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INDIANS TRANSFORMING
ALZHEIMER'S CARE TRAINING

Part Two: Setting a Plan for a Newly Diagnosed Patient

NATIVES ENGAGED IN ALZHEIMER'S RESEARCH

WE CHALLENGE THE STATUS QUO
IREACH
INSTITUTE FOR RESEARCH AND EDUCATION TO ADVANCE COMMUNITY HEALTH

DISCLOSURE

Barak Gaster, MD

No financial relationships with any commercial company which is relevant to this presentation to disclose.

I have no relevant financial relationships with any companies whose primary business is producing, marketing, selling, re-selling, or distributing any healthcare products or services which are used by or on patients.

Three Part Education Series

Part #1	Make a diagnosis of cognitive impairment
Part #2	Set a plan for a newly diagnosed patient
Part #3	Manage dementia as it progresses

Recap of Part #1

Part #1	Make a diagnosis of cognitive impairment
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Recap of Part #1

- We can do cognitive evaluations in primary care. Use the checklist in your EHR to help.
- Having family input (whenever possible) is essential for this evaluation.
- Combine the MoCA and the family input to make your assessment. Consider the AD8.
- Address brain health and key modifiable causes of mild cognitive impairment: Alcohol, sleep apnea, hearing loss, and medications.

Learning Objectives Today

- What are the types of dementia.
- Words to use in discussing the diagnosis.
- Talking about prognosis.
- When to refer to a specialist.

82 year old woman in your office for a wellness visit. Mentioned: “I‘ve been worried about my memory.”

You set up a next visit – with daughter – to evaluate cognition.

Daughter reports she’s repeating same questions over and over.

MoCA test is 21/30.

Still fully independent with activities of daily living.

At the end of cognitive evaluation the diagnosis was:

Mild Cognitive Impairment

“This is a lot to take in and work through. Let’s schedule another visit to review what this means and make a plan.”

Value of Making the Diagnosis

By coding the Mild Cognitive Impairment diagnosis, and putting it on the problem list:

You're helping patients get better, more connected care. You're helping the clinic better communicate.

Care becomes easier and better.

She now arrives for the follow-up visit after diagnosis was made

with her daughter

First: Set the Stage

- First, ask: “**Is it OK if I share what I think is going on?”**
- Acknowledge fear. But also share some hope, some optimism. “**This is good to know, to be more ready**.”
- Make it clear you will be providing ongoing support. We will have follow-up visits to maintain your health.

Int Psychogeriatr. 2021. PMID: 33726880.

Disclose the Diagnosis

Should you say "Mild Cognitive Impairment" or "Early Alzheimer's"?

- Many people have never heard of "Mild Cognitive Impairment"
- Major risk: falsely reassure ("Phew, thank goodness it's not Alzheimers!")
- Better to say: "I'm worried that you most likely have **early Alzheimer's**."
- But also don't scare people too much. If it's MCI: there's a 30% chance that over the next 6-8 years it may not progress.
- "There are things we can do to keep your brain healthy. If this does get worse, it happens very slowly. I think you have years of good living still to come."

Prognosis “no crystal ball”

- Progression is so variable.
- Usually very slow: 6, 10, 12 years.
- Reassure: “For years you’ll be very near to where you are now.”

Brain. 2015 May. PMID: 25693589

Supportive Language

"**By focusing on your brain health,** we will find ways to help you feel better, think more clearly, and find ways to still enjoy your life."

"**You will not have to walk this path alone**."

Living With Memory Loss. 2017. http://depts.washington.edu/mbwc/resources/living-with-memory-loss

Red flags: More urgent referral

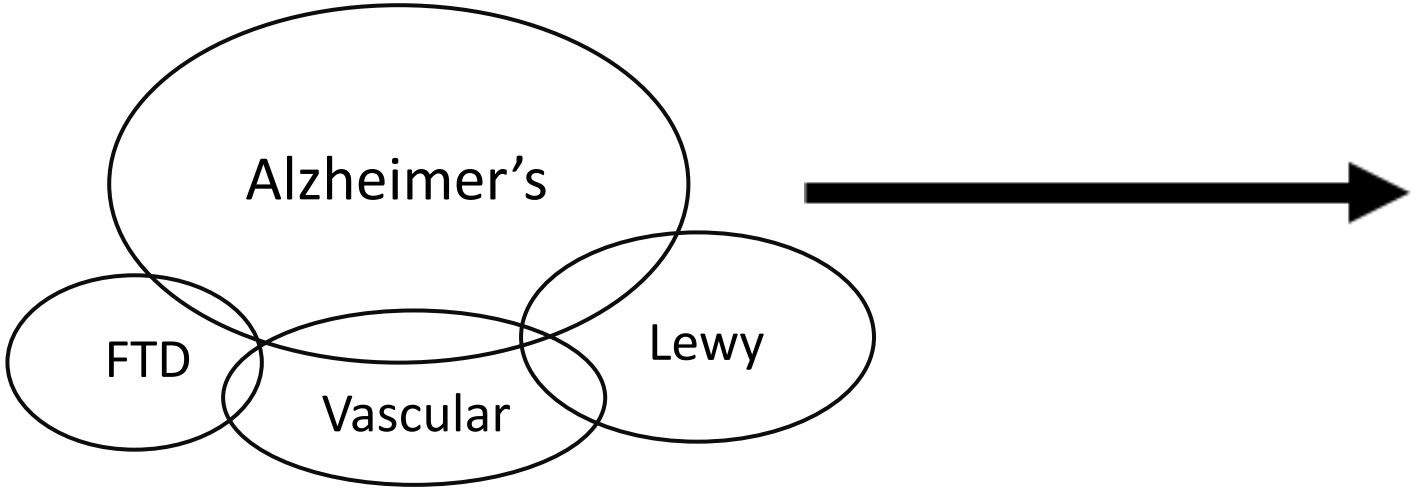
- ❑ Onset before age 65. (rare, unusual)
- ❑ More rapid onset (e.g. over less than 6 months).
- ❑ Other new neurological symptoms.
- ❑ Visual hallucinations (risk of Lewy Body Disease).

Normal aging ····· Mild cognitive impairment ····· Dementia

Slower remembering names. Why did I come up the stairs?

Asks the same question 30 minutes later. Can't complete complex task.

Lose of ability to do ADLs: e.g. cooking, driving, or dressing.

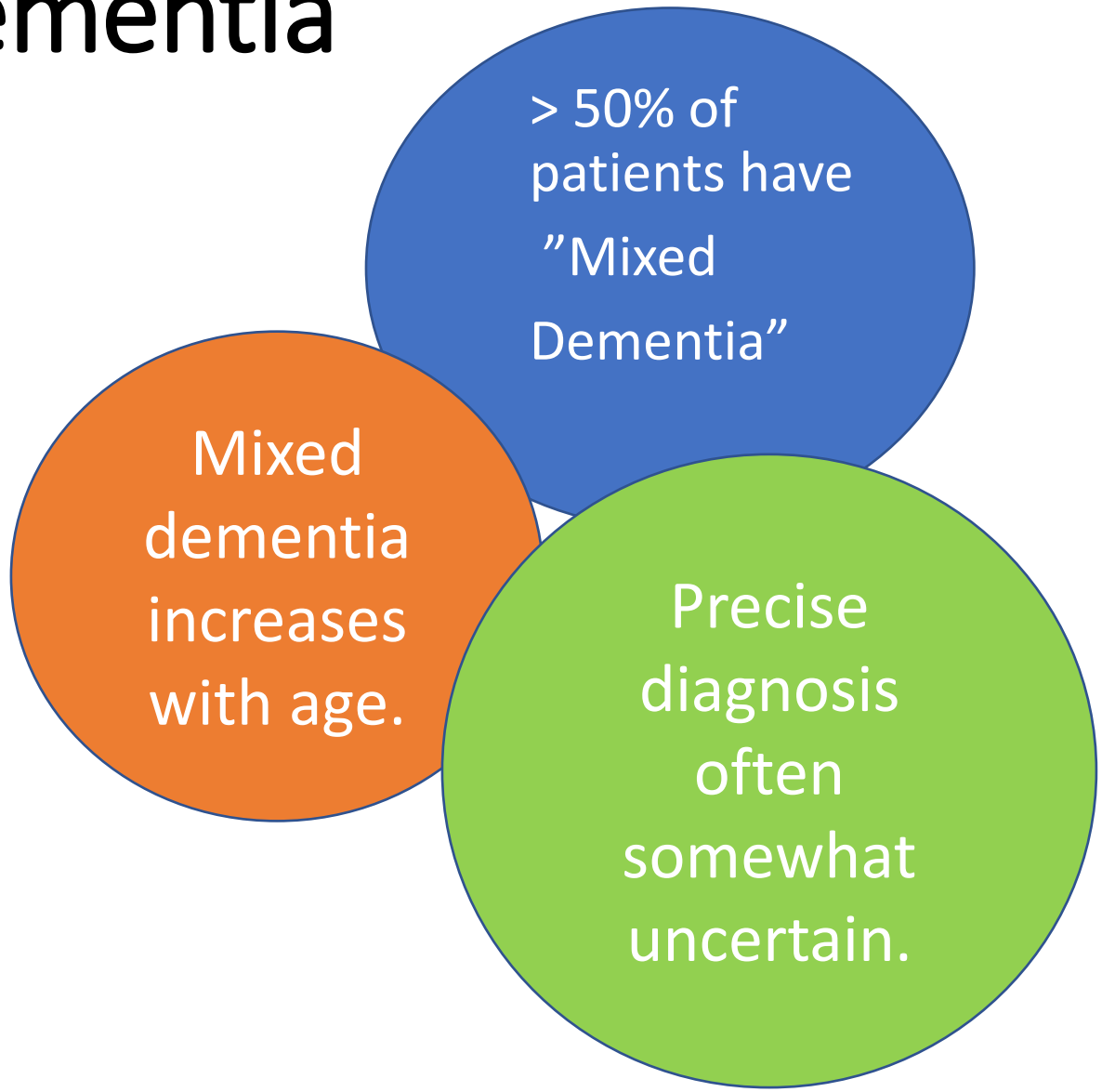


Types of Dementia

Alzheimer's	**80%**	Memory loss is main symptom.
Vascular	**10%**	Very often mixed with AD.
Lewy Body	**5%**	**Visual hallucinations.** Severe adverse reactions to antipsychotics. (Can cause severe Parkinsons.)
Frontotemporal	**5%**	**Young onset** (most are below age 65.) Personality changes, such as apathy, severe mood swings.

Alzheimers Dement. 2021 Mar;17(3):327-406

Mixed dementia

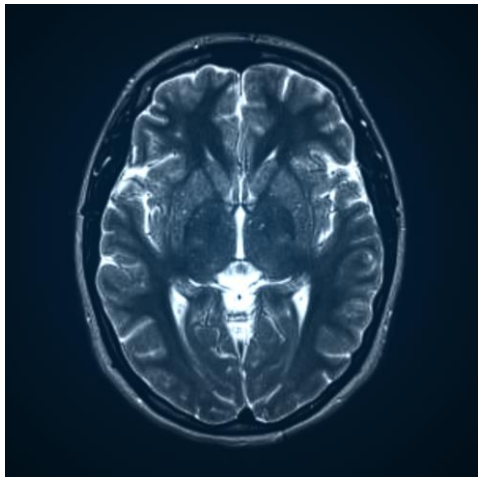


Visual Hallucinations

- Raises question of Lewy Body Disease (LBD)
- LBD often a complex determination.
- Has major treatment implications (if LBD, much higher risk from antipsychotics.)
- Patients with visual hallucinations should be referred to a specialist for diagnostic help.
- Routinely ask about Visual Hallucinations.

Clin Geriatr Med. 2018 Nov;34(4):603-615

A Word on Brain Imaging



- Not required for clinical diagnosis.
- But emerging as a general standard of care.
- Either non-contrast CT or an MRI are reasonable.
- No clear consensus for which is better.
- If urinary/ gait symptoms: concern for normal pressure hydrocephalus: order right away.

JAMA. 2019;322(16):1589-1599

Brain Health Checklist

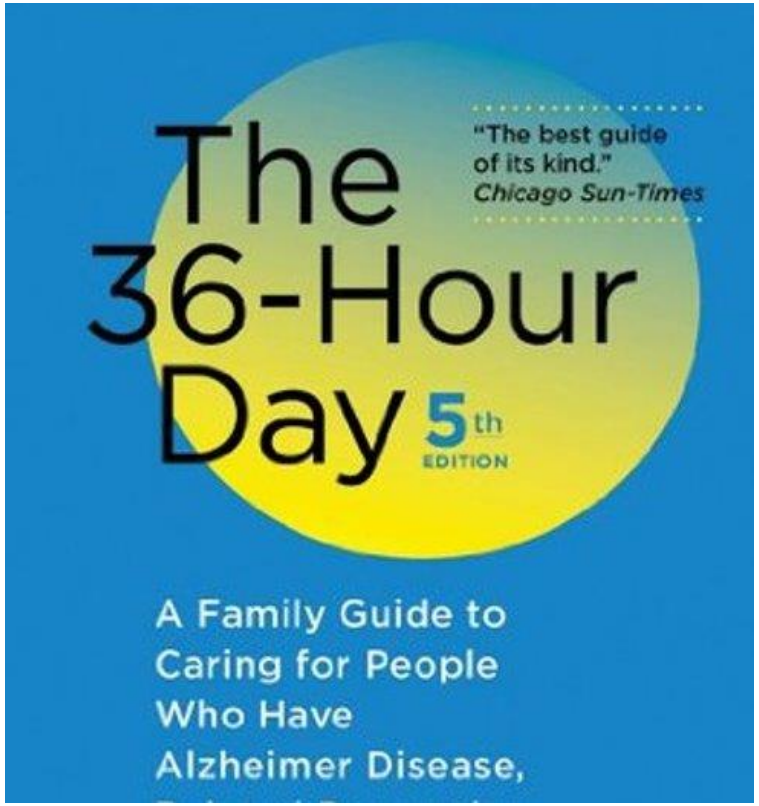
- ❑ **Alcohol (and drugs)**: Limiting to 0-1 drinks will help.
- ❑ **Med List**: Stop sedating or anticholinergics (ask re: OTC's)
- ❑ **Contributing Conditions**: Sleep apnea, hearing loss.
- ❑ **Exercise**: Daily brisk walks with a friend.
- ❑ **Connect to Community** Encourage social engagement.

Patient and Caregiver Resources

- Alzheimer's Association National Helpline: 800.272.3900
- 24/7 staffed by social workers, can give urgent advice.
- Free service. They can connect to tribal resources.

alzheimer's association®

Patient and Caregiver Support and Resources: *Caregivers*



- Acknowledge stress and anxiety.
- Appreciate the burden on caregivers.
- Sometimes a little bit of acknowledgement of the daily stress goes a long way.

EHR Checklist: Follow-up After Diagnosis

NAME OF TOOL: "Cognition - Newly Diagnosed Checklist"

Cognition - Newly Diagnosed Checklist

[ ] Counseled about diagnosis. (Consider saying "possible Alzheimer's" even if diagnosis is mild cognitive impairment.)

[ ] Offered possible specialist referral. (Refer soon if age <65 or visual hallucinations.)

Recommended Brain Interventions:
[ ] Regular exercise.
[ ] Reduce alcohol intake. (> 2-3 drinks per day affects cognition.)
[ ] Brain healthy diet. (Very similar to heart healthy diet.)
[ ] Advance care planning. (High value to setting durable power of attorney with backups.)

Follow-up Visits

- **Return Visits**: Every 1-2 months until checklist complete, then every 6-12 months.
- **DPOA-H:** Important to address as soon as possible while patient still has capacity: a key topic of next session (Part 3.)
- **Considering Medications:** For cognitive decline: a key topic of next session (Part 3.)

Takeaways

- Even if diagnosis is mild cognitive impairment, mention high concern for Alzheimer’s disease.
- Be honest about prognostic uncertainty, but include optimism. With support, people can live well with dementia.
- If visual hallucinations, then refer to a specialist sooner (possible Lewy Body Disease).
- Provide resources. Make clear follow-up plans.

Three Part Series

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Next session

- Medications to treat cognitive decline.
- Managing agitation and other behavioral symptoms of dementia.
- Communication tips for talking to someone with dementia.
- Advance care planning: for dementia.

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Questions and Answers

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