INTACT

INDIANS TRANSFORMING ALZHEIMER'S CARE TRAINING

Part One: Making a Diagnosis of Cognitive Impairment

NATIVES ENGAGED IN ALZHEIMER'S RESEARCH

WORKING TOGETHER FOR HEALTH EQUITY

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

What makes dementia hard?

- The diagnosis in early stages can be tricky.
- Tempting for patients and us to skip over it.
- But we can intervene meaningfully if we identify it earlier!

Diagnosis: a Path to Better Care

- Better communication. Better support. Improved involvement of family.
- Care for patient actually gets easier, less chaotic.
- Steps you can take now which can improve cognition.

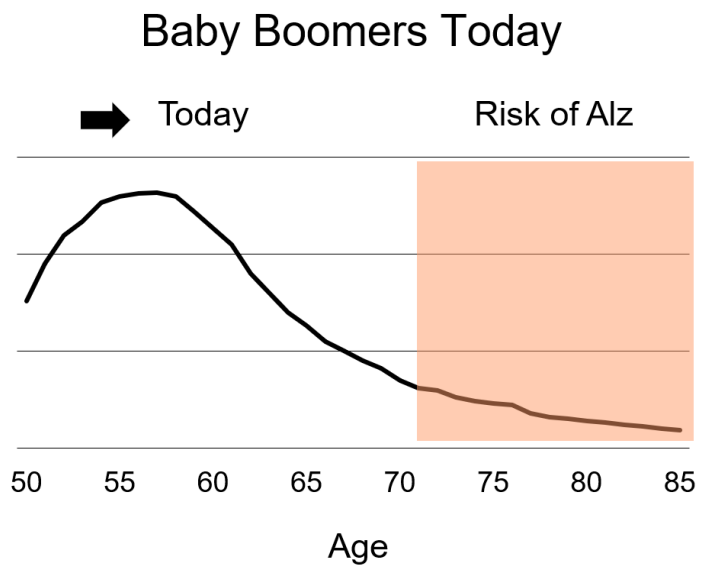
Dementia Shock Coming

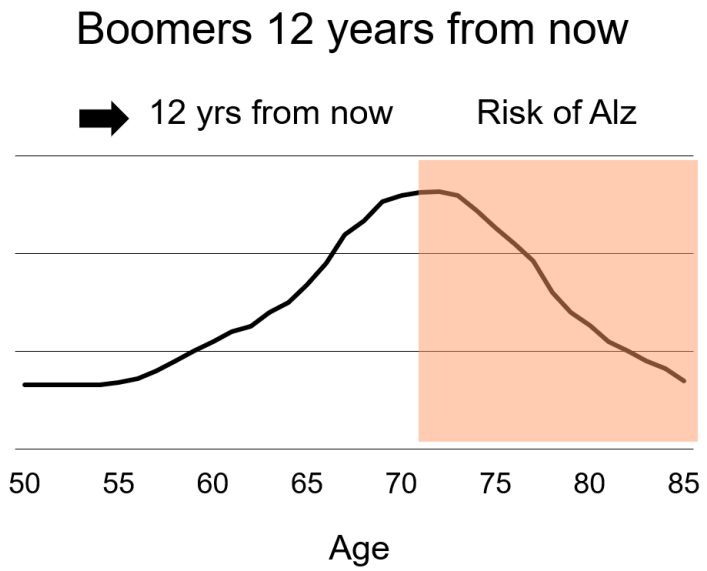
Now: 6.5 million Americans

35% of everyone over age 85

In the next 10 years: will ↑ 40%

Will **double** in the next 20 years





Alzheimers Dement 2023;19(4). DOI 10.1002/alz.13016.

Changes for American Indians

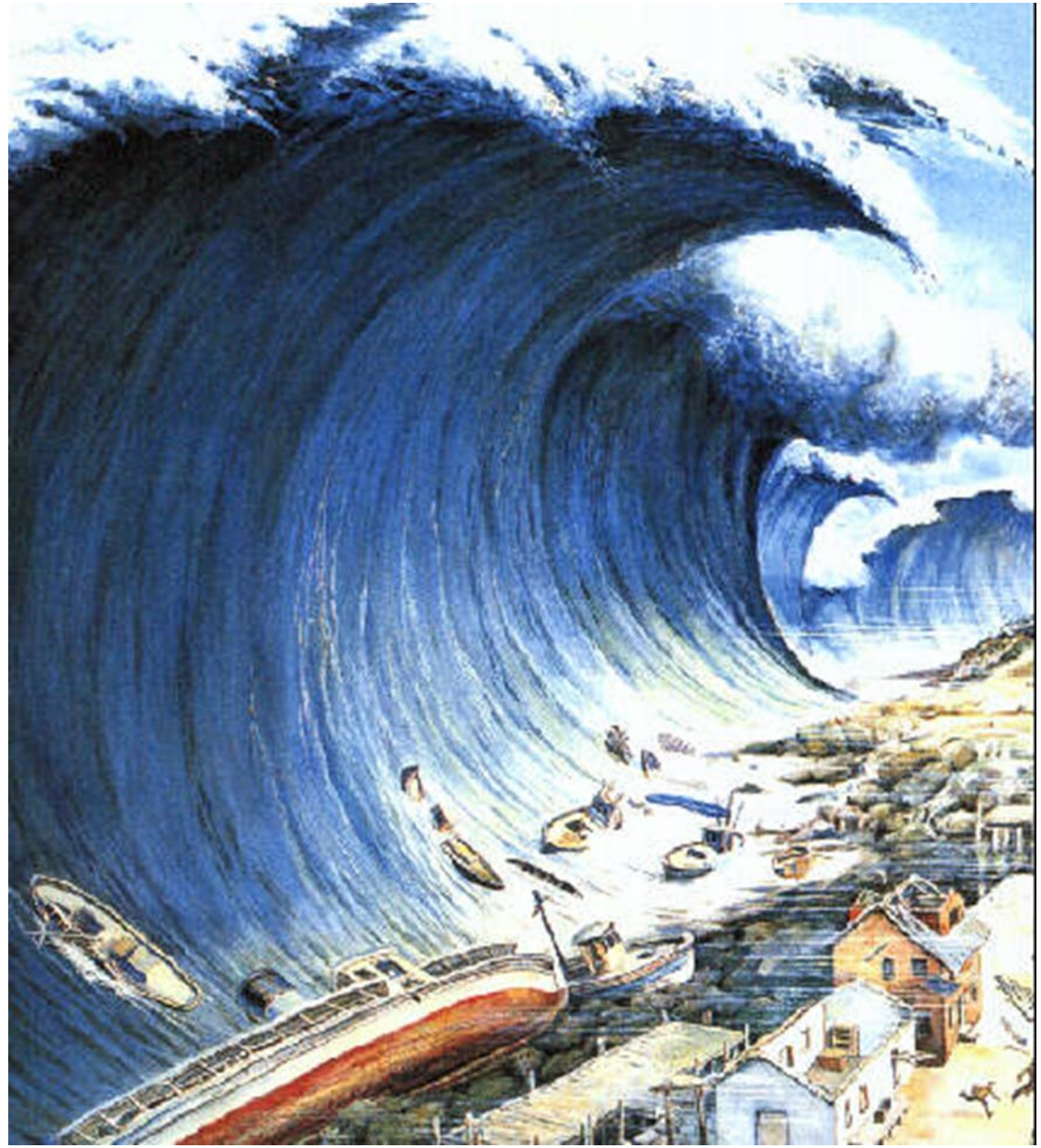
- American Indians (AIs) are living longer! Which is good news. Life expectancy for AIs has increased by 68% in the past 50 years.
- The number of American Indians over age 65 is expected to double in coming years.
- The number over 85 is expected to increase by 7-fold between now and 2050.

Alzheimer's Assoc and CDC, Roadmap for Indian Country. 2019

Challenge Ahead

- Having more older tribal members is a welcome thing. Immense value in their wisdom, experience, and contributions to American Indian communities.
- But huge challenge also: facing a skyrocketing number of American Indians with dementia.
- Coming problems for families, health clinics, tribal leadership, and community supports.

Alzheimer's Assoc and CDC, Roadmap for Indian Country. 2019



Learning Objectives

- Perform a cognitive evaluation.
- Identify reversible and contributing causes of cognitive impairment you can fix.
- Distinguish “Mild Cognitive Impairment” from Dementia

82 year old woman in your office for a wellness visit. Generally very healthy.

Hypertension, osteoarthritis.

Medications: Losartan, rare ibuprofen, rare zolpidem.

She happens to mention, “I‘ve been worried about my memory.”

Should you:

X A. Reassure her? You might say "Don't worry, it's so common and normal to get more forgetful with age."

X B. Automatically refer to a specialist ?

X C. Change course, try to do a cognitive assessment then and there (and then run 35 minutes late?)

D. Offer she schedule an efficient, follow-up visit with you, so you can evaluate this further.

~ BE AWARE

- Patient or family mention a concern.
- At an Annual Wellness Visit: there's a "yes" answer to a concern.
- Anyone in clinic (front desk, MA, PCP, etc.) notices confusion about appointments / medications.

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Hypertension, osteoarthritis.

Medications: Losartan, rare ibuprofen, rare zolpidem.

She happens to mention, “I‘ve been worried about my memory.”

Decide: Ask for a little more information.

Worrisome signs or just normal aging?

Normal: Misplacing keys. Why did I come up stairs?
Slower to remember word/ remember name, but later it comes to you.

Be aware of very worrisome signs:

1. **Forgetting things that just happened?**
   Such as: Repeating same question 30 minutes later.
2. **Harder to do complex task that used to be easy?**
   Such as: Trouble making a complex recipe or organizing documents.
3. **Suddenly unsure where you are in place you've been often?**
   Such as: Suddenly disoriented in a building you should know well.

Decide: Ask for a little more information.

Anyone with concern: it's good to offer a cognitive evaluation.

Framework to help you decide: Should you strongly insist? Or OK to give some reassurance, but still offer evaluation.

Normal: Misplacing keys. Why did I come up stairs? Or slower to remember a word or remember a name, but later it comes to you.

Be aware of far more worrisome signs:

1. **Forgetting things that just happened?** Such as: Repeating same question 30 minutes later.
2. **Harder to do complex task that used to be easy?** Such as: Trouble making a complex recipe or organizing documents.
3. **Suddenly unsure where you are in place you've been often?** Such as: Suddenly disoriented in a building you should know well.

https://www.alz.org/alzheimers-dementia/10_signs

Use a Warning Signs Document

- A 3-question one-pager patients can quickly fill out (MA can give or you give)

Worrisome Signs vs. Normal Aging

Available in your clinic!

Follow-up Questions About Cognitive Concerns

1. Have you noticed that you forget things that just happened more often?
   For example: Repeating the same question or the same story 30 minutes later.

YES	NO	UNSURE

2. Have you noticed it's more difficult to finish a complex task that used to be easy for you?
   For example: Cooking a complex recipe, organizing your documents, or putting up outdoor holiday lights.

YES	NO	UNSURE

3. Have you noticed being unsure where you are in a place you've been to many times?
   For example: Becoming disoriented on a usual route or in a building you know well.

YES	NO	UNSURE

Note: The following changes are <u>normal</u> as people age. They are less a cause for concern:

1. Forgetting the name of someone but remembering it later.
2. Noticing it takes longer to come up with a word you're trying to remember.
3. Misplacing keys or forgetting why you went upstairs, but later you find your keys or remember why you went upstairs.

Adapted from 10 Warning Signs of Alzheimer's: https://www.alz.org/alzheimers-dementia/10_signs

82-year-old woman in for an annual wellness visit.

She happens to mention, “I‘ve been worried about my memory.”

“I’m really having trouble keeping things straight. It’s really not right.”

You decide yes

Schedule a Cognitive Evaluation Visit

- Strongly encourage a **family member** or a close friend to come to that next visit.

Three Parts to a Dedicated Visit to Evaluate Cognitive Concerns

1. **Cognitive Checklist**: reversible causes and other factors you can fix.

2. **Assess cognitive function** e.g. with a MoCA.

3. **Get input** from a family member (e.g. with AD8).

BMJ. 2017;357:j2353

Cognitive Checklist

- ❑ **Labs** B12 + thyroid
- ❑ **Med list** Sedating/ anticholinergic meds
  Oxybutynin, Tylenol PM, benzodiazepines, Ambien
- ❑ **Alcohol** Even mild-to-moderate drinking can impair cognition once people > age 70
- ❑ **Conditions**: Sleep apnea, hearing loss, depression

Simple list: A **Text Template** soon available in your EHR!

Evaluating Cognitive Function

The assessment is a combination of…

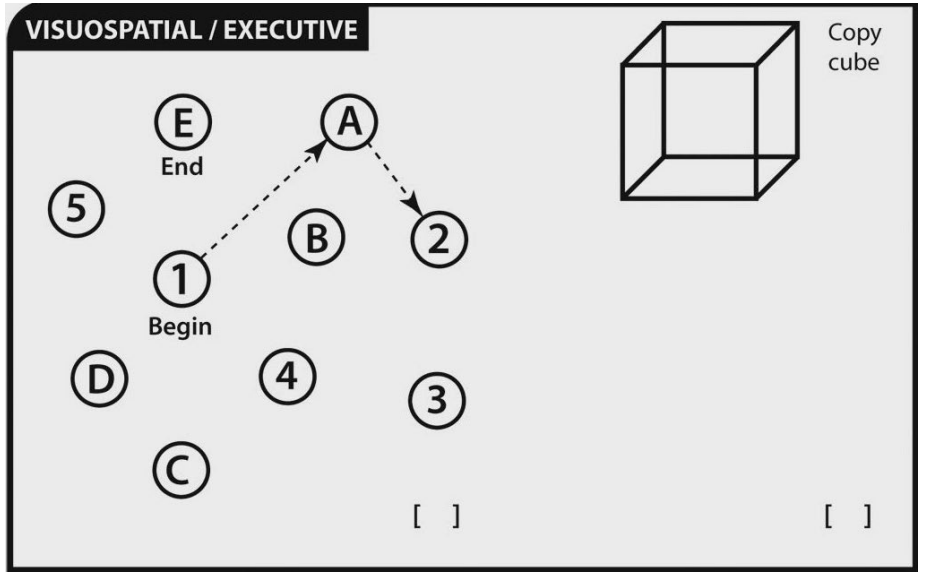
MoCA test + Family input

Ann Intern Med. 2019;171(5)

MoCA Montreal Cognitive Assessment

The best validated tool for identifying mild cognitive impairment in the primary care setting.

More sensitive than MMSE.



JAMA Intern Med. 2015 Sep;175(9)

Enter MoCA results in the EHR
Will soon have a MoCA field to do this

Essential : Make it a *result* to easily find and track

Best practice : Also save / scan the form in chart

Family / Observer Input

History questions to ask family member or a close friend:

- Are they repeating the same question 30 min later?
- Losing ability to do complex tasks that they once found easy to do? (e.g. complex recipe or outdoor lighting)
- Getting disoriented in a familiar place?

Remember these three questions (in the Quick Text)

Or use a validated 8-item form called: **the AD8** in your clinic!

Neurology 2005:65:559

Observer Input

AD8

validated tool to get input from a family member or close friend.

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	YES, A change	NO, No change
1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)		
2. Less interest in hobbies/activities		
3. Repeats the same things over and over (questions, stories, or statements)		

Neurology 2005; 65(4) p. 559-64

Delirium vs. Dementia

- MoCA not accurate during an acute illness.
- Transient drop in cognition common in the elderly. That's delirium, not dementia.
- Delirium post hospitalization can last weeks.
- However, delirium is a warning sign ➔

  Odds of dementia (either present now, or developing later) are much higher.

Int J Geri Psych 2021 Jul;36(7).

Putting It Together

MoCA result + Family input

MoCA less than 20 (out of 30)

+ Observer notes worrisome changes, and

+ Difficulty with *activities of daily living*

= **Dementia**

Putting It Together

MoCA result + Family input

MoCA intermediate 22-26 (out of 30)

+ Observer notes worrisome changes

But still able to dress and cook and clean house

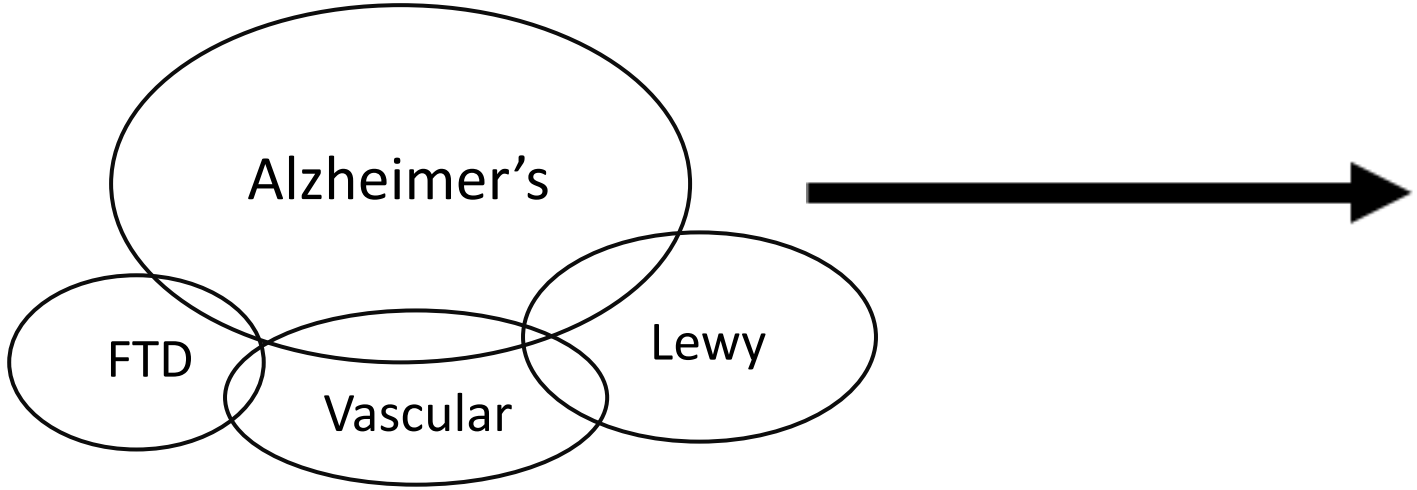
= **Mild Cognitive Impairment**

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.



Mild Cognitive Impairment (MCI)

- MoCA usually 20-26 plus worrisome changes noted

  But activities daily-living **intact.** This is a diagnosis of MCI

  (dementia: requires loss independence with activities)

- MCI is a diagnosis in-itself, not simply “early dementia”.

  In fact: 30% with MCI **don’t** progress to dementia.

  But: 70% do progress. Most people who have MCI do have early Alzheimer’s disease. (but not all)

- **MCI Actions!** Focus on brain health: reduce alcohol, wear hearing aids, sleep apnea.

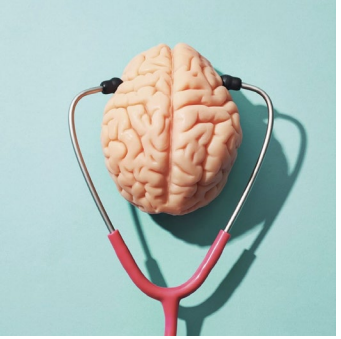
JAMA. 2014;312(23):2551-2561

If the MoCA plus the input from an observer is borderline

- Refer for more testing:
- Specialty referral (neurology or geriatrics), or
- Repeat evaluation in 6-12 months

Either way: address Brain Health Checklist

(also a new **Text Template** coming soon to your EHR)



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.
- ❑ **Cognitive Stimulation** Encourage social engagement.

Follow-up: set next steps

- **If evaluation looks OK**, discuss ways to keep brain healthy, consider repeat evaluation in 12 months.

- **If you found contributing factors:** counsel on reducing alcohol, wear hearing aids more, treat sleep apnea, treat depression.

- **If looks like mild cognitive impairment or dementia:**

  say: "This is a lot to take in and work through. Let's Schedule *another appointment* soon to review what this means and make a plan."

Make that appointment Encourage family to attend!

Set that plan. Don't diagnose and adios.

Takeaways

- We can do cognitive evaluations in primary care. Consider using a checklist.
- 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.

Next session

- What are the types of dementia.
- Words to use in discussing the diagnosis.
- Talking about prognosis.
- When to refer to Neurology.
- High value community resources.

Three Part Series

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Questions and Answers

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