prognosis and stage appropriate care. Specific practice barriers PCPs identified included implementing and interpreting cognitive tests and neuroimaging, and familiarity with diagnostic

criteria. Multiple consensus guidelines recommend cognitive testing and neuroimaging as essential aspects of all NCD evaluations to rule out reversible causes of impairment or to make an accurate diagnosis.⁶ New approaches, such as streamlined tools and training, are being designed to support dementia assessment and management in primary care. These tools may help PCPs contextualize diagnostic test results and reduce referrals, ensuring greater continuity of care. In our study, most (70%) PCPs reported that if they had tools and education, they would be more likely to do neurocognitive assessments. Effective interventions can be achieved given that PCPs are generally eager to improve their decision processes around the identification, diagnosis, and care of their patients with NCDs.

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