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Early detection. Better care.

Adapting the Cognitive Health Assessment for Patients for Hearing/Vision Impairment, Limited Literacy/Illiteracy, and Non-English Speakers

Presenters:

Serggio Lanata, MD, MS

Anna Chodos, MD, MPH

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Introduction

Serggio Lanata, MD, MS
Associate Professor of Clinical Neurology,
University of California, San Francisco
Director of the UCSF Memory and Aging Center Community Outreach Program.

Anna Chodos, MD, MPH
Primary Care & Geriatrics Clinician
Associate Professor, UCSF Department of Medicine
Moderator, Executive Director, Dementia Care Aware

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Financial Disclosures

- All presenters report that they have no financial disclosures.

Dementia Care Aware Program offerings

Warmline:

1-800-933-1789

A provider support and consultation service that connects primary care teams with Dementia Care Aware experts

Trainings:

- Online Trainings
- Live Cognitive Health Assessment (CHA) trainings
- Monthly webinars
- "Dementia Care on Air" Podcasts

Interactive Case Conferences:

UCLA and UCI ECHO conferences

Practice change support:

- UCLA Alzheimer's and Dementia Care program
- Alzheimer's Association Health Systems

Learning Objectives

By the end of the webinar, participants will be able to:

- identify clinical approaches to conduct the CHA in non-English speaking patients
- identify clinical approaches to conduct the CHA in patients with sensory impairments
- identify clinical approaches to conduct the CHA in patients with low literacy

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- Podcasts

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UCLA and UCI ECHO conferences - *Sign up now!*

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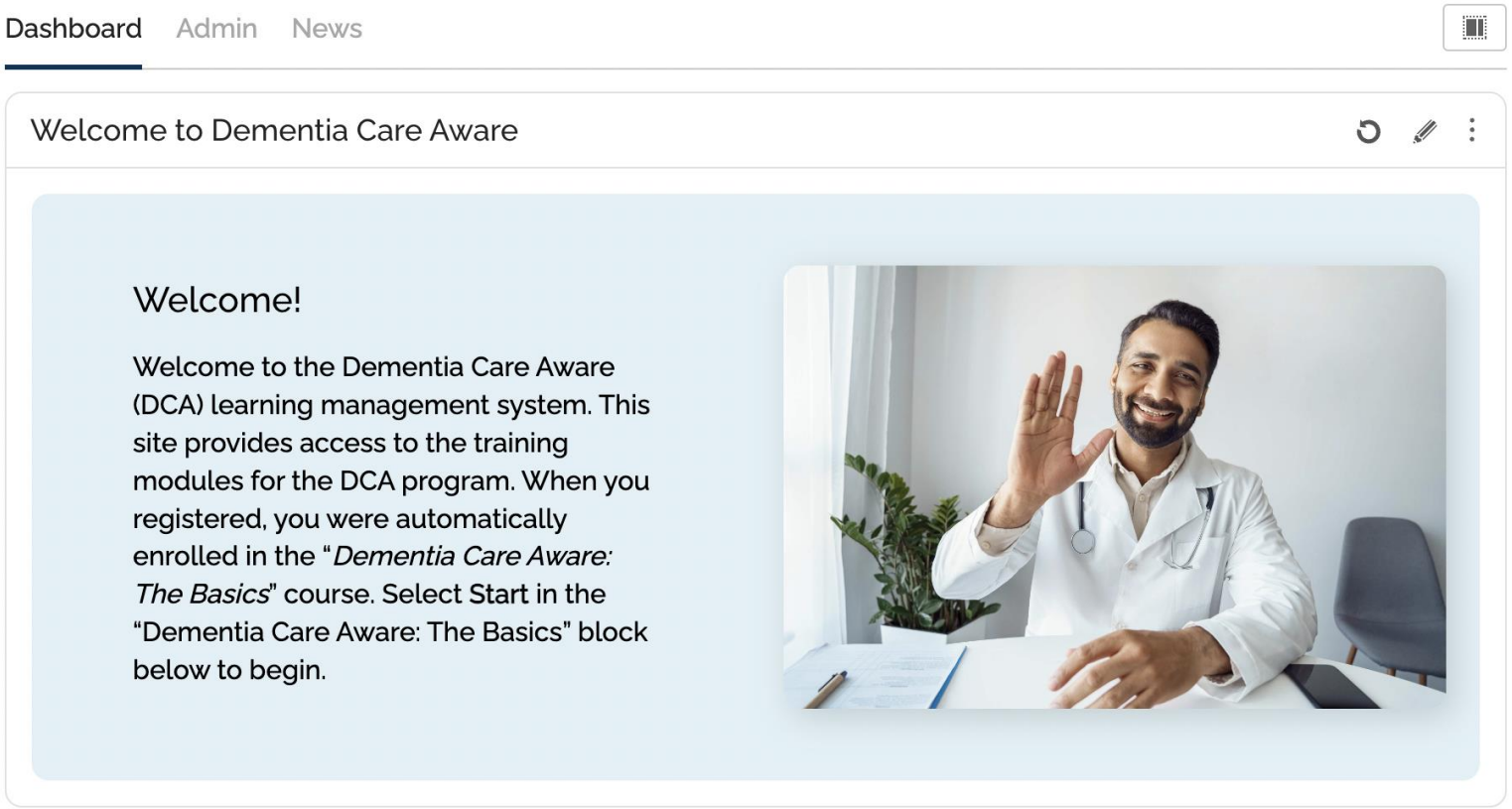
Our Training

dementiacareaware.org



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Screening for dementia: The CHA

Goal: screen patients age 65 and older annually (who do not already have a diagnosis of dementia)

Part 1	Part 2	Part 3
		
Take a Brief Patient History	**Use Screening Tools**	**Document Care Partner Information**

Allows you to start a brain health plan at the earliest detection of symptoms.

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The CHA - Part 1: Take Patient History

Example:

Have you or friends/family noted changes in your mental abilities?

The CHA - Part 2: Use Screening Tools

	Administered to the patient:	Administered to the care partner:
Cognitive Screening Tools	GP-COG: Part 1: General Practitioner assessment of Cognition (for the patient) Mini-Cog	Short IQ-CODE: Short Informant Questionnaire on Cognitive Decline in the Elderly AD-8: Eight-Item Informant Interview to Differentiate Aging and Dementia
Functional Screening Tools	ADLs/IADLs: Activities of Daily Living and Instrumental Activities of Daily Living	GP-COG Part 2: General Practitioner Assessment of Cognition (for the informant) FAQ: Functional Activities Questionnaire

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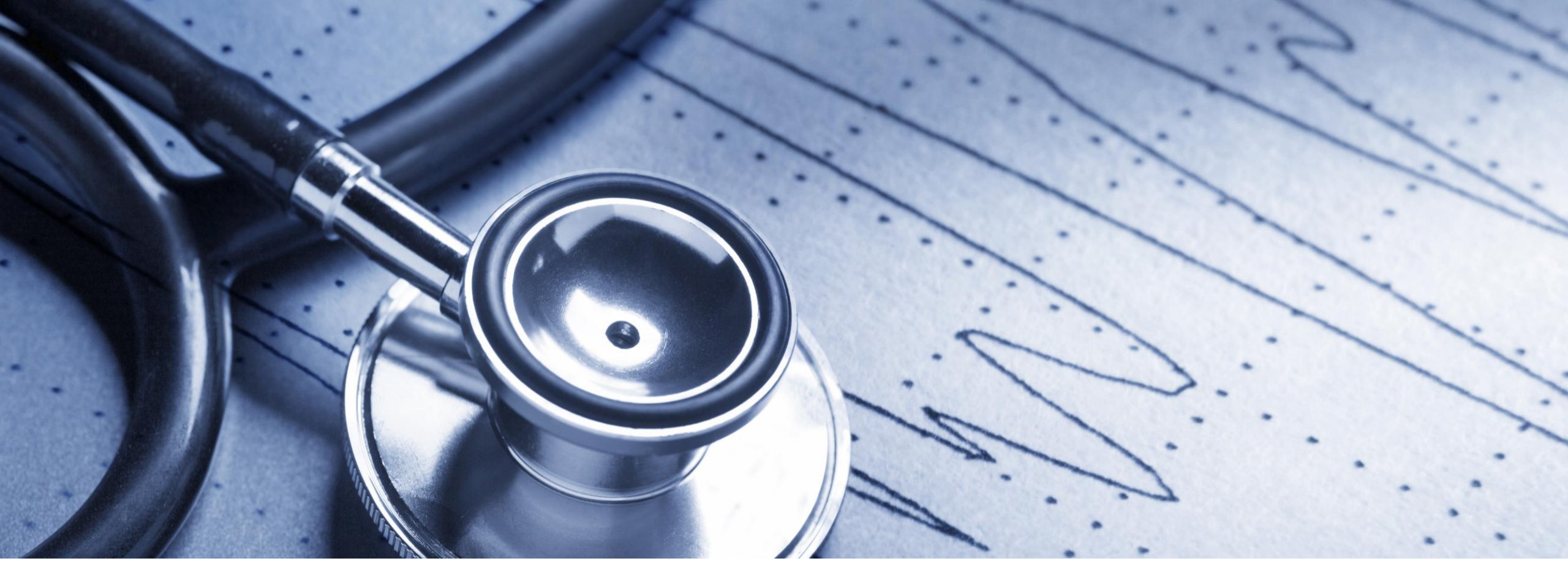
The CHA - Part 3: Document Care Partner

Examples:

Is there someone who supports you with your medical care? Someone who supports you with your daily care or needs?

Do you have a documented "Durable Power of Attorney for Health Care"?



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Epidemiology

How common are these “barriers” in older adults?

- **Hearing loss:** 1/3 people between 65-74, almost half of people 75+
- **Vision impairment:** adults 71 years and older = 27.8%
- **Intellectual and learning disabilities:** lifetime prevalence of Alzheimer’s Disease in people with Down syndrome is 50% (and life expectancy is 60 years)
- **Language diversity in older adults:** In California among those 65 and older, 37% speak a language other than English at home and 24% of those speak English "less than very well" (more than 1.4M people)

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These barriers affect care

The example of language:

- *"Even with my Vietnamese interpreter, some of the Vietnamese are ethnic Chinese. And so, Vietnamese is their second language. And so, yeah I don't know if I'm emphasizing this enough, but there are just considerable...Even in what I consider a really well-run culturally sensitive setting where we've got stable interpretation and long-term relationships, there continues to be some...subtle kind of cultural and linguistic barriers even within that." ~Dr. Bell*

www.cultureofmedicine.org/blog/language-and-culture-in-the-care-of-people-living-with-dementia

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Disabilities can affect the risk of dementia

New Study Links Hearing Loss With Dementia in Older Adults

Findings highlight potential benefit of hearing aid use

Published **January 10, 2023**

- 61% higher prevalence of dementia among the participants with moderate or severe hearing loss (vs. normal hearing)
- 32% lower prevalence of dementia in those with moderate or severe hearing loss who used hearing aids

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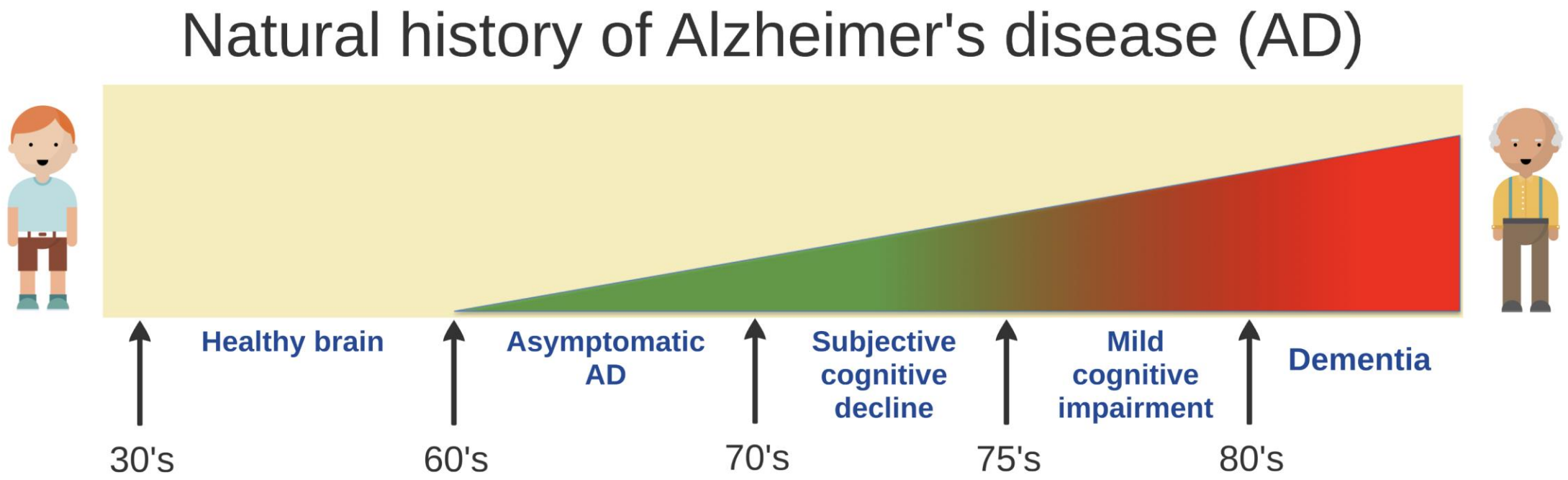
Huang AR, et al. Hearing Loss and Dementia Prevalence in Older Adults in the US. *JAMA*. 2023;329(2):171–173.

What is the overarching goal of the CHA?



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The DSM-5 classification of neurocognitive disorders

Box 2 | Diagnostic criteria for mild neurocognitive disorder

A. Evidence of modest cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual–motor, or social cognition) based on:
   1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a mild decline in cognitive function; and
   2. A modest impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.

B. The cognitive deficits do not interfere with capacity for independence in everyday activities (that is, complex instrumental activities of daily living such as paying bills or managing medications are preserved, but greater effort, compensatory strategies, or accommodation may be required).

C. The cognitive deficits do not occur exclusively in the context of a delirium.

D. The cognitive deficits are not better explained by another mental disorder (for example, major depressive disorder or schizophrenia).

Box 3 | Diagnostic criteria for major neurocognitive disorder (or dementia)

A. Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual–motor, or social cognition) based on:
   1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function; and
   2. A substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.

B. The cognitive deficits interfere with independence in everyday activities (that is, at a minimum, requiring assistance with complex instrumental activities of daily living such as paying bills or managing medications).

C. The cognitive deficits do not occur exclusively in the context of a delirium.

D. The cognitive deficits are not better explained by another mental disorder. Specify:
   - Without behavioural disturbance: if the cognitive disturbance is not accompanied by any clinically significant behavioural disturbance
   - With behavioural disturbance (specify disturbance): if the cognitive disturbance is accompanied by a clinically significant behavioural disturbance (for example, psychotic symptoms, mood disturbance, agitation, apathy, or other behavioural symptoms). For example, major depressive disorder or schizophrenia

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The DSM-5 classification of neurocognitive disorders

Box 4 | Subtypes with diagnostic criteria in DSM-5

- Alzheimer disease
- Frontotemporal lobar degeneration
- HIV infection
- Huntington disease
- Lewy body disease
- Parkinson disease
- Prion disease
- Substance and/or medication use
- Traumatic brain injury
- Vascular disease
- Another medical condition
- Multiple aetiologies
- Unspecified

"Major Neurocognitive Disorder Due to Alzheimer's Disease"

"Major Neurocognitive Disorder Due to Frontotemporal Lobar Degeneration"

"Major Neurocognitive Disorder Due to Parkinson's Disease"

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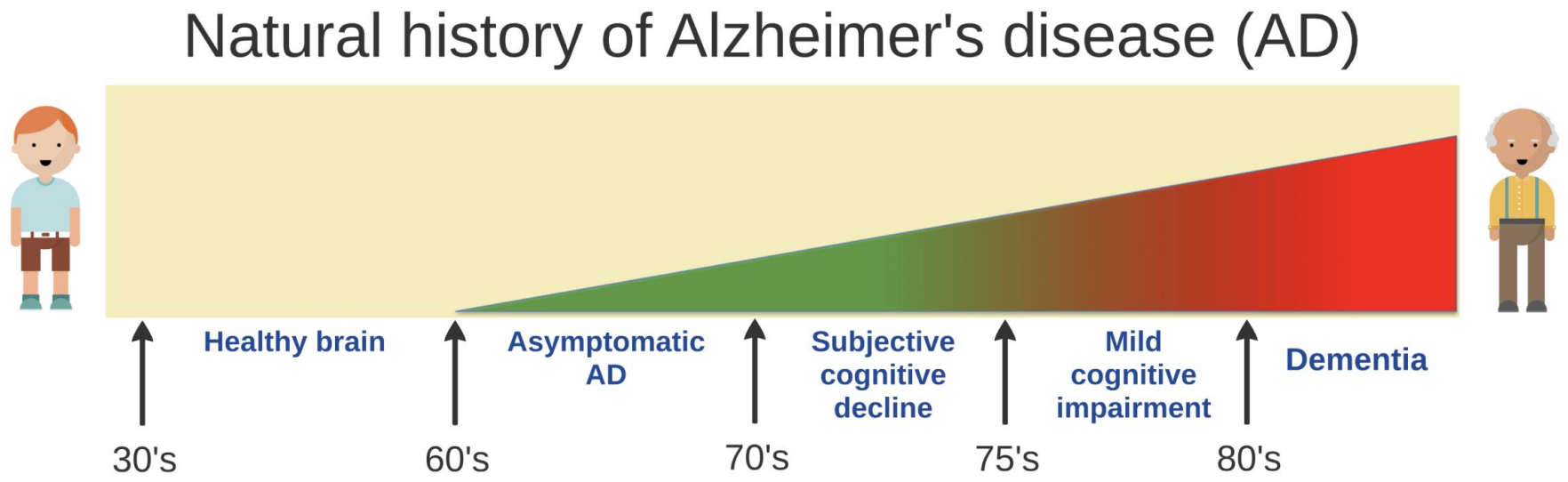
What is the overarching goal of the CHA?



The CHA is a flexible process (not a rigid protocol) that can help you determine if your patient is cognitively healthy, has MCI (Mild Neurocognitive Disorder), or has Dementia (Major Neurocognitive Disorder).

Principal Components of the CHA

1. History
2. Cognitive health screen
3. Functional abilities

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Completing the CHA in a state as diverse as California will sometimes be challenging!

A 67-year-old male, Spanish speaking, presents to clinic with concerns of memory loss in the setting of a 4-year history of homelessness and a longer history of debilitating arthritis of the hips and knees.

He has 3 years of elementary school education.

He doesn't have relatives in California and does not have close friends.

He cannot remember the last time he saw a health provider.

General Strategies for Adapting the CHA for Various Patients

Three General Strategies

1. Establish a baseline
2. Be flexible
3. Use referrals

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Strategy #1: Try to Establish a Baseline

This is a great strategy when you can't get trustworthy data on a first visit. Change your approach to prioritize functional abilities and change over time.

- What has changed from the patient's perceived cognitive baseline—is there a decline? If so, is the patient concerned about this decline?
- How is the patient functioning day-to-day, and is there a decline relative to their perceived functional baseline? Why is this decline occurring?

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Strategy #2: Be Flexible

- Before doing the CHA, think of individual patient characteristics and/or circumstances that would influence the CHA and adjust for them accordingly.
- Not all components of the CHA need be done in one visit, it's ok to spread them over two or more visits.
- The brief cognitive screen that you're most comfortable with will not work for every patient.
- Sometimes, you will need to modify your approach to collecting data pertaining to functional abilities.

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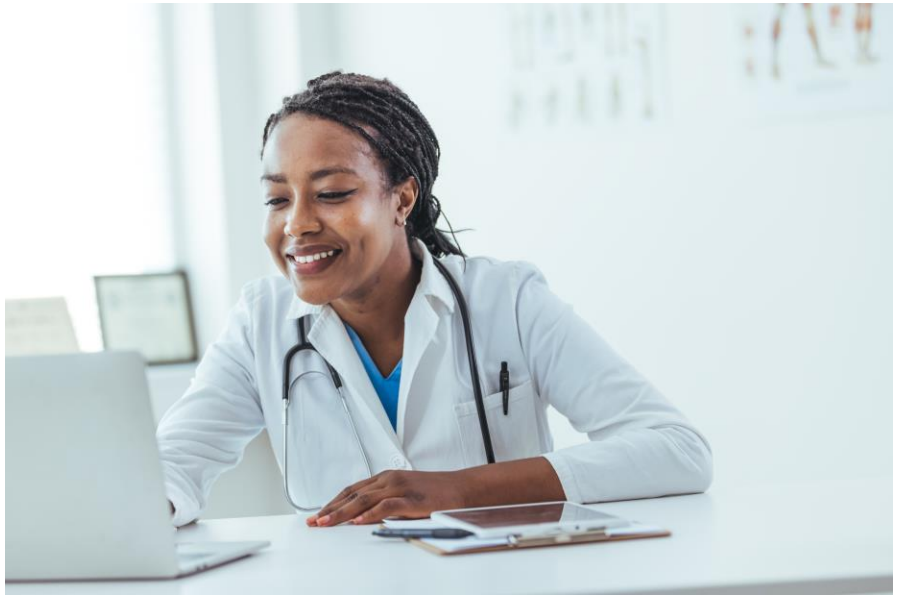
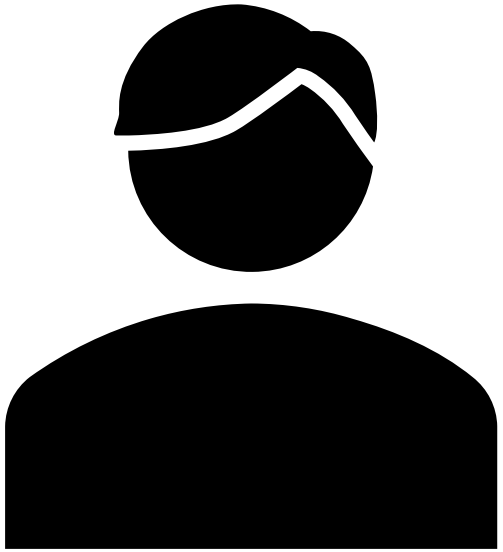
Strategy #3: Use Referrals

- If your patient's characteristics/circumstances make it impossible for you to conduct a CHA, even with adaptations, consider referral to a specialist for further evaluation.
- If you don't trust your adapted version of the CHA, and you are clinically worried about your patient, consider referral to a specialist for further evaluation.
- If you think your adapted CHA is yielding reliable data, but you are seeing signs and symptoms that concern you or are uncommon, consider referral to a specialist for further evaluation.



Case



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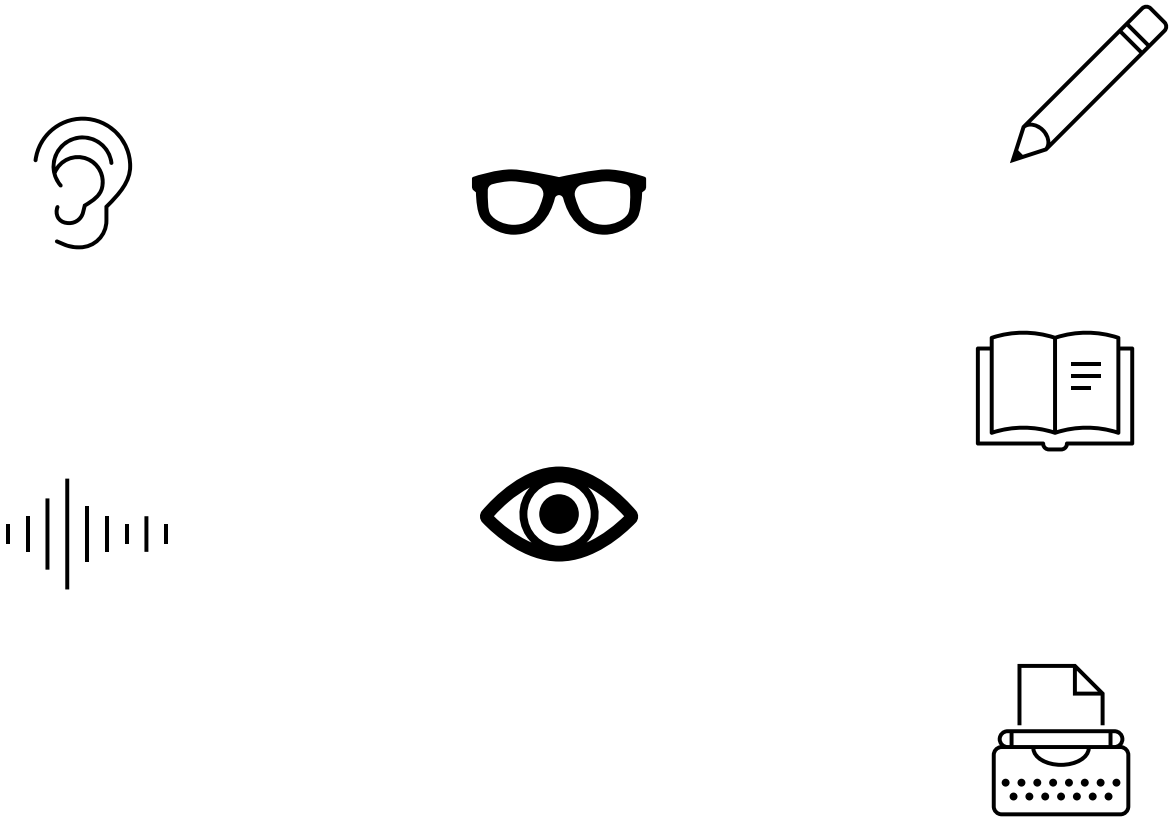
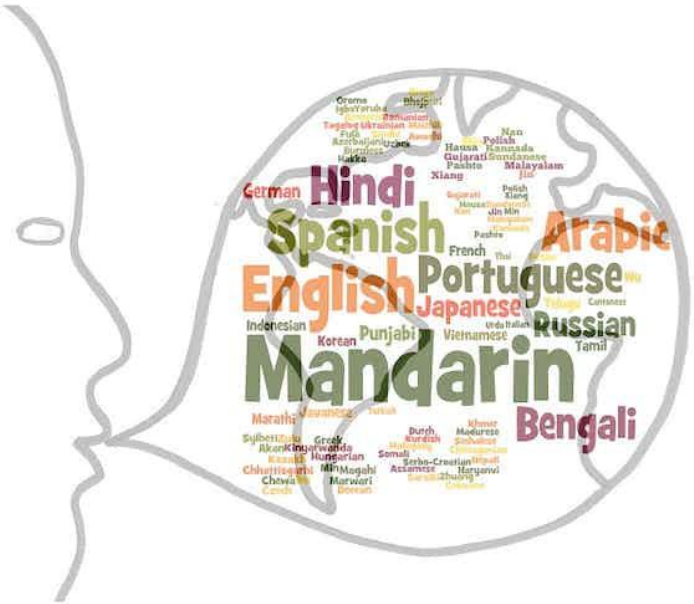
Barriers for Conducting the CHA





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Tips to Counter Common Barriers: Communication Issues

- If your patient doesn't speak English or has a speech/language impediment that hinders verbal communication, you will need an interpreter or an assistive device of some kind.
    - Family members or friends can't be used as interpreters, but they can help with getting the history, a functional screening, and to document care partner information.
    - In the absence of family and close friends, a health provider may be able to help with getting the history and functional screen.

Tips to Counter Common Barriers: Communication Issues

If there is time before the check-up, see about arranging for:

- an interpreter who speaks the patient's native language
    - consider in-person interpretation, which allows for more communication strategies.
- an intermediary or Deaf interpreter for a deaf or hard-of-hearing individual
- a Deaf-blind interpreter for a deaf or blind patient
- a portable hearing aid (e.g., pocket talker) for patients who are very hard of hearing

Tips to Counter Common Barriers: Communication Issues

- When a patient doesn't speak English, work with an in-person or remote certified interpreter.
- Don't use English speaking family members or friends as interpreters for cognitive screening, but these close contacts can be interviewed for collateral history regarding the patient's cognitive health and functional abilities.
    - Sometimes you may need to rely on other health providers for collateral history.
- Use the screening tool in the patient's native/preferred language. There is a list of available languages for the suggested CHA tools in the course conclusion.

Tips to Counter Common Barriers: Learning Challenges

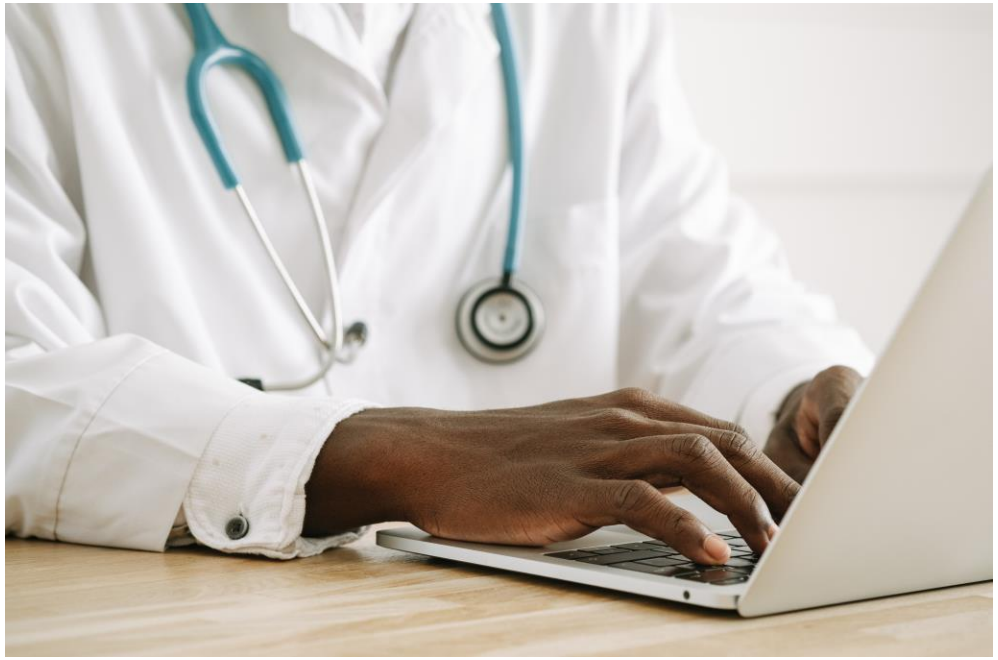
Some general strategies for patients with learning challenges, either due to developmental differences or low educational attainment:

- There are cognitive screening tools designed for patients with low literacy.
- Drawing a clock, for example, may be extremely challenging at baseline for someone with low literacy (false positive).
- When in doubt, refer to a neuropsychologist for a formal evaluation of cognition.
- Pick one test that is reasonably appropriate. Use this test as a baseline. Repeat annually to monitor change.

Tips to Counter Common Barriers: Learning Challenges

With learning challenges, a few tips to follow are:

- For a functional screening, conduct the ADLs/IADLs screen as normal, and run through the questions as usual.
- For a cognitive screening, adjust by using tools that can be administered verbally or with pictures, such as a memory tool to establish a cognitive baseline.



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Tips to Counter Common Barriers: Physical Disabilities

Physical disabilities that precede the onset of cognitive decline may challenge your ability to conduct a CHA because these may affect ADLs/IADLs independently from cognitive impairment.

- Before starting the CHA, get to know your patient's baseline physical challenges and how they have coped.
- The CHA is intended to capture functional changes due to cognitive decline, not due to known preexisting physical disabilities. Document what you can on the first CHA and then look for changes to the baseline you establish. What's the delta, or the change in the patient's "normal" or baseline functional abilities?

Tips to Counter Common Barriers: Unstable Living Conditions

If a patient's living situation isn't stable – they're unsheltered, for example – you should still conduct the CHA, but you'll need to be careful when asking about functional abilities as most available functional screening tools were designed to assess housed individuals.

Tool	Languages	Not available	Cons
COGNITIVE			
Mini-Cog	https://mini-cog.com/mini-cog-in-other-languages/ Arabic, Chinese, English, Korean, Russian, Spanish, Tagalog, Vietnamese	Can be used in translated form: Armenian, Hmong,	
GP-COG	http://gpcog.com.au/index/downloads Arabic, Cantonese, English, Korean, Russian, Spanish, Vietnamese	Tagalog	Sometimes the address used for memory is strange to people because of the towns and streets.
Informants			
IQCODE	English; possibly available in Chinese, Korean, Spanish.	Arabic, Armenian, Hmong, Russian, Tagalog, Vietnamese	5-item Likert scale which is hard for people with lower literacy.
AD-8	English, Chinese, Korean, Spanish, Tagalog.	Arabic, Armenian, Hmong, Russian, Vietnamese	
FUNCTION			
FAQ	English, Spanish	Needs more searching- Arabic, Armenian, Chinese, Korean, Hmong, Russian, Tagalog, Vietnamese	
ADLs and IADLs (not technically a tool but a list of abilities to ask about)	Arabic, Armenian, Chinese, English, Korean, Hmong, Russian, Spanish, Tagalog, Vietnamese		

Take Home Points

- Be practical!
  - Do what you can.
  - Consider function above cognitive performance.

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Thank You

Have more questions? Get answers through our Warmline @ **1-800-933 – 1789** or our support page!

Here are some examples!

What do I prioritize after a positive cognitive health assessment?

Is the cognitive health assessment covered for patients over age 65 who have Medicare but not Medi-Cal?

Can I use the cognitive health assessment with a patient with limited literacy?

Open your phone camera and scan the QR code to submit questions:

Or visit: www.dementiacareaware.org

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How to Claim Continuing Medical Education (CME) Credit?

Step 1. Please complete our evaluation survey using the link provided in the chat and a follow-up email after the webinar. For this activity, we provide CME and California Association of Marriage and Family Therapists (CAMFT) credits. Please select the correct link based on the credit type you are claiming.

Step 2. Upon completing the evaluation survey, please scan a QR code or link to claim credit:

- Use your phone camera to scan a QR code and tap the notification to open the link associated with the CME portal.
- Enter you first name, last name, profession, and claim **1 CE credit** for the webinar.

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Register for Our May Webinar

- **Presenter:** Steve Huege, MD, Geriatric Psychiatrist, Program Director for the Geriatric Psychiatry Fellowship Program at UC San Diego School of Medicine
- **Topic:** A Deeper Dive into Adapting the Cognitive Health Assessment for Patients with Serious Mental Illness
- **Date and Time:** May 2, 2023, 12-1 p.m.

Scan to Register

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