CLINICAL PROVIDER PRACTICE TOOL

COGNITIVE IMPAIRMENT IDENTIFICATION

Annual Exam
Mini Screen

Tools
Mini-Cog or GPCOG AND
Family Questionniare (if family available)

IF

Normal

Follow up in 1 year

Mini-Cog < 4 or GPCOG < 9
Family Questionnaire > 2

Cognitive Assessment
(same day or new visit)
+ include family

Tools
One of the following: SLUMS, MoCA, Kokmen STMS, MMSE-2 or MMSE
AND Family Questionnaire

IF

Normal

Follow up in 1 year

Score falls outside of normal range

Normal Range:
SLUMS = 27–30 (HS education)
MoCA = 26–30 (HS education)
Kokmen STMS = 29–30
MMSE/MMSE-2 = 27–30

Family Questionnaire < 3

Option 1
Do complete dementia workup
(see provider checklist)

Option 2
Refer to: Champion in your practice, neurologist, neuropsychologist*

*Neuropsychological evaluation is typically most helpful for differential diagnosis, determining nature and severity of cognitive functioning, and the development of an appropriate treatment plan. Testing is typically maximally beneficial in the following score ranges:

SLUMS = 18–27
MoCA = 19–27
Kokmen STMS = 19–33
MMSE/MMSE-2 = 18–28

DEMENTIA WORK-UP

Follow these diagnostic guidelines in response to patient failure on cognitive screening (e.g., Mini-Cog) or other signs of possible cognitive impairment.

History and Physical

- Review onset, course, and nature of memory and cognitive deficits (Alzheimer's Association Family Questionnaire may assist) and any associated behavioral, medical or psychosocial issues
- Assess ADLs and IADLs, including driving and possible medication and financial mismanagement (Functional Activities Questionairre and/or OT evaluation may assist)
- Conduct structured mental status exam (e.g., MoCA, SLUMS, MMSE)
- Assess mental health (consider depression, anxiety, chemical dependency)
- Perform neurological exam focusing on focal/lateralizing signs, vision, including visual fields, and extraocular movements, hearing, speech, gait, coordination, and evidence of involuntary or impaired movements

Diagnostics

Lab Tests

- Routine: CBC, lytes, BUN, Cr, Ca, LFTs, glucose
- Dementia screening labs: TSH, B12
- Contingent labs (per patient history): RPR or MHA-TP, HIV, heavy metals

Neuroimaging

- CT or MRI when clinically indicated

Neuropsychological Testing

- Indicated in cases of early or mild symptom presentation, for differential diagnosis, determination of nature and severity of cognitive functioning, and/or development of appropriate treatment plan
- Typically maximally beneficial in the following score ranges: MoCA 19-27; SLUMS 18-27; MMSE 18-28

Diagnosis*

Mild Cognitive Impairment

- Mild deficit in one cognitive function: memory, executive, visuospatial, language, attention
- Intact ADLs and IADLs; does not meet criteria for dementia

Alzheimer's Disease

- Most common type of dementia (60–80% of cases)
- Memory loss, confusion, disorientation, dysnomia, impaired judgment/behavior, apathy/depression

Dementia With Lewy Bodies/Parkinson's Dementia

- Second most common type of dementia (up to 30% of cases)
- Hallmark symptoms include visual hallucinations, REM sleep disorder, parkinsonism, and significant fluctuations in cognition

Frontotemporal Dementia

- Third most common type of dementia primarily affecting individuals in their 50s and 60s
- EITHER marked changes in behavior/personality OR language variant (difficulty with speech production or loss of word meaning)

Vascular Dementia

- Relatively rare in pure form (6-10% of cases)
- Symptoms often overlap with those of AD; frequently there is relative sparing of recognition memory

* The latest DSM-5 manual uses the term "Major Neurocognitive Disorder" for dementia and "Mild Neurocognitive Disorder" for mild cognitive impairment. This ACT on Alzheimer's resource uses the more familiar terminology, as the new terms have yet to be universally adopted.

Follow-Up Diagnostic Visit

- **Include family members, friends, or other care partners**
- Review intervention checklist for Alzheimer's disease and related dementias
- Refer to Alzheimer's Association Minnesota-North Dakota 24/7 Helpline at 1-800-272-3900 and/or the Senior LinkAge Line® at 1-800-333-2433

DEMENTIA MANAGEMENT

Diagnostic Uncertainty & Behavior Management

Refer to Specialist as Needed
- Neurologist (dementia focus, if possible)
- Geriatric Psychiatrist
- Geriatrician
- Memory Disorders Clinic

Counseling, Education, Support & Planning

Family Meeting
- Refer to social worker or care coordinator

Link to Community Resources
- Contact the Alzheimer's Association Minnesota-North Dakota 24/7 Helpline at 1-800-272-3900 or the Senior LinkAge Line® at 1-800-333-2433
- Provide After a Diagnosis[1]
- Provide Taking Action Workbook[7]

Stimulation / Activity / Maximizing Function

Daily Mental, Physical and Social Activity
- Provide Living Well Workbook[5] (includes nonpharm therapies for early to mid stage)
- Adult day services (mid to late stage)
- Sensory aids (hearing aids, pocket talker, glasses, etc.)

Safety

Note: Individuals with dementia are vulnerable adults and may be at a higher risk for elder abuse.

Driving
- Counsel on risks
- Refer for driving evaluation[2]
- Provide At the Crossroads[3]

Medication Management
- Family oversight or health care professional

Financial / Legal
- Encourage patient to assign durable power of attorney; elder law attorney as needed

Advance Care Planning

Complete Advance Care Plan
- Refer to advance care planning facilitator within system, if available
- Encourage completion of healthcare directive forms[4,6]

Medications

- Memory: Donepezil, rivastigmine patch, galantamine and memantine (mid-late stage)
- Mood & Behavior: SSRIs or SNRIs
- Avoid/Minimize: Anticholinergics, hypnotics, narcotics, and antipsychotics (not to be used in Lewy Body dementia)

Tools

Mini-Cog
- Public domain: www.actonalz.org/pdf/Mini-Cog.pdf
- Sensitivity for dementia: 76-99%
- Specificity: 89-93%

Montreal Cognitive Assessment (MoCA)
- Public domain: www.mocatest.org/
- Sensitivity: 90% for MCI, 100% for dementia
- Specificity: 87%

St. Louis University Mental Status (SLUMS)
- Public domain: http://medschool.slu.edu/agingsuccessfully/pdfsurveys/slumsexam_05.pdf
- Sensitivity: 92% for MCI, 100% for dementia
- Specificity: 81%

Measure/Assess IADLs
- http://consultgerirn.org/uploads/File/trythis/try_this_d13.pdf

Family Questionnaire
- www.actonalz.org/pdf/Family-Questionnaire.pdf

Mini-Mental Status Exam (MMSE)
- Copyrighted: www4.parinc.com/Products/Product.aspx?ProductID=MMSE
- Sensitivity: 18% for MCI, 78% for dementia
- Specificity: 100%

Note: The MMSE is not a preferred tool in memory loss assessment. Accumulating evidence shows it is significantly less sensitive than both the MoCA and SLUMS in identifying MCI and early dementia.

Dementia Management Resources

1. **After a Diagnosis**
   www.actonalz.org/provider-practice-tools
2. **American Occupational Therapy Association**
   myaota.aota.org/driver_search/index.aspx
3. **At the Crossroads: Family Conversations About Alzheimer's Disease, Dementia & Driving**
   www.thehartford.com/alzheimers
4. **Honoring Choices Minnesota**
   www.honoringchoices.org
5. **Living Well Workbook**
   www.actonalz.org/pdf/Living-Well.pdf
6. **Minnesota Healthcare Directive**
   www.extension.umn.edu/family/live-healthy-live-well/healthy-futures/health-care-directive/
7. **Taking Action Workbook**
   www.actonalz.org/pdf/Taking-Action.pdf

References: Provider Checklist

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INCREASING DISCLOSURE OF DEMENTIA DIAGNOSIS

Divergence Between Common Perceptions About Dementia Diagnosis and Published Data

Physicians have cited many barriers to diagnosing dementia, including doubts about the value of diagnosis given limited treatment options, concern over risk of misdiagnosis, and lack of knowledge of local dementia support services.[7] However, based on published data, perceptions that disclosure of dementia diagnosis is not preferred or causes psychological distress among individuals and family members should be challenged.

A majority of patients want to know if they have Alzheimer's Disease (AD)

A recent 5-country survey[9] examining public attitudes about AD found that more than 80% of all adults (N=2,678) and 89% of US adults (N=639) responded that if they had memory or confusion symptoms, they would go to a doctor to determine if the cause was AD. This US finding is consistent with previously published reports over the last 2 decades.[10,11]

> "In gaining knowledge and developing a treatment plan, individuals may realize that they can take an active role in managing the illness, enhancing a sense of self-efficacy where before they might have felt helpless."[4]

Most family members appreciate the benefits of diagnosis

Connell and colleagues surveyed 178 adults who had a family member with AD.

- More than 75% of family members rated the following benefits of diagnosis as being very or extremely important: 1) let family know what was wrong with relative; 2) allowed family to get information about AD; and 3) allowed family to plan for the future.
- Only 6% of all respondents strongly agreed that "it is easier to not know what the diagnosis is."

Diagnosis does not cause psychological stress in most patients and their families

Physician conjecture that a dementia diagnosis may lead to depression or even suicide has been reported.[12] Empirical findings on the issue are primarily limited to retrospective or review studies in populations with comorbid depression, a well-known risk factor for suicide.[13,14] To examine psychological stress, Carpenter and colleagues evaluated 90 individuals and their companions before a dementia evaluation and after dementia disclosure using the Geriatric Depression Scale (GDS) and the State-Trait Anxiety Inventory (STAI).[15]

- No clinically significant changes were noted in depressive symptoms in either the persons diagnosed with dementia or their companion (Figure 1).
- Anxiety decreased or remained unchanged after diagnostic feedback for most groups (Figure 2).

Figure 1: Depression[15]

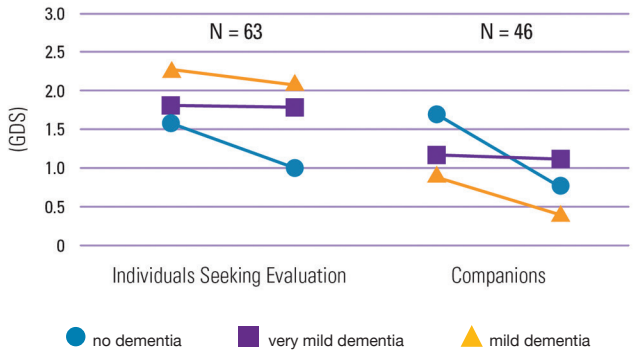
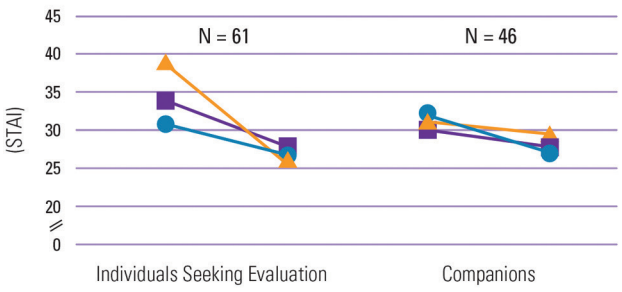


Figure 2: Anxiety[15]



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